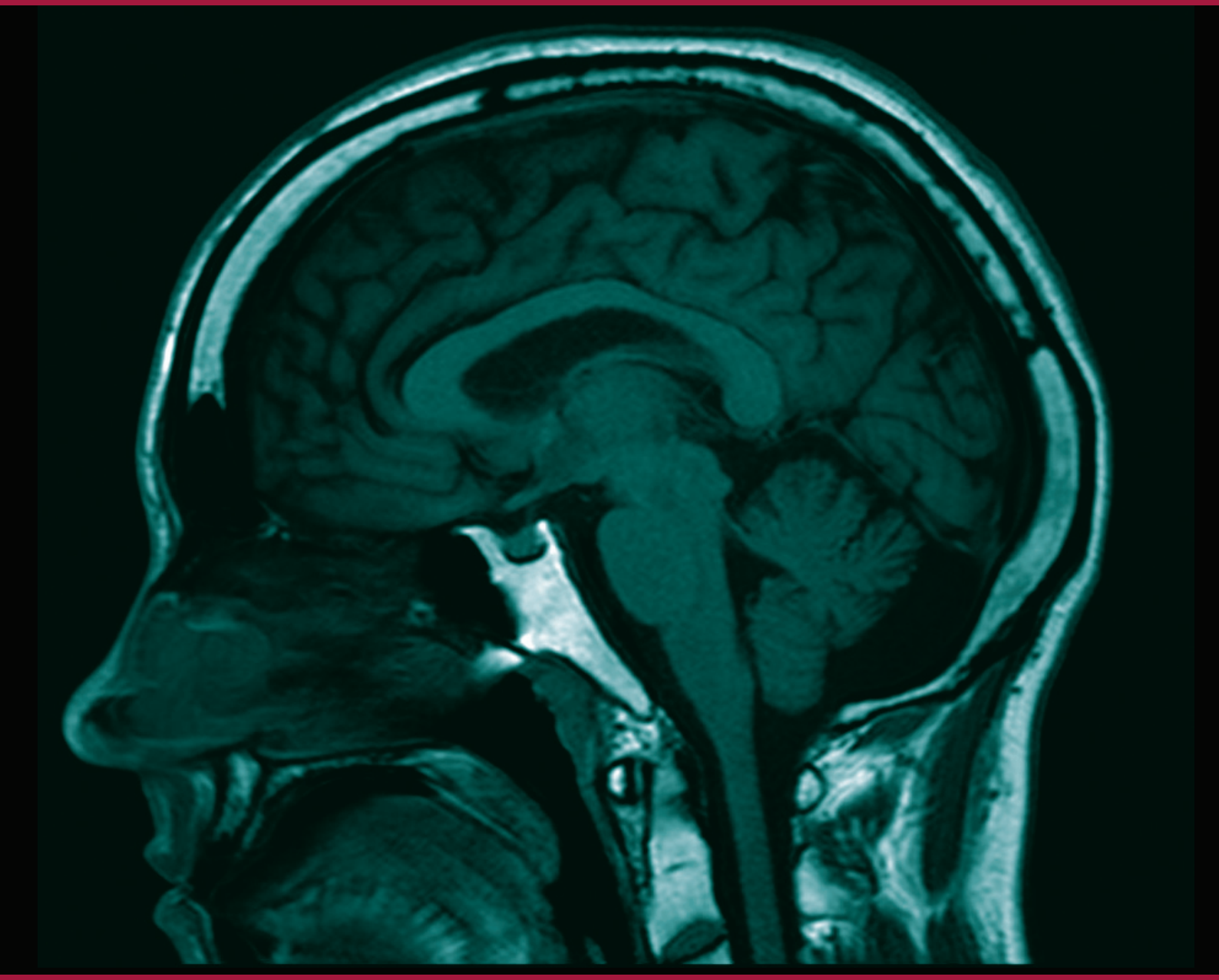
Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA



Annual Report 07/08

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Preface

This report presents Capital & Coast District Health Board's (C&C DHB) performance for the year 1 July 2007 to 30 June 2008. It outlines our progress against our Statement of Intent (SOI) 2007/08, and provides a detailed account of how funding has been allocated.

The SOI is an annual statutory document which determines our course of activities for the financial year including milestones and measures. The SOI includes long term goals and annual accountability objectives.

Chairman's Foreword

The 2007/08 year was a profoundly challenging time for Capital & Coast District Health Board. At the end of the first five months the then Chief Executive Officer Margot Mains resigned and Dr Derek Milne was appointed Acting CEO until April 2008. I acknowledge the contribution they both gave to the overall management of the DHB's activities during the 2007/08 year.

In November many new Board members were elected and appointed, including my own introduction as Chair. I would like to pay tribute to my predecessor as Chair, Dr Judith Aitken, for her diligence and hard work in that role.

Most significantly, the 2007/08 year saw us facing a number of issues which asserted the clear need for introspection and change.

When the Board and I were appointed half way through the financial year, there was a clear brief to resolve the issues which have prevented C&C DHB from performing at its peak. Some of the major issues included:-

- The lack of any cash reserves. Over the past six years deficits and interest payments on the New Regional Hospital have totalled $92 million, which has depleted all the cash reserves the DHB has had

- Addressing the underlying deficits, for such deficits undermine the ability for management to have best practice in systems and procedures, and undermines the support the clinicians require in providing services to the community

- Appointing a new CEO, in this case a vital appointment of an experienced leader to manage the changes required in the DHB

- Completion of the new Wellington Regional Hospital and a successful transition of the old hospital facilities to the new facilities

To comment further on these issues:-

- A new CEO was appointed. Mr Ken Whelan, is a New Zealander who has held many positions in health over 30 years, including roles as CEO of Northland DHB, and of Townsville Hospital in Australia

Since Ken arrived in April 2008, significant changes have been made to the DHB executive, including a new Chief Operating Officer, Director of Planning & Funding, Director of Finance, Head of Information Technology and Head of Change Management

- In terms of the deficit the 2007/08 year should be put behind us. However in future years the deficits relate to two different issues:-

  a) Operational Deficit

  This relates to operational issues within the DHB, including failure to collect all revenues owed to it, undercharging of certain aspects of inter-district flow, inefficiency in some systems within the provider arm, inadequate use of resources, including Kenepuru and technology.

  The operational deficit is budgeted at nearly $33 million for 2008/09; however the current operational plan has been formulated to return the DHB to operational breakeven within the next three years.

  b) Regional Hospital Deficit

  This relates to the way major capital projects such as the new Wellington Regional Hospital, are financed in the Public Health Sector. The relevant factors around this deficit are as follows:-

  - The cost of the new hospital is estimated at $377 million
  - The DHB funds this amount from two sources; from debt, which attracts interest; and from capital from the Crown which attracts a capital charge. Effectively the facility is fully debt funded
  - Depreciation and financing costs amount to approximately $50 million per annum ongoing. The DHB will require deficit support funding to meet these costs in the foreseeable future

The challenge around capital projects is shared by any DHB undertaking a major capital project. It does not diminish the exceptional standard and utility of the new Wellington Regional Hospital which is due to open early in 2009.

Despite the challenges and issues C&C DHB continued to make progress in many of its key priority areas during 2008 and this is reflected throughout this Annual Report.

I began this foreword by acknowledging that 2007/08 was a very difficult year, but we face the future with optimism, and a strong sense of determination.

In many ways the organisation which begins the 2008/09 years is a very different one from that which began the previous year. It has fresh personnel in many senior roles, and with that a set of fresh approaches to the substantial challenges which lie ahead.

I give thanks to fellow Board members for their contribution and support of the DHB, to Committee members who have brought voices from the community to our deliberations, and to the CEO and his management team for their professionalism and enthusiasm in dealing to the matters before us.

Most importantly however is the Board's and my own thanks to the clinicians and the staff of this organisation – and the many hundreds of GPs, nurses, physiotherapists, pharmacists and others in the community who we fund to provide services – who are a dedicated and caring group of people who have devoted their careers to caring for the health needs of this community.

Sir John Anderson
Chair
Capital & Coast District Health Board

Introduction from the Chief Executive Officer

As Sir John Anderson rightly pointed out in his Foreword, the challenges facing this DHB are not inconsiderable, but nor are they insurmountable.

Since I first arrived at C&C DHB in April 2008 I have been sincerely impressed by the calibre of those who work here – and I feel particular tribute must be paid to our clinicians. Many of them have been working in recent years in cramped clinical spaces – a necessary step to make space for the construction of the new Wellington Regional Hospital. Yet, almost without exception, their spirits are up and their focus is on delivering quality care to the patients.

The new hospital is an undoubted asset, and quite a massive improvement on the facilities which have existed in this region in the past. I feel that both clinicians and patients are entitled to this improved standard of facility, especially those who have turned a blind eye to the inadequacies of our current accommodations.

But it isn't just a matter of bricks and mortar. The new buildings will also allow our clinicians to deliver care in a more contemporary way, and to bring our services on a par with many of the best in the western world.

A small example – the new approach to ward-layout will allow us to bring all of our inpatient neurosciences – neurology, neurosurgery, stroke services and ophthalmology – together for the first time. That sort of co-location helps to promote excellence – with allied services working in close co-operation – as compared to the current hospital where they have been scattered across different floors in different buildings.

As part of the shift to this new facility we are developing and adopting up-to-date models of care, which will help to optimize co-operation for clinicians and enable better care for patients.

One of my first moves as the new CEO was to realign the management structure – in order to empower clinicians to take a lead role in decision making. One thing I have learned in my 30 years working in health is that often the best solutions come from those with hands-on experience in the delivery of care.

I also used the management restructure to group services more logically – so that, for example, surgery, anaesthesia and operating theatres are now together in one directorate instead of being split across different groups. That structure – which divides our hospital and health services into seven directorates - is now fully in place, and gives us a solid platform for adapting to the changes and challenges ahead.

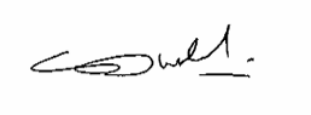
Of course the hospital is only one part of the equation, and true gain in health will require a co-ordination of services across the whole spectrum of health need. The DHB maintains a close relationship with hundreds of health services, GPs, pharmacists and other health professionals in the community. Through our Planning & Funding Directorate we contract these private providers to deliver services at all levels – from Maori Health to mental health, from fitness campaigns to vaccination. The old adage about an ounce of prevention being worth a pound of cure – while outdated by the shift to metrics – still holds true.

Nowhere is this more evident than in the gains which have been made in our relationship with the primary sector in the past year. Co-ordinated work alongside PHOs saw immunisation targets for two-year-olds exceeding our targets. We are also working alongside PHOs to design an effective plan for the treatment of long-term conditions in the community, and in a separate workstream to improve the integration of primary and secondary care. Collaboration with primary care providers and organisations in the past year has also enabled us to increase the availability of GP services in some of the high priority locations within our DHB area.

These types of co-operative approaches with the primary sector have a significant role to play in managing illness, creating wellness, and preventing the existing illnesses of patients from deteriorating to the point where hospital care is required.

I am confident that C&C DHB can become one of the top five DHBs in New Zealand within the next three years. I made a vow to deliver that in my first day as CEO, and that's a vow I intend to stand by. We may not have everything fixed by then, but in terms of key issues such as the quality of care, and our focus on the needs of patients, we are determined to deliver.

I want to close by thanking our staff, and those in the private health sector who work alongside us in the delivery of care to this region. Your commitment and expertise give us a solid base to build on, and that will be crucial as we turn the corner to improved performance in the years ahead.



Ken Whelan
Chief Executive Officer
Capital & Coast District Health Board

About Capital & Coast District Health Board

C&C DHB receives around $590 million to improve, promote, and protect the health of people and communities and ensure health services are available to its communities either by contracting with external providers (such as PHOs, GPs, primary care practices/services, NGOs, rest homes, dentists, pharmacists, and Maori and mental health providers) or providing the services directly (eg hospital services)

Currently about 270,000 people reside in Wellington, the Porirua basin, and the Kapiti Coast including Waikanae.

The people of the Wellington region enjoy, on average, better health and longer life spans than people in other districts of New Zealand.

We assess the health status of the population and determine what funds should be directed to preventing illness and early intervention of illness (via primary health and public health services) while continuing to provide and improve existing hospital and other specialist services.

C&C DHB is the leading provider of specialist tertiary services for the upper South and lower North Islands for a population of about 900,000.

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

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

C&C DHB operates two hospitals; Wellington and Kenepuru supported by the Kapiti Health Centre and other community based services. It is a major employer in the Wellington region with about 3,200 full-time equivalent staff

A new Wellington Regional Hospital in Newtown is scheduled to open in March 2009.

The health of our population

The people of the Wellington region enjoy, on average, better health and longer life spans than people in other districts of New Zealand. We receive only 5.93 % of the health funding budget, because of our relative affluence and younger age, yet we have almost 7 % of New Zealand's population.

This means the DHB has less money than other District Health Boards, per person, to spend on health services. Our challenge is to ensure our population receives the services it expects and deserves.

Our DHB spans three territories; Wellington City, Porirua City and part of Kapiti Coast District. The combined population of these three districts, at the time of the 2006 Census was 266, 658. Sixty eight per cent of the district's population resides in Wellington city, 18 % in Porirua and 14 % in Kapiti.

The Māori and Pacific populations are younger than other groups in the district, and comprise more children and fewer elderly people. Our Health Needs Assessment identified several characteristics of the district's population that influence the planning and funding of health services. These characteristics include;

- the district's population is ageing –the number of people year 65 is predicted to increase by about a third in the next 10 years
- life expectancy is rising
- 81.5 % of the district population sits in the 'other' ethnic group (non-Māori, non-Pacific), 10.5 % are Māori and 8 % are Pacific

The three territories we serve are unique:

- Kapiti has a high number of people over 60 and a low percentage of people aged 15-45. The combined Māori and Pacific ethnic groups make up just over 10 % of the population and comprise mainly children and younger adults. Most of the population lives in NZDep 3 to 7 areas (relatively less deprived)
- Around 23 % of Porirua's population is Māori and 20 % Pacific people. These populations are young compared to other groups. Porirua has a high percentage of children under 15 and lower than national average of people over 60. About 37 % of the Porirua population live in NZDep 10 (most deprived area) and 29 % live in NZDep 1 areas (least deprived)

- The Māori and Pacific populations of Wellington are relatively small, with very few people over 60. The region has a high percentage of people aged 20-40, and a low number of people in the under 15 and over 60 groups. Almost 90 % of the population is in the 'other' ethnic grouping. About 26 % of the population lives in the least deprived areas (NZDep 1)

The Health Needs Assessment has identified the following priorities, which support the priorities of the various strategies of the Government.

- Māori health and Pacific health – both populations carry a higher burden of disease compared to 'other' ethnic groups
- Cardiovascular diseases - the greatest burden of disease representing 40 % of the district's mortality
- Cancer - second greatest burden of disease representing 28 % of the district's mortality
- Diabetes - morbidity and mortality from diabetes is rapidly increasing and Māori and Pacific people are disproportionately affected
- Population health - income, employment, housing are determinants of health status which affect smoking, nutrition, obesity and physical activity rates
- Suicide - death by suicide increased by 15 % between 1988 to 2000 and suicide accounted for 19 % of all youth (15-24 years) deaths in the district
- Respiratory health - respiratory conditions account for 15 % of hospitalisations in the 1-19 years age group
- Disability - 1 in 5 New Zealanders has a disability. This is the same rate for Māori. Pacific people have a 1 in 7 disability rate. Sixty percent of people with disabilities have more than one disability
- Child and youth health - especially respiratory diseases, hearing, oral health, avoidable hospitalisations, cellulitis and teenage pregnancy
- Health of older people - the population aged over 65 years is predicted to increase by over 10 % in the next five years, and by 2021 will account for over 15 % of the district's population
- Mental health

Further details of our population profile and Health Needs Assessment can be found on our website www.ccdhb.org.nz:

C&C DHB's Strategic framework

Our Vision	**Better health and independence for people, families and communities.**		
Our High Level Outcomes (Health Goals)	**Reduced 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

Our Achievements during 2007/08

In this section we highlight our achievements as they align with the goals and strategies from our District Strategic Plan (DSP) 2006-2012. These goals and strategies are:

Goal 1: Reducing disparity in health status.
Goal 2: Reducing incidence and impact of chronic disease.
Strategy 1: Focusing on people through integrated care.
Strategy 2: Managing our money.
Strategy 3: Working with communities.
Strategy 4: Developing our workforce.
Strategy 5: Supporting and Promoting Healthy lifestyles
Strategy 6: Updating our hospitals

Goal 1 - Reducing disparity in health status

While our Health Needs Assessment shows the district population has a high health status on average, compared with the rest of New Zealand, there is still a significant group with a low health status.

Our Board has prioritised reducing illness and disease among populations with high health needs such as Māori, Pacific peoples, refugees and migrants, and those living in socially deprived areas.

We undertook the following initiatives to address these disparities:

- Progressing the Primary Health Care Strategy
- Improving Māori health status
- Improving Pacific peoples health status
- Improving the health of children and young people
- Progressing the NZ Disability Strategy
- Implementing the Health of Older People Strategy by 2010

Progressing the Primary Health Care Strategy

- We strengthened the relationship between C&C DHB and district PHOs and their Boards Two PHO appointees have attended most of the DHB's Executive Management team meetings
- We made excellent progress on immunisation coverage for two year olds achieving 84 % against a target of 80% in the 07/08 year. We achieved this through improved immunisation coordination in Primary Health Organisations (PHOs), appointing a DHB immunisation facilitator and by investing and reconfiguring funding for outreach immunisation services

- We undertook joint PHO and DHB planning for long term conditions management and palliative care and appointed a long-term conditions programme manager
- We established a joint primary/secondary interface clinical governance group with a goal of improving primary care/secondary service integration
- We established an avoidable admissions working group. The group's first project is to enable community treatment of cellulitis to reduce hospitalisation for this condition
- We increased general practice capacity for the Kapiti region and developed a Pacific Health Service GP service in Porirua
- We invested in increasing general practice in both the South Wellington region (Pacific Health Services, Wellington) and in Kapiti – 500 people have recently enrolled in Kapiti

Improving Māori health status

Our Māori Partnership Board (MPB) continues to have a strong relationship with the C&C DHB. The MPB focuses on ensuring DHB members are well briefed on Māori health initiatives. We:

- published Te Plan II 2007-2012 (Māori health action plan) with implementation progressing
- developed a local marketing strategy aimed at encouraging uptake of healthy lifestyles
- opened the adolescent oral health service at Ora Toa PHO in January 2008 improving access to oral health services for Māori between 13-18 years
- worked with Maori Well Child providers to standardise their data capture and improve reporting
- supported our Māori providers to offer community services such as, physical activity programmes, a healthy housing project, support for vulnerable youth and further HEHA programmes
- facilitated greater information sharing on Māori health initiatives, achievements and "good news stories"

We are working hard to increase the capacity and capability of our Māori health workforce. Key achievements include:

- eleven of 15 Māori health workers graduating in the NZIM (New Zealand Institute of Management) Diploma in Frontline Management
- supporting forum for Māori Nurses and Māori allied health professionals
- completed Tikanga Best Practice guidelines for the Hospital and Health services
- provided Cultural Awareness training for C&C DHB board and staff

C&C DHB have led two projects on behalf of the DHBs in the Central Region. Key achievements include:

- thirty one from 45 Māori health workers graduating in the NZIM (New Zealand Institute of Management) Diploma in Frontline Management
- a central region marketing project aimed at encouraging rangatahi into the health sector

Improving Pacifica peoples health status

- We invested in a general practice service in Cannon's Creek to help improve access for high need Pacific people. Facilities are currently being fitted out and the workforce trained to support the service which is scheduled to open September 2008
- Our Pacific Strategic Action Plan II (2007-2012) was approved by the DHB Board in December 2007 and will inform investments as funds are available
- We recently established a Pacific advisory group to the DHB Board. This group will ensure a focus is maintained on reducing disparities for our Pacific population
- We supported our Pacific providers to offer community services such as 'suitcase clinics' for arthritis, heart failure, respiratory illness and screening
- Our primary care providers work closely with our Pacific Unit in the hospital and with Regional Public Health to maintain our excellent rates for ambulatory sensitive hospitalisations and population avoidable hospitalisations in young children
- The First Pacific Diabetes Society was launched in Wellington.
- We worked with vulnerable youth in Wellington (FBI Gang) and Porirua (Streets Ahead 237 and Hope City). Key areas for focus are incorporated into the 2008/2009 District Annual Plan

Improving the health of children and young people

- Our Child Health Strategy has been developed in partnership with the sector and will be shared with the community during the review of our District Strategic Plan in 2008/09
- Our ambulatory sensitive hospitalisation rates for all children under 5 years are decreasing annually
- We are making steady progress in reducing low birth-weight babies, improving breastfeeding rates and improving early parenting support though our smoking cessation programmes and Healthy Eating Healthy Action (HEHA) initiatives. (See promoting healthy lifestyles section)
- We developed an ante-natal HIV screening strategy with Hutt Valley and Wairarapa DHBs which will be rolled out during 2008/09
- We finalised our Youth Action Plan, and our youth health advisory group meets bi-monthly. Support has been provided for a youth programme in Porirua as part of an inter-agency approach to improve youth health and wellbeing, and reduce youth offending
- We are optimistic the Ministry of Health will approve the child and adolescent oral health business early in 2009

Progressing the NZ Disability Strategy

- We continue to work to ensure staff are responsive and competent in dealing with the needs of people with disabilities
- Up to 5,000 people attended our Hearing Expo during Deaf Awareness Week in September 07 with 1,750 people taking a hearing test. Many thanks to the Wellington City Council, ACC and the audiology community
- We held blindness and sight impairment, Deaf Culture and NZ Sign Language and generic disability workshops which were well attended. Evaluation results are positive
- Our Disability Support Advisory Committee held a workshop to review the Promoting Participation strategy and ensure it stays aligned with the New Zealand Disability Strategy
- Our GP services report some access improvements and upgrades including acquiring new premises, accessible parking, and hi-lo plinths

Implementing the Health of Older People Strategy by 2010

- We transitioned our existing home based support service clients onto restorative packages of care through the Care Coordination Centre
- Our Care Coordination Centre is managing referrals to ACC's falls prevention programmes. We are also working with ACC to trial the InteRAI assessment tool which will minimise assessment duplication and enable a joint funding approach
- Our Mental Health Services for Older People project is developing a proposed service structure and development plan for services for people with a combination of needs of ageing and mental illness
- We continue taking a proactive, preventative approach to our home based support services including assessing the needs of carers as necessary

Goal 2 - Reducing the incidence and impact of chronic disease

These strategies focus on enabling people to maximise opportunities for independence and maintain or improve their quality of life, particularly high health need populations. We targeted resources in the following areas in 2007/08 to address this goal:

- Developing a population health strategy
- Improving nutrition and physical activity –Healthy Eating Healthy Action (HEHA)
- Improving the management of cardiovascular disease
- Reducing the incidence and impact of diabetes on people and their families
- Increasing the range and effectiveness of Mental Health Services
- Improving cancer control
- Improving palliative care and end of life services

Developing a Population Health Strategy

- We appointed a public health physician to work across the DHB and with Regional Public Health. This has improved collaboration, ensuring DHB input into development of the regional health promotion plan Keeping Well
- Our population health strategy will be a key input into the revision of our District Strategic Plan in 2008/09. It will guide our future investment so we maximise health gains for our local population and our investments target reducing inequalities and the incidence and impact of long term conditions

Improving nutrition and physical activity rates (HEHA)

- We have developed a Five Year HEHA Strategic Plan
- Improving nutrition in schools has been a major focus again this financial year. We supported 53 schools and early childhood centres with funding to develop local HEHA initiatives. These ranged from supporting school gardens to funding water fountains and equipment to assist with promoting nutrition
- We worked hard to improve coordination of all nutrition and physical activity stakeholders in the district
- There has been ongoing engagement with stakeholders to develop new breastfeeding services and consider new services for Māori and Pacific as priority groups

We invested in improved management of cardiovascular disease

- We worked with our PHOs to implement a cardiovascular risk assessment programme
- We dedicated funding to increase cardiac rehabilitation and the heart failure service
- We finalised our Long Term Conditions Management Framework and Action Plan. The plan aims to encourage clients to integrate effective self management strategies into their lives and give them greater control of their conditions
- We set aside funding for respiratory, cardiovascular and diabetes self management, and self management support approaches

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

- Funding for free diabetes annual checks has increased and we expect to see an increase in people using the service in the next year
- We held a workshop with PHOs and local providers to improve detection of diabetes and increase uptake of free annual diabetes check ups for Maori
- We worked across primary and specialist services to develop more Māori specific capacity in our diabetes services
- We provided the hospital with funding to deliver diabetes services in the community and this service has started
- We funded bariatric (weight reduction) surgery operations – five operations were undertaken

Increasing the range and effectiveness of our Mental Health Services

- We continue to implement the Journey Forward (our local plan for mental health services). All activities in the plan are mapped against national and regional mental health plans to ensure alignment and common purpose
- We continue to improve our acute and crisis services. Ward 27 continues to stabilise its occupancy and improve its therapeutic programmes. Acute services continue to be enhanced with community based services for people with acute needs who don't need to be in hospital. Early indications show our recovery houses established in 2007 have a positive effect on meeting the health needs of consumers
- Data shows our strategies to increase access into mental health services are having a positive impact
- We are progressing a multi agency wet hostel for homeless heavy drinkers

- The development of a joint addictions plan across the C&C DHB and Hutt Valley is progressing
- We increased funding to PHOs to improve access to primary care services for people with mild to moderate mental health issues
- We worked with MSD on a mild-to-moderate mental health programme with a goal of getting people back to work

Improving Cancer Control

- We will commission a new linear accelerator machine in late 2008 which will make major inroads into improving the timeliness of service delivery to our population
- We established the Central Region Cancer Control Network in 2007. It is one of the four regional cancer networks set up to facilitate initiatives contained in the Cancer Control Strategy Action Plan 2005-2010. The network focuses on undertaking leadership, facilitation and co-ordination roles to progress cancer initiatives. Service improvement facilitators have been appointed to map the lung cancer journey and addressing inequalities workstreams
- The network's first regional Hui to engage with Iwi/Maori was held on 23rd of June in Palmerston North. It focused on partnerships, future engagement, and the network's 'addressing inequalities' project
- A Kaiwhakatere/navigator has been recruited to analyse, identify and address barriers to accessing cancer services in the Māori and Pacific populations

Improving Palliative Care and end of life services

- We have established a Community Education and Liaison role with Mary Potter Hospice and held a successful Palliative Care education and planning day

Strategy 1 - Focusing on people through integrated care

We are committed to improving outcomes for patients by ensuring services are provided in an integrated manner. We take a 'whole of DHB' approach in developing and providing services to our communities. These services work across providers and are not affected by location of care. Services for older people, including services provided in the home, are a focus.

We are also moving towards integrating mental health services and primary and specialist care with initiatives such as the long term conditions programme manager and the establishment of a primary secondary clinical governance group.

Integrated Home Community Care

Our Care Coordination Centre is well established and expanding its services based on the restorative approach. This approach uses support plans developed from an InteRAI assessment and the service user's goals. It aims to help people remain connected to the community, active and in control of their lives. Expanded services include;

- InteRAI trainers supporting and training hospital patient care coordinators to use the InteRAI screening tool in hospital prior to discharge
- rolling out the InteRAI comprehensive assessment tool for use in the Assessment, Treatment and Rehabilitation (AT&R) and psychogeriatric services for people in the community
- Managing referral to ACC fall prevention programmes. Older people who have suffered a fall or at risk are referred to Tai Chi or to the Otago Exercise Programme, both of which have been shown to prevent falls in older people
- Trialling approaches to using the InteRAI as a common assessment tool serving mutual clients with ACC. This will minimise assessment duplication and enable joint funding and provide seamless service to shared clients
- Supporting all clients assessed as requiring home based care with a restorative package of care. From July 2006 all new clients have received this service, and over the last two years about three and a half thousand people who were receiving existing home support services have been progressively transferred into the new package approach

Strategy 2 - Managing our money

We are committed to investing in health and disability services to improve the experience of our patients, and our efficiency and effectiveness. These investments contribute to our ability to improve health outcomes, be responsive to changing health needs and maintain a sustainable financial position.

The DHB recorded an operating deficit of $40,676m including new Wellington Regional Hospital costs of $7.1m compared with the budget deficit of $10.9m. Revenue and expenditure during this financial period were higher than budgeted for.

Note that result is provisional and excludes contribution of Associates (HIQ) for which we are still awaiting a final result.

Personnel costs (including outsourcing), outsourced clinical services, clinical supplies, infrastructure and non-clinical supplies were key contributors to over spending.

The overspend has been offset by a favourable variance in revenue of $17.8m.

In 2007/08 we concentrated on:

- Efficient service delivery
- Service reconfigurations
- Quality improvement
- Revenue realisation

Efficient service delivery

- Our theatre productivity has improved and we achieved 80 % productivity against a target of 75 %
- Our financial management information system has been approved but not yet implemented
- We reached an agreement with Hutt Valley DHB to have shared access for clinicians to the electronic health records of each DHB
- We restructured services in the hospital to enable more clinical staff to have a greater say on our priorities and resources
- Work on medical patient flow is ongoing, focusing on the streaming of short stay patients to a Medical Assessment and Planning Unit (MAPU) and the management of longer stay admissions
- We see major improvements in the timeliness of medical typing and clinical coding
- We are supporting regional purchasing of materials and participating in developing national frameworks for procurement

- We are able to demonstrate that Tertiary prices do not cover the costs of providing these services. As the second highest "in-flow" hospital in New Zealand we are put at a significant financial disadvantage by this model

Service Reconfiguration

- We have jointly worked with the central region DHBs to develop a Regional Clinical Services Plan to guide future service development in the region

Quality Improvement

- We achieved a two year QHNZ (Quality Health New Zealand) Accreditation and MOH Certification status
- Seven finalists in our annual Quality Quest gave oral presentations covering; management of fevers in children, electronic foetal monitoring, mental health community reach project, cancer centre staff and patients benefits due to practice change, alternate non emergency patient transfers, Wellington Hearing Expo journey, and improving referral processes
- Three of the Quality Quest finalists have been chosen as NZ Health Innovation Awards (NZHIA) finalists. The NZHIA are a joint venture between ACC and MOH to recognise improvements in the health and rehabilitation of New Zealanders. The initiatives are;
    - 'Where do your referrals Go'(Excellence in Quality Improvement Category)
    - Change is as good as a Rest (Excellence Process Improvement Category) and
    - Hearing Expo 2007(Excellence in Primary Care)

- Our Lavalava Initiative is a first in New Zealand. Created by theatre staff to help preserve the dignity of patients during surgery, patients are provided with specially designed wrap-around garments. The initiative has been hailed by patients and received special acknowledgement from the Race Relations Commissioner for its positive contribution to race relations in New Zealand
- See also Strategy 6 – improving clinical service quality and patient safety

Revenue Realisation

- We participate in national work related to pricing programmes, value for money, and quality and development of service frameworks
- We resourced clinical coding to ensure we capture all data accurately and in time to feed into national data sets
- Our processes for capturing the correct purchaser for events is steadily improving with all ACC and Breast Screening service events being fully invoiced in 2007/08

Strategy 3 - Developing our workforce

Demand for regulated and unregulated health workers continues to put pressure on workforce supply. This leads the DHB to explore further efficiencies in the way we deploy our workforce. Our workforce plans integrate actions contained in the national DHB 'Future Workforce Plan' – this includes national initiatives to improve branding, recruitment, infrastructure (information and education) and retention.

During 2007/08 we concentrated our efforts on:

- Changing our care delivery model to meet the demands of service delivery in a diminishing workforce
- Sustaining and nurturing our workforce
- Developing our workforce and sector capability

Changing our care delivery model

Our Nursing & Midwifery Model of Care Project provides a standardised, efficient nursing and midwifery service for migration into the new Wellington Regional Hospital and beyond. Team nursing/midwifery will be introduced using current full-time equivalent configurations in advance of the migration.

The Project aims to reorganise the nursing and midwifery service to;

- provide patient-centred care by the right person, with the right skill at the right time
- streamline roles, responsibilities and processes to maximise benefits offered by the zonal design of the new WRH and ensure standardisation of tasks occurs
- allow for better cost attribution and budgeting within agreed national benchmarks – allowing more appropriate and responsive resource allocation to services (Nursing Hours Per Patient Day Model – NHPPD)

- better distribute patient care tasks
- educate and train staff so they are appropriately skilled, can effectively, delegate tasks and work within their scope of practice/training

Benefits of a Team Nursing model;

- Increased patient satisfaction scores, improved patient care and staff retention
- Less staff turnover
- Increased work satisfaction for Registered Nurses who shift to team nursing
- Strongly associated with better communication and coordination of care
- Better for teaching clinical decision-making and skills

Three year plan for Team Nursing organisation wide

- Team nursing in all inpatient wards, ambulatory and outpatient services/clinics
- Teams evaluated, adjusted and dynamic in relation to patient acuity

Sustaining and nurturing our workforce

- Our staff satisfaction survey was completed and now drives further human resource developments with programmes such as management, clinical leadership and team leader training being rolled out, including follow-up workshops
- We introduced new recruitment web pages and electronic applications have been developed to improve search visibility
- We improved our processes around recruitment of new graduates.
- Communication and teamwork are now key 'whole of organisation' focus areas
- Our relationships with local universities are well utilised to progress education to meet the Health Minister's priorities
- Our Board regularly acknowledge staff quality achievements and performance excellence

Developing our workforce and sector capability

- We appointed our first Nurse Practitioner in youth health
- We work collaboratively with the central region on Māori workforce development. A social marketing project to encourage rangitahi (young people) into health career options has been a key initiative.
- We provided the NZIM Diploma in Frontline Management to 15 health workers resulting in 13 gaining qualification in frontline management

- We provided support to Maori workers in our Whanau Care service to expand Maori Health services to Kenepuru Hospital
- We provided mentorship support to Pacific workers in our Pacific Health services to support expansion of Pacific services in primary care settings
- Our Pacific Workforce Strategy is near completion
- Thirty new cadets working in primary and community settings took part in the Mahi ki te Ora Cadetship programme which was funded by the Ministry of Social Development

Strategy 4 - Working with communities

We work with communities and community agencies such as local councils, the Ministry of Social development, Housing New Zealand, SPARC (Sport & Recreation New Zealand), ACC and schools to advance important health issues.

Priority areas where we provided support and investment in 2007/08 are;

- Intersectoral engagement
- Working with the Pacific community.
- Minimising family violence.

Intersectoral Engagement

We renegotiated our Letter of Agreement with the Ministry of Social Development in July focusing on the following areas;

- identifying opportunities to work collaboratively with clients experiencing middle-to-moderate mental health issues
- developing our cadetship programme within the health environment to assist with labour market development
- improving access to correct benefit entitlement
- expanding our settings-based community nursing model in Work and Income centres where possible
- collaborating on extending the intersectoral approach across the social sector
- The DHB has continued to work with local councils and social sector agencies such as Housing NZ and MSD to support healthy housing projects across the district. The DHB has focused on improving air quality and heat retention for low-socioeconomic homes
- We have negotiated a partnership with the Accident Compensation Corporation (ACC) to work towards improving injury prevention co-ordination and social marketing. The DHB and ACC will benefit from reduced injury related admissions and subsequent demand for rehabilitation services in the longer term.

- Over the past six months our PATHS (Providing Access to Health Solutions) interdisciplinary team has doubled in size. With a caseload of around 230 clients, the service works across the district to create individual development plans to address a client's specific health and social needs
- We have completed our Family Violence Screening and Referral Strategy. We are engaging with MSD, Police, Child Youth & Family and Regional Public Health to explore collective joint training programmes to reduce workforce development burdens

Pacific Community Involvement

- We continue supporting our Pacific communities, funding community initiatives with Cook Islands, Samoa, Fiji, Tokelau, Tonga, Niue and Tuvalu
- We support Strong Pacifica Families in Partnership with Ministry of Social Development and ACC which advocates against family violence
- We support youth driven events that have included workshops and sports events

Strategy 5 - Supporting and promoting healthy lifestyles

Our goals, objectives, milestones and responsibilities in 2007/08 for these initiatives include:

- Improving nutrition, physical activity and breastfeeding rates
- Reducing the rate of smoking and exposure to tobacco smoke

Improving nutrition, physical activity and breastfeeding rates.

- We completed the HEHA Plan for 2007/08
- We held Food and Nutrition Workshops for schools and early childhood education (ECE). We continue promoting nutrition in these environments
- See also Goal 2

Reducing the rate of smoking and exposure to tobacco smoke.

- We started the Tobacco Plan
- We are supporting our two Pacific Providers (Pacific Health Services Wellington and Porirua) to deliver a Regional Smoking Cessation programme for the Pacific population. Their mobile service has been the most successful method of engagement

Strategy 6 - Updating our hospitals

The new Wellington Regional Hospital is on track for completion by Christmas 2008 and ready for operational commissioning in the first quarter of 2009.

We restructured our Change Programme to allow easier decision making and a realistic scope for safe migration to the new Wellington Regional Hospital and for progressing change beyond the move.

During 2007/08 we concentrated on:

- The new Wellington Regional Hospital (WRH) building programme
- The Hospital and Health Services (HHS) Change Programme
- Information management and systems development
- Improving clinical service quality of patient safety

The WRH Building programme

- We marked the Newtown building reaching its full height in August 2007 with a "topping off" ceremony
- We relocated our Dental Service Porirua to Kenepuru
- We occupied our expanded recovery rooms at Kenepuru
- We commissioned the 3rd theatre at Kenepuru
- Diagnostic Radiology equipment valued at $7.35m has been ordered and will lead to a state-of-the-art Radiology Department in the new WRH

The HHS Change Programme

- Our Clinical Directors and Leaders have been given greater responsibility and authority
- We established quarterly Senior Medical Officer forums and monthly medical reference groups meetings
- Our Team Nursing Model of Care is progressing with phase 4 implemented in June 2008
- We are implementing an enterprise data warehouse to support clinical and management leaders with their information needs

Information Management and Systems Development

- Our Information System Strategy has been rewritten with a three year CAPEX (capital expenditure) plan developed for implementation
- We received Ministerial and National Capital Committee approval of the Electronic Health Record phase 2 - implementation is underway

Improving Clinical Service Quality of Patient Safety

- We are developing a business case for a Medical Assessment and Planning Unit (MAPU) to address acute medical patient flow
- We developed the Fit-for-Surgery project to monitor patients scheduled for surgical procedures and reduce cancellations
- We standardised our medication charts to improve patient safety and reduce medication errors
- Electronic adverse event reporting has been implemented
- We introduced Healthpoint (www.healthpoint.co.nz) - an information portal which enables our referrers and their patients to access information about our hospital services, including our referral guidelines. It also offers plain English information to the public. It has potential to help reduce unnecessary referrals and improve our ability to inform and up-skill GPs on our management of certain conditions in preparation for outpatient visits

Good Employer Statement

1 - Leadership, Accountability and Culture.

The DHB has processes and systems in place to reinforce accountable leadership. The structure and organisational systems are being aligned to a model of devolved accountability with the requisite controls. Various leadership programmes and workshops are ongoing to improve the performance of leaders. Organisational values, EEO and Māori initiatives are imbedded in the organisations processes and systems. Culture training\awareness programmes have been made available to staff and also forms part of our induction programme

2 - Recruitment, Selection and Induction

Recruitment processes and systems have been reviewed for effectiveness and work programme is ongoing to improve our ability to attract and retain staff.

3 - Employee Development, Promotion and Exit

Profession development and training is available to all staff and highly utilised. There are specific programmes to support maintenance of practicing requirements and professional progression. Investment is made in a multi-level leadership programme.

4 - Flexibility and Work Design

The needs of individuals and the organisation are taken account in endeavouring to create an accessible and flexible workplace within the parameters of the 24 hour health sector environment
We aim to work in partnership with unions to achieve mutually beneficial outcomes. Forums and processes in place reflect this.

5 - Remuneration, Recognition and Conditions

Employment conditions and job sizes are determined through national multi-employer agreements (MECAs) for most of our staff remuneration. We work closely with the CTU and individual unions. Staff not covered by collective agreement pay and conditions have pay and conditions that are consistent with a MECA or our standard Individual Employment Agreement (IEA).

IEA remuneration and conditions are generally benchmarked to the market and applied within the financial restraints of the sector. An action plan following the 2007 Pay and Employment Equity survey has been established and followed through.

6 - Harassment and Bullying Prevention

Policy and processes are in place to deal with work place bullying. Our Code of Conduct has been reviewed this year and our policy and procedures around harassment and bullying revisited. Our bi-partite representatives were involved in this process.

7 - Safe and Healthy Environment

The DHB has robust health and safety employment practices, workplace practices and governance structures. This includes rehabilitation management and access to professional support.

Governance of C&C DHB

Governance Structure

The governance structure is based on the DHB's three key roles:

- Planning and funding health and disability services for the Capital & Coast district
- Providing health and disability services to its communities. These services include: medicine and cancer; surgical, ICU and anaesthesia; women's and children's health, mental health, community and clinical support services
- Governing the District Health Board.

Board Members

Sir John Anderson Board Chair, *Appointed Member*
Ken Douglas Deputy Chair, *Appointed Member*
Margaret Faulkner, *Elected Member*
Virginia Hope, *Elected Member*
Donald Urquhart-Hay, *Elected Member*
Peter Roberts, *Elected Member*
Ruth Gotlieb, *Elected Member*
Helene Ritchie, *Elected Member*
Judith Aitken, *Elected Member*
Peter Douglas, *Appointed Member*
Selwyn Katene, *Appointed Member*
Ian Brown, *Crown Monitor*

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 (held in October 2007) and four are appointed by the Minister of Health. A Crown Monitor was appointed during the year.

Our Objectives as a District Health Board

The objectives of DHBs are described in the section 22 of the New Zealand Public Health and Disability Act 2000 and are:

- 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 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 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

The Board delegates specific matters to the Chief Executive Officer of our DHB. The Board has established four committees to the Board and these are made up of Board members, DHB staff and community representatives. Three are required under the NZPHD Act 2000, that is, they are statutory committees. Each Board committee operates within a formal terms of reference.

Hospital Advisory Committee (HAC)

The functions of the hospital advisory committee are to: monitor the financial and operational performance of the hospitals (and related services) of the DHB; assess strategic issues relating to the provision of hospital services by or through the DHB; and give the board advice and recommendations on that monitoring and that assessment.

Community and Public Health Advisory Committee (CPHAC)

The CPHAC provides the Board with advice on the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the DHB and priorities for use of the health funding provided.

The aim of the Committee's advice must be to ensure that all service interventions the DHB has provided or funded or could provide or fund for the care of that population; and all policies the DHB has adopted or could adopt for the care of that population, maximise the overall health gain for the population served by C&C DHB.

The Board is committed to Mental Health, and as such a sub-committee of CPHAC is being established to ensure Mental Health receives an appropriate focus.

Disability Support Advisory Committee (DSAC)

The DSAC advises the Board on the disability support needs of the resident population of the DHB; and priorities for use of the disability support funding provided.

The aim of the Committee's advice must be to ensure that the kinds of disability support services the DHB has provided or funded or could provide or fund for those people; and all policies the DHB has adopted or could adopt for those people, promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population.

Members of the public are welcome to observe most of the meetings of the groups mentioned above. The meetings are held monthly or bi-monthly. Details of Board and statutory advisory committee meetings (agendas, minutes, membership, and attendees) are publicly available on our website: http://www.ccdhb.org.nz/Aboutus/Board.htm

Occasionally these groups may need to have discussions about some subjects where it is better if the public does not attend, and this is allowed for in the NZPHD Act 2000.

Other Committee

To enhance the governance function of the Board we have also established a Risk and Quality Assurance Committee which itself has an Audit Sub-Committee. The Audit Sub-Committee has focused overview of the financial situation of the Board.

To ensure the cohesiveness of the governance function during 2007/08, the Board Chair and Committee Chairs met regularly.

Statement of Responsibility

For The Year Ended 30 June 2008

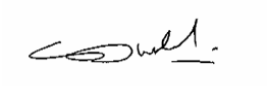
1. In terms of the Crown Entities Act 2004, the Board and Management of Capital & Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.

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 & Coast District Health Board, the annual Financial Statements for the year ended 30 June 2008, fairly reflect the financial position and operations of Capital & Coast District Health Board.

Sir John Anderson
Chair
06/11/08

Ken Douglas
Deputy Chair
06/11/08



Ken Whelan
Chief Executive
06/11/08

Theo Koenders
Director of Finance
06/11/08

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 2007 to 30 June 2008. 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

This report provides a mix of milestone measures, outputs, and key performance measures that signal improvements in the health of our population. These milestones and key performance measures are based on our Health Needs Assessment (HNA) and the directions set out in our District Strategic Plan (DSP), the Minister's priorities and the need to ensure ongoing clinical and financial viability for the DHB.

We have rated our milestone measures and key performance measures as:

Achieved – where the work has been completed within the timeframe or target reached.

Partially Achieved – where the work has been completed within the 2007/08 year, some of the targets within the performance measure have been achieved or actions have been undertaken to support future achievement of the desired outcome.

Not Achieved - where the milestone has not been completed or no targets within the performance measure have been achieved.

DHB Goal 1: Reduced disparity in health status

Maori, Pacific peoples, refugees and new migrants, and people who live in areas that are considered to be deprived are high health need populations. These populations have different health needs to other groups in our district.

Our three key performance indicators are reducing avoidable or ambulatory sensitive hospitalisations (ASH), improving utilisation of mental health services, and the percentage of children passing hearing tests. We focus on these to measure our success in reducing inequalities. These indicators measure activity across the primary, specialised care and public health services. We also identified milestones that support the longer term achievement of this goal.

We have made substantial progress, but not all milestones and targets have been fully achieved. Our continued low rates for ASH demonstrate the good access to primary care and management of chronic conditions in our district.

In 2007/08 the DHB monitored the following milestones and indicators to ensure progress is being made to reduce health disparities.

Milestone	Achievement
We will develop a Population Health Strategy that will guide our future investment aimed at improving health and reducing inequalities **Date:** Dec 2007 **Output Class:** Funder	**Partially Achieved** The population strategy was completed within the 2007/08 year. Delay in achieving this output has in part been due to the alignment with the regionally driven 'Keeping Well' strategy, and coordinating engagement with the next District Strategic Planning process during 2008/09.

Milestone	Achievement
We will Develop and Deliver a Pacific Primary Health Service in Porirua to help address hospital admissions that are preventable with early primary care interventions **Date:** Jun 2008 **Output Class:** Funder	**Partially Achieved** We have contracted for a Pacific Primary Health Service in Porirua. The fit out of the facility is awaiting Porirua City Council Building consent and the workforce is undergoing training and development. Negotiations with a GP are occurring and clinics are anticipated to commence in the current setting in August. The service is expected to be launched in Oct 2008 and we expect that this initiative will lead to decreasing avoidable hospitalisations for Pacific in the future.
We plan to monitor all our indicators by age, ethnicity, gender and NZDep. To enable new funding to be targeted to areas of high need. **Date:** Jun 2008 **Output Class:** Governance	**Partially Achieved** We have the capacity to monitor all indicators that capture National Health Index (NHI) on patients by age, ethnicity, gender and NZDep. Priority indicators are routinely monitored by age and ethnicity. We do not monitor all our priority indicators by gender and NZDep but undertake this analysis if appropriate to support funding decisions. All National Minimum Data Set indicators are standardised by NZDep and age.

Key Performance Measures

Ambulatory sensitive hospitalization (ASH), rates by age group and ethnicity

Partially achieved

Output Class: Funder

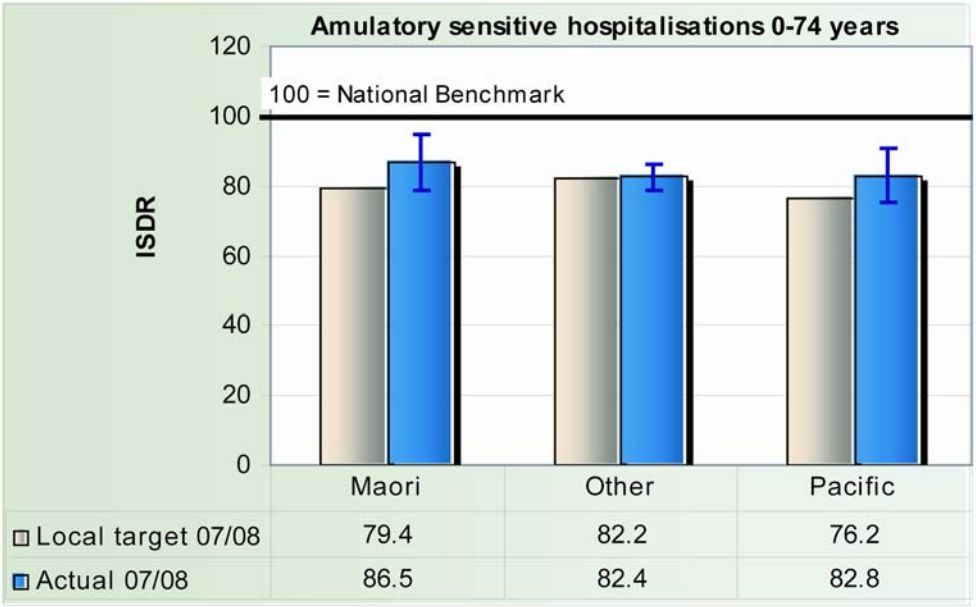
The Ministry of Health has changed the reporting requirements for ASH during the 2007-08 year this compromises reporting historical trends. In 2007-08 the national benchmark was to maintain an indirectly standardised discharge ratio (ISDR) of below 100. The Ministry of Health set stretch targets to further reduce our ASH rate below the national benchmark. At a 99% confidence level we have achieved these stretch targets for all age-groups except Maori aged 45-64 years and Pacific children aged 0-4 years.

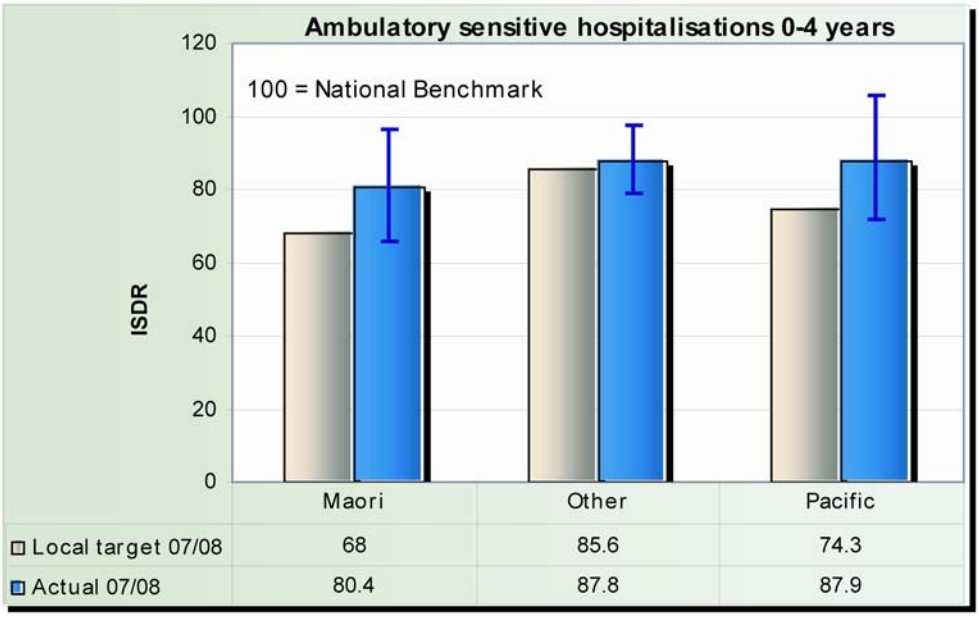
Chronic conditions, especially diabetes, cardiovascular disease, and respiratory disease, contribute to a large proportion of avoidable admissions. The combined effects of our long term conditions action plan, existing and planned ambulatory programmes, primary care activity in these areas, plus improvements in disability assessment help C&C DHB maintain ASH rates below the national benchmark.
Current actions to reduce ASH and those we are in the process of implementing include:

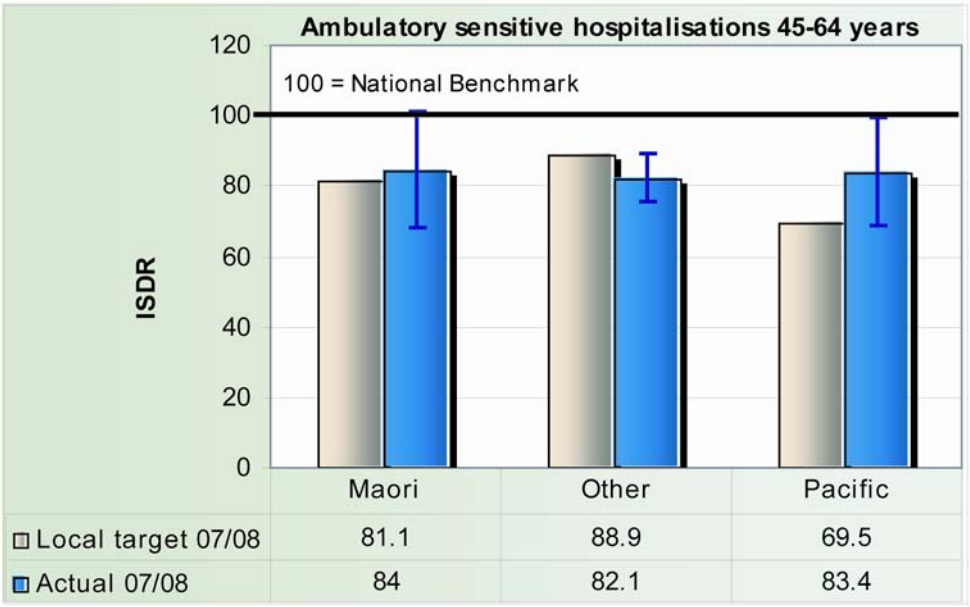
- Improving access to primary care services, for example, increasing primary care capacity for Pacific in Porirua and GP/nurse capacity and PHO enrolment in Kapiti
- Implementation of our Long Term Conditions (LTC) framework and action plan
- Increasing diabetes nurse educator services in primary care and increasing resource for diabetes in Hospital and Health Services (HHS) to provide outreach and more community-based support
- An expanded heart failure initiative strengthened cardiac rehabilitation services and evaluation of the Maori cardiac navigation service
- Enhanced CarePlus
- Intersectoral initiatives – healthy housing in Wellington, Porirua and Kapiti, initiatives with Work and Income /Ministry of Social Development (Nurse in Porirua)

- Emphasis by our joint primary/community/secondary clinical network on improving the processes around discharge to reduce readmissions will be an important focus for 2008-09. The primary/secondary clinical governance group and the 'admission avoidance' initiatives will help achieve this

ASH trend by C&C DHB Population Groups:







Mental Health Service utilization for all age groups

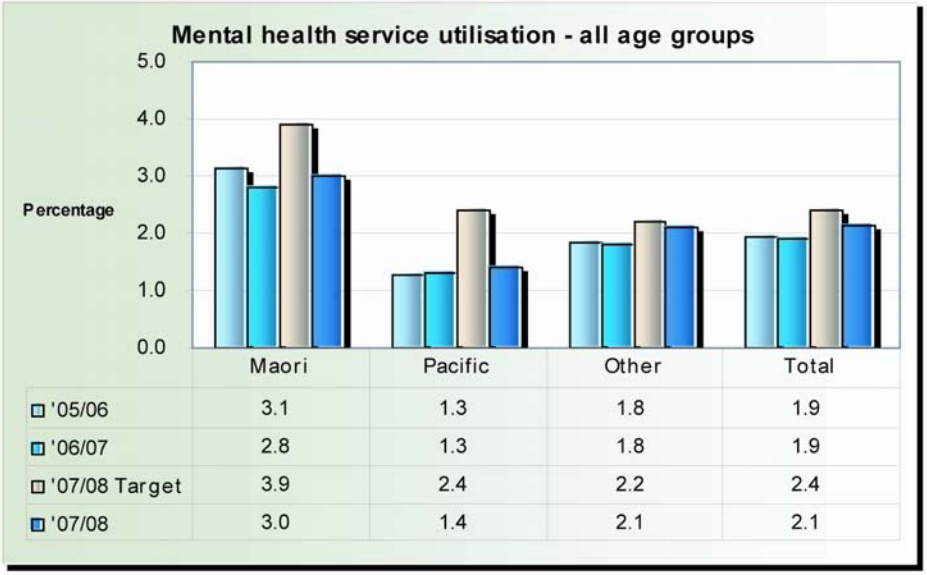
Partially Achieved

Output Class: Funder

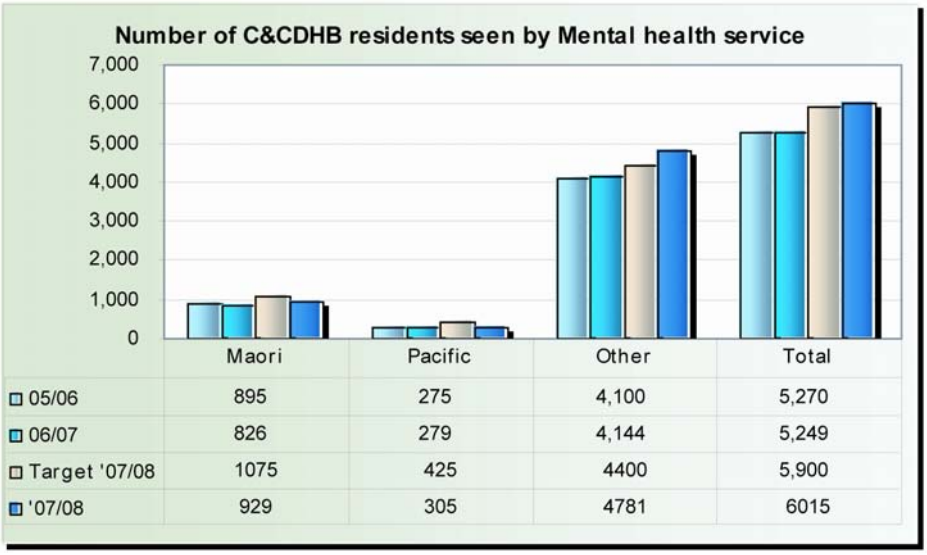
The percentage of the DHB's population accessing Mental Health Services increased across all ethnic groups in 2007-08 and number of patients accessing our services overall exceeded our target, however, our targets for Maori and Pacific people were not achieved.

To mitigate this community teams have adjusted their processes over the last year to ensure patients receive their assessments earlier and ongoing case management is improved. This activity is leading to an increasing number and percentage of our population accessing specialist mental health services.

Implementation of a new Patient Management System in November 2006 has led to problems reporting data. The data reported is for the year to 30 May 2008.



	Maori	Pacific	Other	Total
'05/06	3.1	1.3	1.8	1.9
'06/07	2.8	1.3	1.8	1.9
'07/08 Target	3.9	2.4	2.2	2.4
'07/08	3.0	1.4	2.1	2.1



	Maori	Pacific	Other	Total
05/06	895	275	4,100	5,270
06/07	826	279	4,144	5,249
Target '07/08	1075	425	4400	5,900
'07/08	929	305	4781	6015

Relapse prevention plans for people in contact with mental health services for two years or more

Not Achieved

Output Class: Provider

Fifty three per cent of people in contact with mental health services for two years or more had relapse prevention plans. Our target is 95%.
The DHB Client Pathway is the framework for service provision. It provides treatment planning protocols and risk management processes.

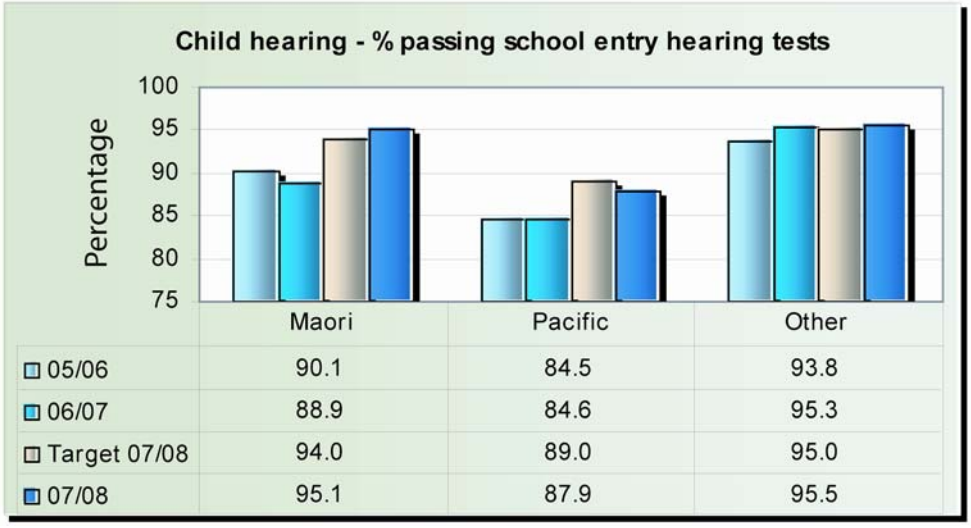
This client pathway is under review and is being updated to ensure that tangata whaiora/ service users are actively involved in planning their relapse prevention. Compliance with the national target of 90-100% is expected to be achieved in quarter 2 of 2008/09

Child hearing loss - school entrant testing and pass rate by ethnicity

Output Class: Funder

We have not assessed this indicator as an error in the entry of the data was identified, particularly for Maori and Pacific children in Porirua area. As a result our pass rates may be higher than would be expected in comparison with previous years.

To ensure we continue to improve our results we agreed a plan with Regional Public Health to continue working collaboratively in addressing the wider determinants that influence poor ear health in the Porirua region. Our Mobile Community Ear Clinic visits highly deprived areas in Porirua with high numbers of Maori and Pacific families four days a week. We strengthened communication with PHOs to include ear health as a priority. We are working in partnership with families that require support to access the Mobile Ear Clinic and with Kenepuru Hospital outpatients to influence the prioritisation of Maori and Pacific children for treatment.



	Maori	Pacific	Other
05/06	90.1	84.5	93.8
06/07	88.9	84.6	95.3
Target 07/08	94.0	89.0	95.0
07/08	95.1	87.9	95.5

DHB Goal 2: Reduced incidence and impact of chronic disease

Chronic conditions, such as diabetes, cardiovascular disease, respiratory 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 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 Health Minister's priorities.

We aim to reduce chronic conditions incidence and impact through a long term conditions management framework, increasing availability of home and community support, and developing and implementing a tobacco plan.

The key performance indicators that we monitor to assess progress on this goal are the identification and management of diabetes by ethnicity in primary care, and assessing the number and timeliness of patients accessing radiation cancer treatment in the secondary service.

Milestone	Achievement
We will finalise our chronic care management project **Date:** Dec 2007 **Output Class:** Funder/Provider	**Achieved** Our chronic care management framework and action plan was developed with input from a range of local stakeholders. It has now been finalised as C&C DHB's Long Term Conditions Framework and Action Plan and disseminated throughout the district. It includes specific action plans for care of diabetes, cardiovascular disease, respiratory and renal conditions.
We will improve availability of home and community support for people in the last year of life including homecare and residential care. **Date:** Jun 2008 **Output Class:** Funder/Provider	**Partially Achieved** A community education and liaison role has been established and is being delivered through Mary Potter Hospice. Recruitment is underway for two programme coordinators to develop Cancer Control and Palliative Care Plans.

	The Cancer Plan will be developed and implemented in conjunction with the regional Cancer Advisory Group and Hutt Valley DHB. It will be aligned with the Central Region Cancer Control Plan. The Palliative Care Plan will be developed in conjunction with the Palliative Care Forum to ensure district wide consultation and implementation occurs. Recruitment has begun for a Kaiwhakatere – Patient Navigator Cancer to undertake a project to track a cohort of high need patients from primary care through hospital cancer services and potentially beyond. In this way, we plan to identify access barriers and develop an approach for an appropriately targeted navigator.
We will develop with the Ministry of Health a tobacco plan for our region **Date:** Jun 2008 **Output Class:** Funder/Provider	**Achieved** We collaborated with Regional Public Health (funded by the Ministry of Health) and Hutt Valley DHB to implement a new smoking cessation framework across the region. This involves the creation of new positions, better systems of smoking cessation practice and more linkages and referrals with the local smoking cessation service. We have completed our final draft smoking cessation plan and submitted it to the Ministry of Health. We are currently developing business cases to submit to the Ministry to secure additional

	funding for the purpose of strengthening our screening and referral training across primary and secondary care settings.

Key Performance Measures

A number of factors have contributed to our performance results for diabetes in 2007/08. The reporting period changed and we are now reporting on the financial year compared with calendar year previously. A new national reporting database for PHOs was introduced in quarter 3 and it is not producing robust data at this point in time. We are working closely with providers using this database to address the transitional issues and ensure that all annual checks are being captured in the new database. Issues include incomplete data capture and rejection of batches of data if there is one error in the batch.

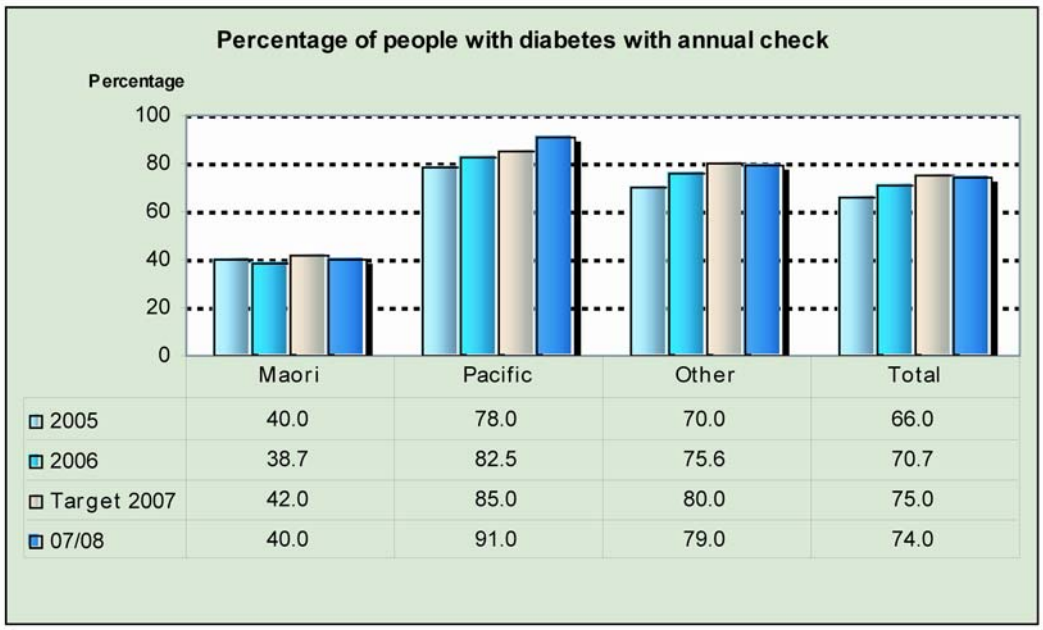
Diabetes indicators will be included in the PHO performance management programme from 1 July 2008 and we expect improved confidence in our reporting during 2008/09.

Diabetes Mellitus Management – percentage of people with diabetes with an annual check

Output Class: Funder

During 2007/08 we have increased our efforts to improve the uptake and delivery of annual diabetes checks and this has led to improved uptake of annual checks across all ethnicity groups. These efforts include:

- advertising in several local newspapers in May 2008 highlighting the need for annual checks for people who have diabetes, especially Maori
- increasing price paid to providers to complete an annual check in early 2008
- working with PHOs to ensure all annual checks carried out are captured in the new database
- local radio programmes promoting wellbeing specifically targeted across all Pacific ethnicity groups and youth



	Maori	Pacific	Other	Total
2005	40.0	78.0	70.0	66.0
2006	38.7	82.5	75.6	70.7
Target 2007	42.0	85.0	80.0	75.0
07/08	40.0	91.0	79.0	74.0

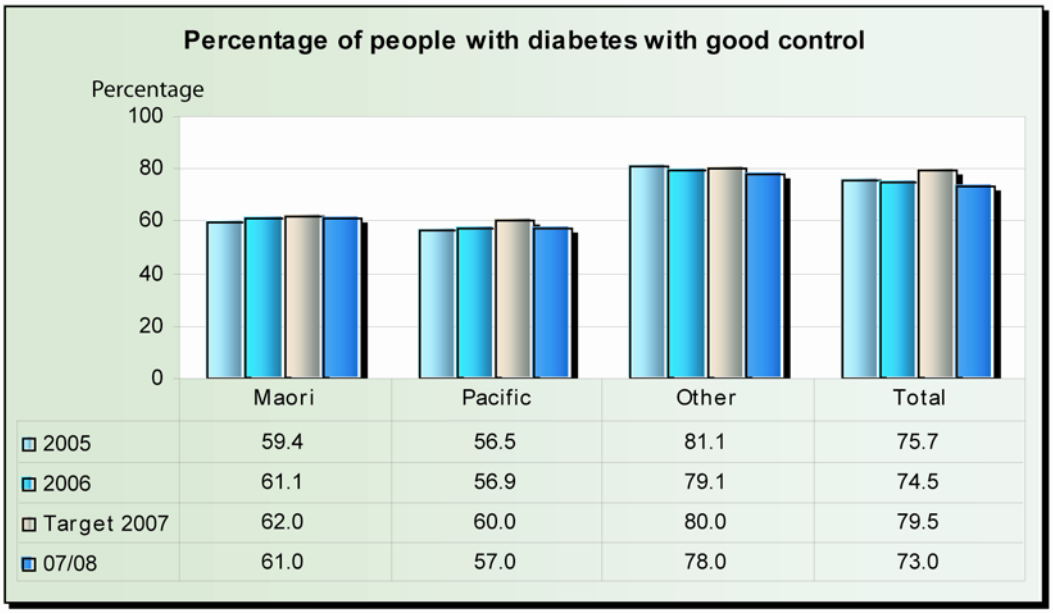
Diabetes Mellitus Management – percentage of people with diabetes with good control

Output Class: Funder

Case management of Maori with diabetes has improved in 07/08. Extra funding support for diabetes education and management by Maori providers has led to improved management of Maori with diabetes. We are also continuing to support workforce development in the hospital, primary care and through our work with education providers.

The long term conditions management action plan for diabetes is being implemented and we expect this, along with improved confidence in our data collection to demonstrate improved outcomes in 2008/09. Actions in our plan include:

- Funding to support Maori self/whanau management
- Funding to support self-management resources for child/youth including peer support training
- A flexible funding approach to support specialist outreach, case discussion in primary care with specialists and telephone work by district nurse educators in the hospital
- Increasing the Pacific diabetes specialist nurse hours across both the hospital and primary care
- Supporting a quarterly diabetes multi-disciplinary clinical forum
- Supporting the Wellington local diabetes team



	Maori	Pacific	Other	Total
2005	59.4	56.5	81.1	75.7
2006	61.1	56.9	79.1	74.5
Target 2007	62.0	60.0	80.0	79.5
07/08	61.0	57.0	78.0	73.0

Diabetes Mellitus Management – Retinal screening

Output Class: Funder

Data for this measure is reported from the Retinal Screening database and measures the total number of retinal screening episodes, by ethnicity. It is independent of the number of people with diabetes who received a free annual review. The district wide database system change early in 2008 means the data cannot be accurately extracted, therefore it is not included in this report. We are taking steps to ensure robust reporting in future.

Cancer treatment waiting times

Partially Achieved

Output Class: Provider

The Ministry of Health's national health target for radiation therapy treatment waiting times is that all patients in category C and above receive treatment within eight weeks of referral[1].

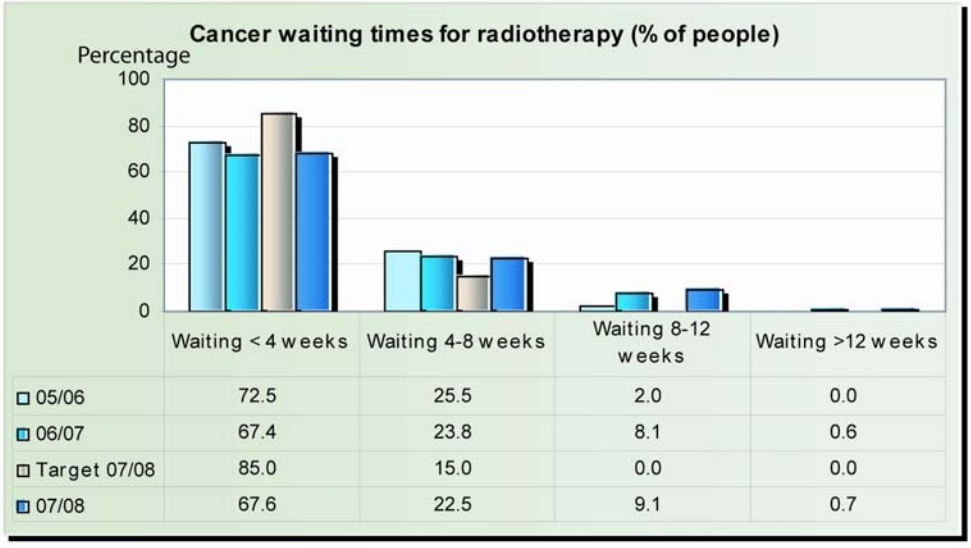
[1] Cancer waiting time priority categories: Priority A (Urgent), Priority B (Curative), Priority C (palliative and other radical) Priority D (Combined chemotherapy and radiation treatment). The cancer waiting time is the time between receipt of referral for First Specialist Assessment (FSA) and the start of radiation treatment for patient who receive the FSA at the cancer centre.

Overall, we treated more people in 2007/08 compared to previous years and we have treated an increasing percentage within four weeks. We treated 865 people compared to our target of 849, and the 776 people treated in 2006/07. However, the number and percentage of people waiting between eight to12 weeks has increased slightly.

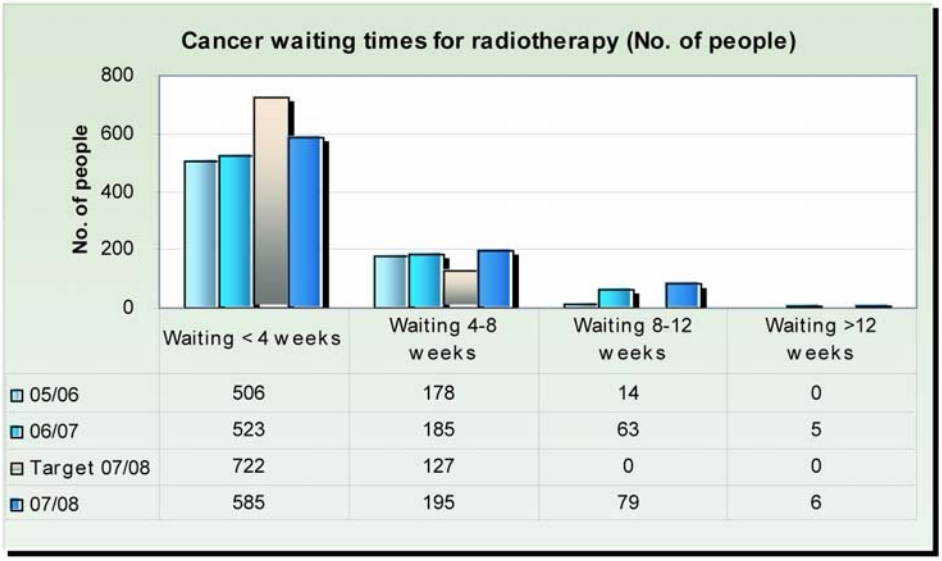
We have increased our workforce capacity in 2007/08 in preparation for the new linear accelerator (radiation therapy cancer treatment machine). This, along with the increased in physical capacity provided by the linear accelerator should enable us to meet the stretch target of seeing all patients within six weeks in 2008/09.

The business case for the third linear accelerator was supported by the Health Minster in January 2008. A delivery date of 22 September is anticipated. The commissioning plan is under development.

Commissioning the 3rd linear accelerator will initially provide a level of functionality to increase capacity, and reduce the delay experienced by patients for radiation treatment. Once this is achieved additional functionality will provide improved quality of service.



	Waiting < 4 weeks	Waiting 4-8 weeks	Waiting 8-12 weeks	Waiting >12 weeks
05/06	72.5	25.5	2.0	0.0
06/07	67.4	23.8	8.1	0.6
Target 07/08	85.0	15.0	0.0	0.0
07/08	67.6	22.5	9.1	0.7



	Waiting < 4 weeks	Waiting 4-8 weeks	Waiting 8-12 weeks	Waiting >12 weeks
05/06	506	178	14	0
06/07	523	185	63	5
Target 07/08	722	127	0	0
07/08	585	195	79	6

DHB Strategy 1: 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 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 clients receiving restorative packages of care - and establishing care managers through ACC.

The percentage of eligible patients enrolled in CarePlus in the primary sector, and our stroke service performance in the secondary care service, are key performance indicators we measure to assess our progress on this strategy. Our milestones reflect our activity to ensure integrated services in the community setting.

Milestone	Achievement
We will expand the range of services accessed through the InterRAI assessment tools and the care coordination centre. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** The Care Coordination Centre InteRAI trainer has been involved in training and supporting the HHS patient care coordinators to use the InteRAI screening tool in the hospital prior to discharge. We are also in the process of rolling out the InteRAI comprehensive assessment tool to be used within the Assessment, Treatment and Rehabilitation (AT&R) and psychogeriatric services for people in the community.

Milestone	Achievement
100% of clients assessed as requiring community based care will be receiving a restorative package of care **Date:** Jun 2008 **Output Class:** Funder/Provider	**Achieved** The restorative approach is based on a support plan developed from an InteRAI assessment and the consumer's goals. It aims to help people to remain connected to their community, active and in control of their lives. All clients assessed as requiring home based care and support now receive a restorative package of care. From July 2006 all new clients have received this service, and over the last two years about 3,500 people who were receiving existing home support services have been progressively transferred into the new package approach.

Milestone	Achievement
We will establish Care Managers as ACC contracted services **Date:** Dec 2007 **Output Class:** Funder	**Achieved** The Care Coordination Centre is managing referral to ACC falls prevention programmes. Older people who have suffered a fall or who are deemed to be at risk of falling are referred to Tai Chi or to the Otago Exercise Programme. Both of which have been shown to prevent falls in older adults. The Care Coordination Centre is working with the ACC to trial approaches to using the InteRAI as a common assessment tool that will serve mutual clients, minimise assessment duplication and enable a joint funding approach to provide seamless service to shared clients. We are also working with ACC and the Ministry of Health to explore opportunities to create more consistency across services for our population.

Key Performance Measures

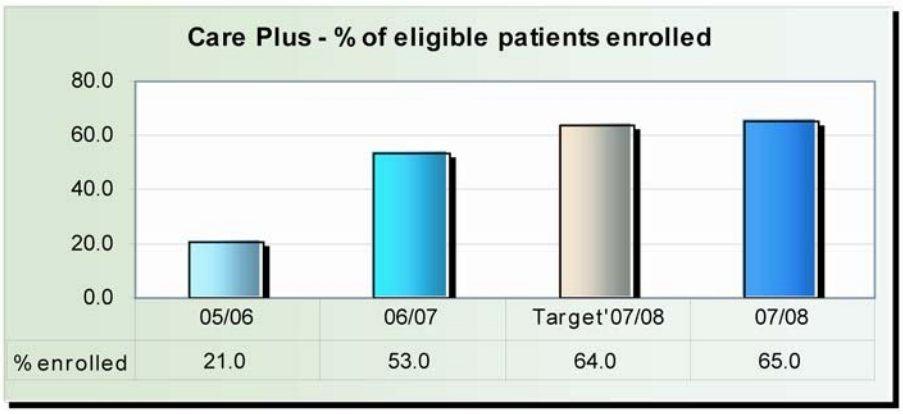
Care Plus coverage

Achieved

Output Class: Funder

Care Plus is a national initiative which aims to improve the care management for patients with long term conditions such as diabetes, heart disease, arthritis and mental illness. 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. PHOs receive extra funds allowing Care Plus patients to receive extra appropriate care by reducing the costs of care and improved access to their doctors and nurses.

As a District we achieved 65% enrolment in Care Plus, exceeding our target of 64% of all eligible people in the region enrolled. All DHB PHOs are now above the 50% threshold. The DHB is supporting enhancements of Care Plus that will offer further incentives for Care Plus enrolment and is actively working with all PHO/providers to increase uptake.



Improved outcomes for patients with a principal diagnosis of stroke

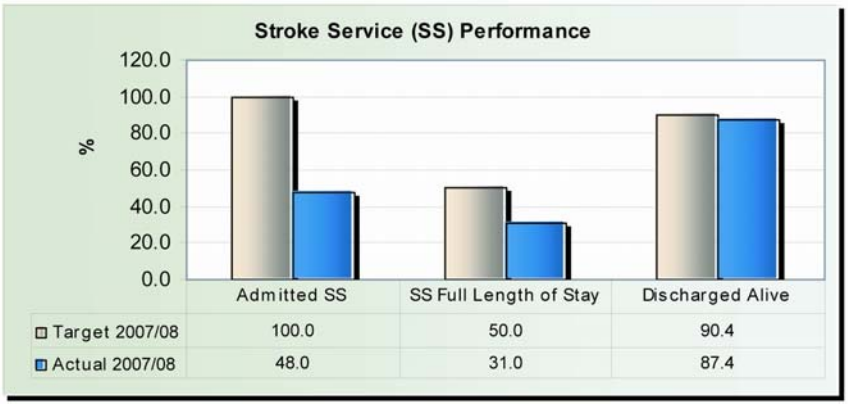
Not achieved

Output Class: Provider

This indicator measures the number of people who have suffered a stroke event and were admitted to an organised strike service. Evidence suggests the most important intervention in improving outcomes for stroke patients is the provision of organised stroke services. Organised stroke services cover from the acute stroke event to the eventual discharge from rehabilitation services.

A Specialist Stroke Nurse, dedicated to the acute aspect of stroke management, has been in place since April 2007. Since this time education for nursing staff has been established, and the organisation of the multi-disciplinary team for stroke patients coordinated. There has been significant improvement in coordination. This has resulted in more timely transfers of patients from front door to the stroke unit.

A four bed acute stroke unit was commissioned on 4 February 2008, and since this time only patients with stroke have been admitted to this unit. Every effort has been made to admit patients to a co-located ward where beds are not available in this unit. Since February 2008 coordinated acute stroke care is provided by two general physicians and one neurologist. 182 patients admitted with stroke.



DHB Strategy 2: Managing our money

We are committed to investing in health and disability services to improve efficiency while maintaining the quality and effectiveness of the services we provide. These investments enable us to improve health outcomes and be responsive to changing health needs.

Our financial performance is a key performance measure. We have also identified milestones related to areas that help us ensure value for money over the longer term such as improving our efficiency through establishing a district diabetes register, working collaboratively with other DHBs and government departments in our region, and implementing the goals of our pharmacy review.

Milestone	Achievement
We will establish a district wide diabetes register available to all stakeholders to track out progress against our health goal for chronic disease **Date:** Jun 2008 **Output Class:** Funder	**Achieved** All PHOs are now administering their own diabetes annual reviews using the Canary Data Solutions database. Once fully utilised this will enable comprehensive reporting and benchmarking, including feedback to practitioners and teams of any relevant information, audit and review, through PHO clinical governance groups. We are working with providers to ensure they are confident with, and fully utilising the Canary system.

	Effectively identifying and managing diabetes will deliver long term health gain for our DHB.
We will collaborate nationally with other DHBs to increase our intersectoral engagement with government departments to resolve issues that adversely affect our ability to manage funding **Date:** Jun 2008 **Output Class:** Governance	**Achieved** We continue working proactively with other agencies to identify joint initiatives impacting on population health, and to assert influence in areas where improving social determinants of health will contribute to sustainable services provided by the DHB. Income adequacy and housing are the two key areas of focus, with significant intersectoral work happening between C&C DHB, Ministry of Social Development (MSD), Housing New Zealand Corporation (HNZC) and Wellington City Council (WCC). Funding for joint initiatives such as the Providing Access to Health Solutions (PATHS) partnership service with MSD have also been agreed to the extent the programme is delivering outcomes measurable in terms of health outcomes and financial benefit to the health system. Other joint initiatives we continue to secure intersectoral funding for include: • Healthy Housing • Primary Care Mental Health Services • Work and Income (W&I) service centre district nursing initiative

	• Primary and Community Health sector workforce development • Wellington South Community Nursing and Parenting Programme
We will implement the goals of the pharmacy service review. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** We have implemented medication use reviews as part of the Pharmacy Service Framework and undertaken a sharps disposal pilot which is outside the base pharmacy contract. No further actions are planned.

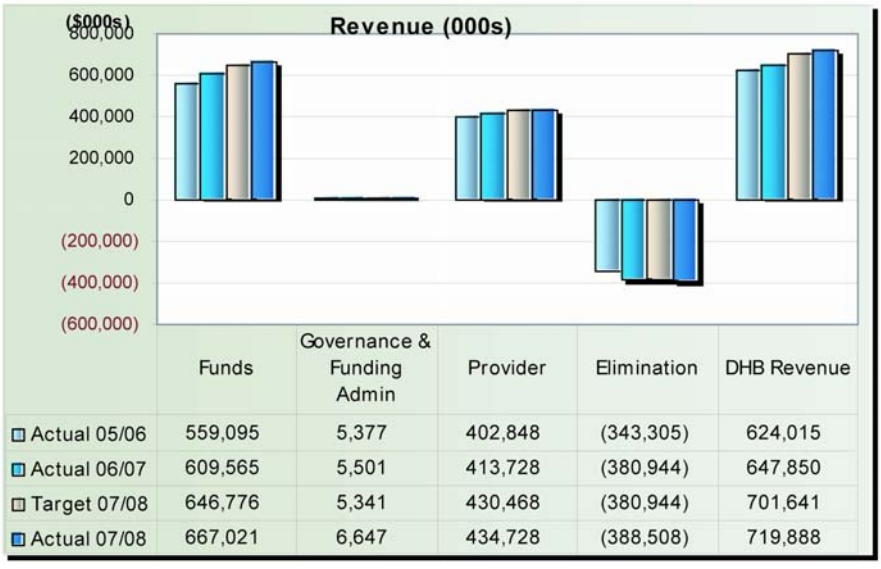
Key Performance Measures

Net surplus

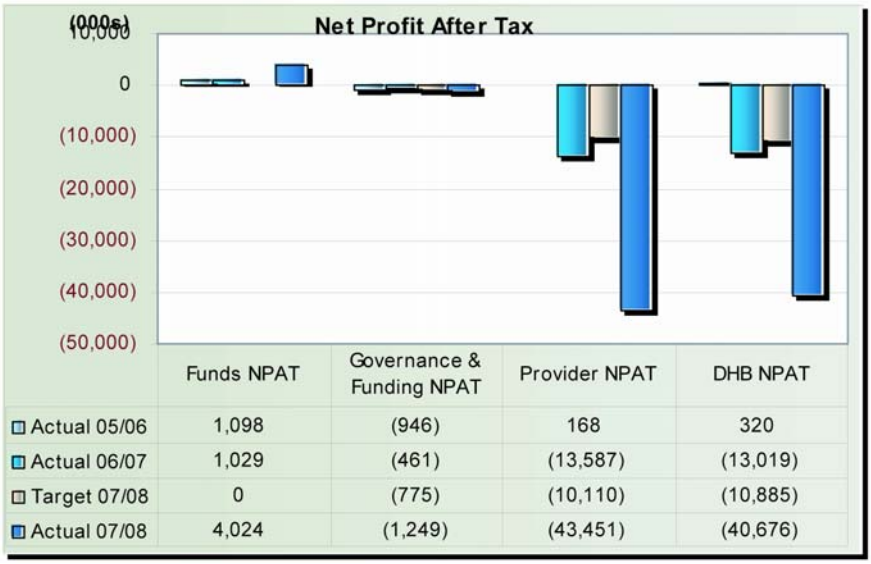
Not achieved

Output Class: Governance

The DHB recorded an operating deficit of $40,676,000 including new Wellington Regional Hospital costs of $7.1m compared with the budget deficit of $10.9m. Revenue and expenditure during this financial period were higher than budgeted for.



	Funds	Governance & Funding Admin	Provider	Elimination	DHB Revenue
Actual 05/06	559,095	5,377	402,848	(343,305)	624,015
Actual 06/07	609,565	5,501	413,728	(380,944)	647,850
Target 07/08	646,776	5,341	430,468	(380,944)	701,641
Actual 07/08	667,021	6,647	434,728	(388,508)	719,888



	Funds NPAT	Governance & Funding NPAT	Provider NPAT	DHB NPAT
Actual 05/06	1,098	(946)	168	320
Actual 06/07	1,029	(461)	(13,587)	(13,019)
Target 07/08	0	(775)	(10,110)	(10,885)
Actual 07/08	4,024	(1,249)	(43,451)	(40,676)

	Funds	Governance & Funding Admin	Provider	Elimination	DHB Expense
Actual 05/06	557,997	6,323	402,680	(343,305)	623,695
Actual 06/07	608,536	5,962	427,156	(361,622)	680,032
Target 07/08	646,776	6,116	440,578	(380,945)	712,525
Actual 07/08	662,997	7,896	478,179	(388,508)	760,564

DHB Strategy 3: Developing our workforce

The health sector faces an international shortage of medical, nursing/midwifery, allied health, technical and other community based workforces. It is necessary to adapt the mix of workforce skills and numbers to meet the changing needs of our population, and take advantage of the opportunities afforded by new technologies and service models. The objective of workforce development is that our people contribute to innovative service delivery models. In turn these models will drive workforce development. Our workforce development objective is to increase recruitment, retention and workplace development, and to offer services that are provided by a cost-effective, well-trained and committed workforce.

Milestone	Achievement
We will implement systems to support workforce development and improved recruitment, retention and workforce development. **Date:** Dec 2007 **Output Class:** Provider	**Achieved** Support systems implemented: Role description system designed and implementation commenced. Coaching programme implemented including leaders trained as coaches. Ongoing Leadership and Management Programmes, Clinical Leadership Programmes and workshop series for new managers. Recruitment branding, administrative processes improved and print advertising improved (and costs reduced) new website implemented.
We will develop a succession planning strategy. **Date:** Mar 2008 **Output Class:** Provider	**Achieved** Approach to Talent Management signed off.
We will improve recruitment capability and processes through regional collaboration and health branding. **Date:** Jun 2008 **Output Class:** Provider	**Achieved** National Health Branding project leveraged where possible. New recruitment collateral being developed. Collaborating regionally where there is value in doing so.

DHB Strategy 4: Working with communities

Reducing the impacts of chronic diseases such as diabetes and cardiovascular disease requires attention to preventative measures to strengthen capabilities of individuals, families, and whanau to make health and well being decisions. We hope to improve collaboration with communities by developing community based strategies around family violence, physical activity and nutrition, and breastfeeding promotion and support.

Our key performance indicators for assessing our health promotion programmes relate to oral health and immunisation.

Milestone	Achievement
We will develop a DHB Family Violence Intervention Project plan. **Date:** Dec 2007 **Output Class:** Funder	**Achieved** A three year strategic plan (2008-2011) to reduce the health harm of family violence has been implemented. It uses quality early intervention programmes in health services across the DHB underpinned with quality evaluation processes. It advises the DHB on how to respond collaboratively and efficiently with the wider community agencies to reduce the incidence and impact of family violence in the Wellington and Kapiti Coast District.

Milestone	Achievement
We will develop an integrated network of key stakeholders and providers involved in physical activity and nutrition. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** The DHB has developed a number of networks of key stakeholders and providers involved in nutrition and physical activity. This includes a Healthy Eating Healthy Action (HEHA) Steering Group, an education subgroup, a breastfeeding subgroup, a Wellington HEHA Locality Group and a Kapiti HEHA Locality Group. The DHB also attends the Porirua HEHA Group and an intersectoral group implementing the Wellington Urban Region Physical Activity Strategy.
We will consolidate the Pacific breastfeeding promotion initiative and increase other breastfeeding support services in the community. **Date:** Dec 2007 **Output Class:** Funder/Provider	**Achieved** This is an integrated initiative with Pacific Primary Care and the Pacific Health Unit in the hospital. It identified a gap in Pacific peer counseling in this area. Over the last year the trainee Pacific lactation consultant in the Pacific Health Unit initiated ante natal classes with a Pacific midwife in the community as well as one on one home visits whilst following up on all Pacific women post delivery. This service has seen over 50 Pacific women attend these classes. The trainee lactation consultant has (with the support of Le Leche), trained the Volunteers of Pregnancy Help and other NGO professional organisations as breastfeeding peer counsellors.

	Currently eight Pacific mothers are going through the training process as breastfeeding peer counsellors.
We will achieve our target of 80% of 2 year old children fully immunised. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** We achieved 84 % immunisation coverage at two years of age. Investments in immunisation coordination and outreach immunisation services have been successful.

Key Performance Measures

Oral health – percentage of children caries-free at age five years

Not Achieved

Output Class: Funder

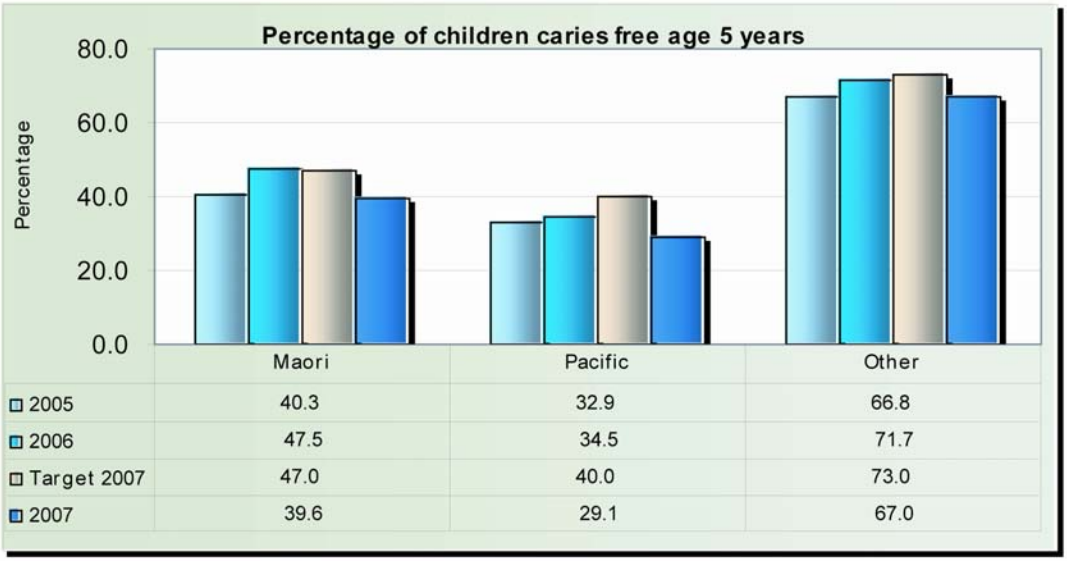
In 2007 the oral health targets were not achieved for children of any ethnic group. The number of children examined has decreased quite significantly across all groups from 2,747 in 2006 to 1,569 in 2007, which is likely to contribute to the variations in oral health status between the two years.

Throughout 2007, the DHB has been working with Hutt Valley DHB, the provider of our School Dental Service, to develop the joint regional Oral Health Business Case for Children and Adolescents. Through this process, we have gained a better understanding of the pressures and issues on services, especially the School Dental Service, including staffing shortages and information system issues.

Implementation of the business case requires significant changes to the child oral health service, including encouraging early enrolment into the service beginning as early as at birth.

Aside from the business case process, we are proposing to work closely with Hutt Valley DHB to look at improving enrolment and coverage of oral health services for school-age children, including:

- Implementing the new EXACT information system for the service, this will ensure more robust data collection and reporting
- Improving monitoring and reporting processes for the service across and between the two DHBs
- Increasing work with pre-school groups and providers to provide oral health education and increase enrolments before children attend school
- Further engagement with Māori Health providers and Pacific Health providers to improve enrolment – a pilot service in a Wellington PHO for this is currently underway
- Implementing a targeted Māori private dental service, provided by a local Māori health service provider, in a high needs area
- Educating care givers and other health providers on the importance of oral health for pre-schoolers and school children, through the Oral Health Promotion and Public Health Nurse services provided by Regional Public Health
- Further promotion of preventative health programmes outside of oral health, like Healthy Eating-Healthy Action initiatives, to improve the oral health of children



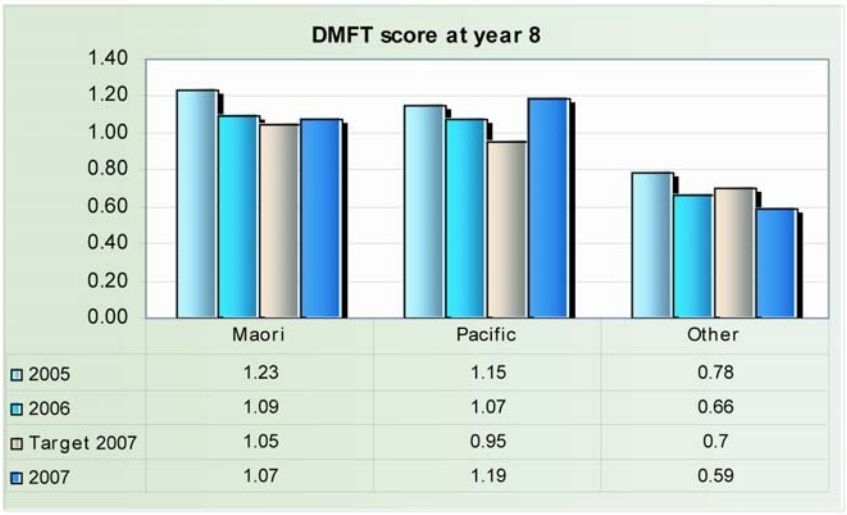
	Maori	Pacific	Other
2005	40.3	32.9	66.8
2006	47.5	34.5	71.7
Target 2007	47.0	40.0	73.0
2007	39.6	29.1	67.0

Oral health – mean decayed, missing and filled teeth (DMFT) score at year 8

Not Achieved

Output Class: Funder

The DMFT score indicates the average number of decayed, missing and filled teeth per person. For 2007 C&C DHB exceeded the target for 'Other' children however, we did not achieve the targets for Māori or Pacific children. This figure has improved compared to 2006 for both Māori and 'Other' children. However, the score has declined for Pacific children.

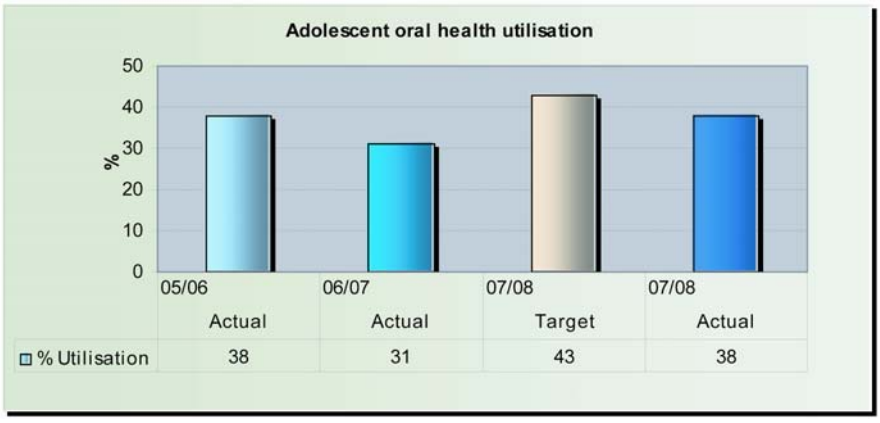


	Maori	Pacific	Other
2005	1.23	1.15	0.78
2006	1.09	1.07	0.66
Target 2007	1.05	0.95	0.7
2007	1.07	1.19	0.59

Progress towards 85% adolescent oral health utilisation (NHT)

Not Achieved

Output Class: Funder



	05/06	06/07	07/08	07/08
	Actual	Actual	Target	Actual
% Utilisation	38	31	43	38

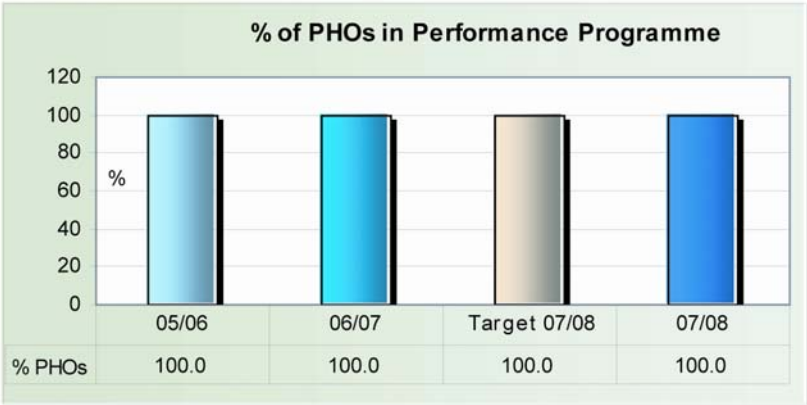
PHO management programme

The percentage of PHOs in Management programme

Achieved

Output Class: Funder

All Capital & Coast PHOs are in the PHO Performance Management programme. The PHOs are required to meet prerequisites to remain on the programme, which has been achieved.



PHO Coverage of Maori

The percentage of eligible Maori enrolled in our district PHOs

Output Class: Funder

In 2005/06 73 % of Maori enrolled in a C&C DHB PHO. More detailed analysis during the 2006/07 year indicated that 89 % of C&C DHB Maori residents were enrolled in a PHO, including in PHOs outside our district. However, we are unable to routinely measure the number of Maori enrolled in PHOs outside our district. There was an error in the target of 98% set in 2007/08 SOI. Our locally set target of 75 % has been achieved.

DHB Strategy 5: Supporting and promoting healthy lifestyles

Improving nutrition, increasing physical activity and reducing obesity are crucial components to the prevention of chronic conditions such as diabetes. The increasing incidence and impact of chronic conditions has lead to increased social and economic costs. Supportive environments to address lifestyle factors can be created by working with other agencies such as territorial authorities, schools and regional sports trusts. This can mitigate risk factors such as tobacco use, low physical activity, poor nutrition, and drug and alcohol misuse.

Milestone	Achievement
We will develop and implement a Pacific smoking cessation service **Date:** Mar 2008 **Output Class:** Funder	**Achieved** This regional service is a joint service between two DHB Pacific Primary Care providers and is totally funded by the Ministry of Health. The DHB was involved in the initial project scoping and development of service specifications.
We will implement DHB-wide HEHA strategy and plan. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** The DHB worked collaboratively with a range of stakeholders to develop an annual plan (Ministry Approved Plan 1 – MAP1) and a five year strategic plan. MAP1 outlined a range of deliverables and activities which have been implemented.

Milestone	Achievement
We will provide training in schools and early childhood centres on the Food and Nutrition Guidelines. **Date:** Jun 2008 **Output Class:** Funder	**Achieved** A HEHA Education Coordinator was appointed to focus on promoting nutrition in school and Early Childhood Education services. Areas of focus have been implementing the Food and Nutrition Guidelines and the Food and Beverage Classification System (FBCS). At the end of June 2008 five training sessions had been held and at least half of all schools and Early Childhood Education services had received a visit to promote the Guidelines and FBCS.

DHB Strategy 6: 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 also have a change programme in place to support an improved patient journey. Our milestones relate to the building programme and our key performance measures relate to our processes within the hospital that contribute to an improved patient experience.

Milestone	Achievement
We will continue to progress the Wellington Hospital redevelopment with roofing and plant room structures completed **Date:** Dec 2007 **Output Class:** Governance	**Achieved** By late November the work of Fletcher's structural team was complete and Fletchers moved their structural engineering team off site to other projects. By December the walkway to the helipad was framed and partially clad, and the levels 4 and 5 plant rooms close to complete. Cladding to the level 8 plant-

	room had commenced with a substantial amount of the large items of major plant to level 8 in place at that time. Ducting and 2nd fix plant-room services had commenced prior to year end. 
We will complete Kenepuru theatre. **Date:** Dec 2007 **Output Class:** Governance	**Achieved** The additional theatre T93 was completed in the last quarter of 2007 and included seven first stage recovery beds and sixteen second stage recovery places. Both new areas were certified for public use in October 2007. The new facility has been used in lieu of one of the existing theatres for more complex surgery. The existing theatre is being assessed for the transfer of some procedures. This will allow additional gastroenterology procedural work at Kenepuru Hospital. A change to the exit door of the second stage recovery room has been made following a request from users.
We will upgrade the Theatre IT System and integrate with the EHR. **Date:** Jun 2008 **Output Class:** Governance	**Partially achieved** Significant process has been made toward implementation, but there have been a number of capacity issues within Health Intelligence Ltd (our ICT provider) that have led to delays. Currently project is expected to be complete by September 2008.

Milestone	Achievement
We will finalise the model for administration support for the New Regional Hospital through an occupancy agreement **Date:** Sept 2007 **Output Class:** Provider	**Partially achieved** We have agreed the model for administration support for the new Wellington Regional Hospital. The model is based upon centralised reception and administrative support. All medical typing is now centralised and the integration of departmental records into a central repository is continuing.

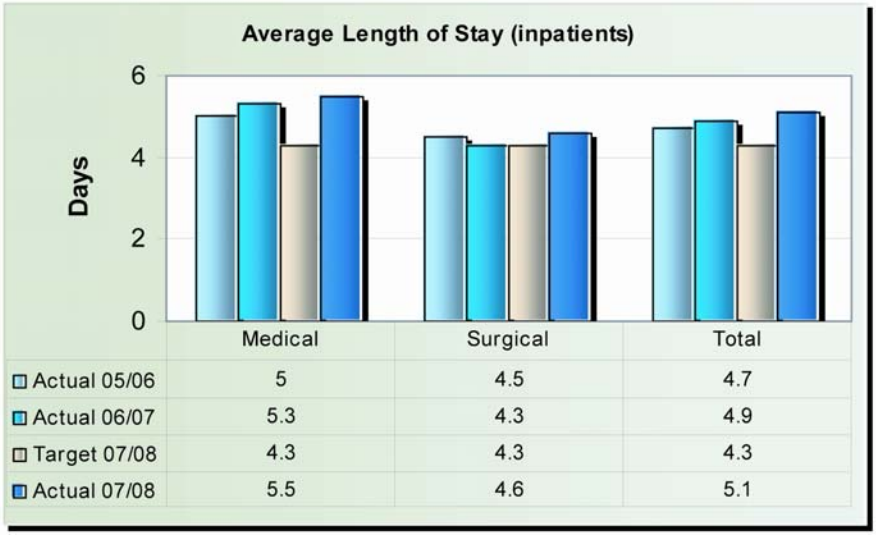
Key Performance Indicators

Inpatient length of stay

Not achieved

Output Class: Provider

Our average length of stay indicator has continued to increase in 2007/08. We made improvements in some specialty areas but general medicine and respiratory medicine contribute to the increase. We continue improving our support systems for patients to receive adequate care in the community, such as the Care Coordination Centre managing packages of care and support for treatment of cellulitis in the community setting. We hope the latter will contribute to improvements in the next year.



	Medical	Surgical	Total
Actual 05/06	5	4.5	4.7
Actual 06/07	5.3	4.3	4.9
Target 07/08	4.3	4.3	4.3
Actual 07/08	5.5	4.6	5.1

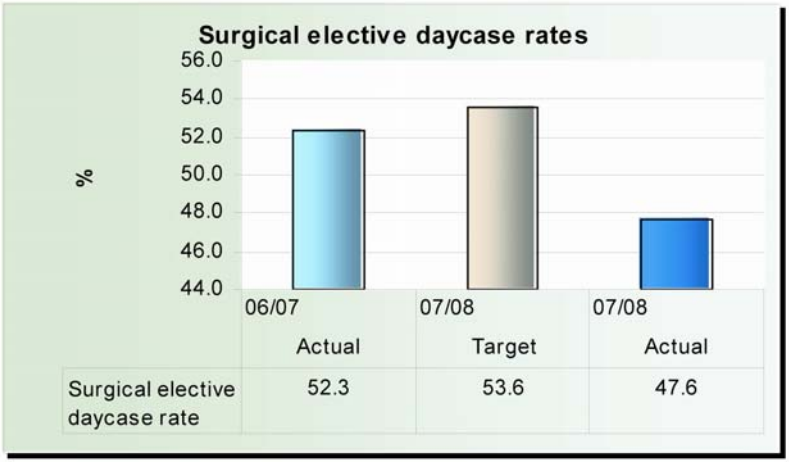
Surgical elective day case rates

Not achieved

Output Class: Provider

We are now more than 90 % staffed but workforce shortages, particularly anaesthetists and anaesthetic technicians, over the last year have prevented achievement of planned elective surgery.

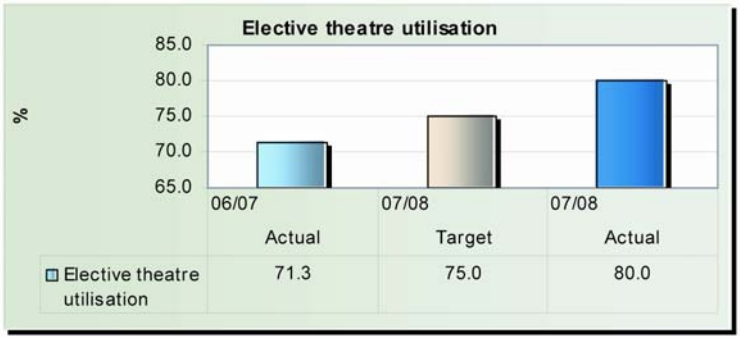
We have also worked to improve patient flow through the organisation with a focus on ensuring the surgical day unit and the surgical wards are dedicated, where ever possible, to surgical patients.



Elective theatre utilisation

Output Class: Provider

Nationally, the standard day for counting of theatre utilisation is available minutes between 0815 and 1200, and 1230 and 1615. Over the last year this indicator was measured using available minutes between 0900 and 1700. Both methods cover an 8 hour period but the later start leads to a higher utilisation result.
We will be counting via the national standard day during 2008/09 to enable benchmarking with other DHBs.

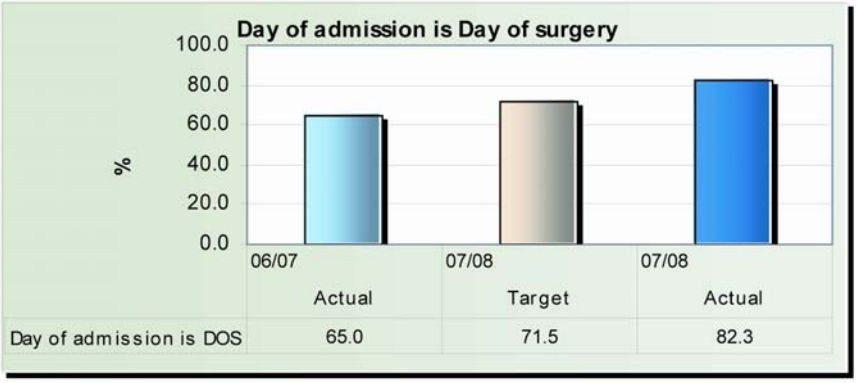


Day of admission is day of surgery

Achieved

Output Class: Provider

Significant work has been completed to achieve this outcome. There are now limited surgical procedures that require hospitalisation the night before surgery as most preparation can be completed in the patient's home. Out of town patients are bought into hospital for work up the day before surgery and stay locally the night prior to surgery.



AUDIT REPORT

TO THE READERS OF CAPITAL AND COAST DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS AND STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2008

The Auditor-General is the auditor of Capital and Coast District Health Board (the Health Board). The Auditor-General has appointed me, Stephen Lucy, 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 2008.

Unqualified Opinion

In our opinion:

- The financial statements of the Health Board on pages 75 to 139 :
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect:
    - the Health Board's financial position as at 30 June 2008; 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 35 to 70:
  - 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 6 November 2008, and is the date at which our opinion is expressed.

The basis of our opinion, which refers to a fundamental uncertainty about the validity of the going concern basis on which the financial statements and statement of service performance have been prepared, 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 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 statement and statement of service performance disclosures are adequate.

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

Fundamental Uncertainty – Validity of the Going Concern Assumption

In forming our opinion, we considered the adequacy of the disclosures made in note 31 on page 138 of the financial statements about the validity of the going concern assumption on which the financial statements are prepared. We consider those disclosures to be adequate. The Health Board has received a letter of comfort from the Ministers of Health and Finance, expressing the Government's commitment to work with the Board in its endeavours to maintain financial viability, including providing deficit support where necessary. The letter covers a period of 12 months from the date of this audit report.

Beyond that 12 month period, the validity of the going concern assumption is reliant on the Board successfully negotiating additional funding from the Crown to support its cash flow requirements and to ensure that the Health Board's borrowing requirements do not exceed its available borrowing facilities. The outcome of these negotiations is uncertain at this stage.

If the Health Board was unable to continue in operational existence for the foreseeable future, adjustments may have to be made to reflect the situation that assets may need to be realised other than in the amounts at which they are currently recorded in the Statement of Financial Position. In addition, the Health Board may have to provide for further liabilities that might arise, and to reclassify non-current assets and non-current liabilities as current assets and current liabilities.

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and 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 2008 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.

In addition to the audit we carried out a procurement policy review. This assignment is compatible with those independence requirements. Other than the audit and this assignment, we have no relationship with or interests in the Health Board.

S B Lucy
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Matters Relating to the Electronic Presentation of the Audited Financial Statements and Statement of Service Performance

This audit report relates to the financial statements and statement of service performance of the Capital and Coast District Health Board (The Health Board) for the year ended 30 June 2008 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the website. We have not been engaged to report on the integrity of the website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 6 November 2008 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial information may differ from legislation in other jurisdictions.

Statement of financial performance

For the year ended 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2008 Budget	2007 Actual
Revenue	1	719,888	701,640	667,172
Share of net surplus of joint venture		-	-	-
Total income		**719,888**	**701,640**	**667,172**
Employee benefit costs	3	288,034	274,984	260,892
Depreciation and amortisation expense	6,7	19,222	25,702	19,769
Outsourced services		22,402	6,662	16,999
Clinical supplies		77,805	81,336	70,799
Infrastructure and non-clinical expenses		56,674	36,343	47,359
Payments to non-health board providers		274,490	265,832	246,846
Other operating expenses	2	5,002	3,271	5,119
Finance costs	4	10,352	12,529	7,503
Total expenses		753,981	706,659	675,286
Surplus/(deficit) before Capital Charge		**(34,093)**	**(5,019)**	**(8,114)**
Capital charge	5	6,264	5,866	4,905
Surplus/(deficit) after Capital Charge		**(40,357)**	**(10,885)**	**(13,019)**
Share of profit of associates	9a	(319)	-	-
Surplus (deficit) before and after tax	18	**(40,676)**	**(10,885)**	**(13,019)**

Explanations of significant variances against budget are detailed in note 27.

The accompanying notes form part of these financial statements.

Statement of recognised income and expense

For the year ended 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2008 Budget	2007 Actual
Revaluation of property, plant and equipment	18	-	-	(184)
Cash flow hedges (foreign exchange and interest rate swap contracts): Effective portion of changes in fair value	18	-	-	-
Other changes recognised directly in equity	18	-	-	-
Net income recognised directly in equity		**-**	**-**	**(184)**
Surplus for the year	18	**(40,676)**	**(10,885)**	**(13,019)**
Total recognised income and expense for the year		**(40,676)**	**(10,885)**	**(13,203)**

The accompanying notes form part of these financial statements.

Statement of financial position

As at 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2008 Budget	2007 Actual
Assets				
Non-current assets				
Property, plant and equipment	6	450,024	454,588	367,933
Intangible assets	7	764	-	249
Investments in associates	9a	20,032	14,298	6,862
Investments in joint ventures	9b	-	-	-
Total non-current assets		**470,820**	**468,886**	**375,044**
Current assets				
Inventories	8	5,864	6,500	5,632
Trade and other receivables	10	80,547	158,215	129,469
Cash and cash equivalents	11	14	13	13
Trust/special funds	12	5,845	4,400	5,183
Assets classified as held for sale		-	-	-
Total current assets		**92,270**	**169,128**	**140,297**
Total assets		**563,090**	**638,014**	**515,341**
Equity				
Crown equity	18	231,250	271,806	208,133
Other reserves	18	33,010	33,195	33,010
Retained earnings/(losses)	18	(147,392)	(114,046)	(106,716)
Total equity		**116,868**	**190,955**	**134,427**
Liabilities				
Non-current liabilities				
Borrowings	13	283,000	305,854	217,400
Employee entitlements	14	2,370	5,000	4,402
Provisions	15	126	-	120
Patient and restricted funds	17	-	154	-
Total non-current liabilities		**285,496**	**311,008**	**221,922**
Current liabilities				
Bank overdraft	11	18,859	34,720	1,553
Borrowings	13	28,000	28,000	62,074
Employee entitlements	14	51,385	36,500	42,627
Provisions	15	799	-	280
Trade and other payables	16	61,508	36,831	52,288
Patient and restricted funds	17	175	-	170
Liabilities classified as held for sale		-	-	-
Total current liabilities		**160,726**	**136,051**	**158,992**
Total liabilities		**446,222**	**447,059**	**380,914**
Total equity and liabilities		**563,090**	**638,014**	**515,341**

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2008 Budget	2007 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		674,820	643,587	638,269
Other receipts		22,864	19,964	22,246
Cash paid to suppliers		(429,418)	(390,508)	(390,612)
Cash paid to employees		(280,744)	(279,387)	(250,339)
Cash generated from operations		**(12,478)**	**(6,344)**	**19,564**
Interest received		1,089	585	1,085
Interest paid		(8,557)	(15,119)	(6,330)
Goods and Services Tax (NET) (a)		1,576	178	705
Capital charge paid		(7,440)	(6,866)	(3,541)
Net cash flows from operating activities	11	**(25,810)**	**(27,566)**	**11,483**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		4,404	3,800	10
Acquisition of property, plant and equipment	6	(95,359)	(122,888)	(93,773)
Acquisition of investment property		-	-	-
Advances to associates		(13,489)	-	(4,424)
Acquisition of intangible assets	7	(5,550)	-	(3,296)
Net appropriation from trust funds	12	(662)	(4,519)	(358)
Net cash flows from investing activities		**(110,656)**	**(123,607)**	**(101,841)**
Cash flows from financing activities				
Proceeds from equity injection		91,118	50,885	-
Borrowings raised		121,600	66,920	162,400
Repayment of borrowings		(90,074)	-	(53,074)
Repayment of equity	18	(3,483)	-	(3,483)
Net cash flows from financing activities		**119,161**	**117,805**	**105,843**
Net increase in cash and cash equivalents		(17,305)	(33,368)	15,485
Cash and cash equivalents at beginning of year		(1,540)	(1,339)	(17,025)
Cash and cash equivalents at end of year	11	**(18,845)**	**(34,707)**	**(1,540)**

(a) The Goods and Services Tax (net) component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The Goods and Services Tax (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial reporting purposes.

(b) During the period the DHB acquired property, plant and equipment totalling $Nil(2007 $Nil) by means of finance leases.

The accompanying notes form part of these financial statements.

Statement of contingent liabilities

As at 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2007 Actual
Legal proceedings against the DHB		464	491
		464	**491**

The DHB has been notified of 4 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2008 (2007: 7).

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

The DHB has no contingent assets (2007 $nil).

The accompanying notes form part of these financial statements.

Statement of commitments

As at 30 June 2008

in thousands of New Zealand Dollars

	Note	2008 Actual	2007 Actual
Capital commitments		**36,640**	**81,963**
Non-cancellable commitments – provider commitments			
Not more than one year		90,045	83,891
One to two years		15,156	14,350
Two to five years		20,472	34,822
Over five years		131	-
		125,804	**133,063**
Non-cancellable commitments – operating lease commitments			
Not more than one year		1,882	1,125
One to two years		2,495	792
Two to five years		564	811
Over five years		75	501
		5,016	**3,229**

The accompanying notes form part of these financial statements.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2008

Reporting entity

Capital & Coast District Health Board (the DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, and the Crown Entities Act 2004.

The primary objective of the DHB is to provide goods or services for the community or social benefit rather than making a financial return. Accordingly, the DHB has designated itself as a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS). The DHB is a public benefit entity, as defined under NZIAS 1.

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

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes a requirement of compliance with New Zealand generally accepted accounting practice("NZ GAAP"). They comply with New Zealand equivalents to International Financial Reporting Standards, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are the DHB's first NZIFRS financial statements and NZIFRS 1 has been applied. An explanation of how the transition to NZIFRS has affected the reported financial position and financial performance of the DHB is provided in note 29.

NZ IAS 1, Presentation of Financial Statements (revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (issued 2004) and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives the DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). The DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

Basis of preparation

The financial statements have been prepared for the period 1 July 2007 to 30 June 2008. Comparative figures and balances relate to the period 1 July 2006 to 30 June 2007.

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand.

The financial statements are prepared on the historical cost basis except where modified by the revaluation of certain items of plant, property and equipment, and the measurement of equity instruments and derivative financial instruments at fair value.

This is the first set of financial statements prepared using NZ IFRS, and comparatives for the year ended 30 June 2007 have been restated to NZ IFRS accordingly. Reconciliations of equity and surplus/(deficit) for the year ended 30 June 2007 under NZ IFRS to the balances reported in the 30 June 2007 financial statements are detailed in note 29.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZIFRS Statement of Financial Position at 1 July 2006 for the purposes of the transition to NZIFRS.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2008

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

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

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2008

Basis for consolidation

Associates

Associates are those entities in which the DHB has significant influence, but not control, over the financial and operating policies.

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

Joint ventures

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

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

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.

Foreign currency

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Foreign exchange differences arising on translation are recognised in the statement of financial performance. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- leasehold improvements
- plant and equipment
- fixture and fittings/other equipment
- surplus properties
- work in progress.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2008

Owned assets

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

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

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

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

Disposal of Property, Plant and Equipment

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

Leased assets

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

Subsequent costs

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

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method. Land is not depreciated.

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

Class of asset	Estimated life	Depreciation rate
• Buildings structure	1 to 60 years	1.7-100%
• Building fitouts	1 to 25 years	4-100%
• Plant and equipment	5 to 15 years	6.7-20%
• Leasehold Improvements	1 to 25 years	4-100%

The residual value of assets is reassessed annually.

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

Intangible assets

Research and development

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

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	10 years	10%
Licences	10 years	10%

Financial Instruments

Non-derivative financial instruments

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

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

Trade and other receivables

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

Inventories

Inventories are held for the DHB's own use, and are stated at the lower of cost and net realisable value. Cost is based on weighted average cost.

Cash and cash equivalents

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

Impairment

The carrying amounts of the DHB's assets other than investment property, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.
If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.
An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

Notes to the financial statements

Significant accounting policies

Calculation of recoverable amount

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

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

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

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

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

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

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

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

Employee benefits
Short-term employee entitlements
Employee entitlements that the DHB expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date.

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

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

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

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

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

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

Trade and other payables
Trade and other payables are stated at amortised cost using the effective interest rate.

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

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

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

Hedging

Cash flow hedges

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

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

Income tax

The DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is therefore, exempt from income tax under the Income Tax Act 2004.

Notes to the financial statements

Significant Accounting Policies

Goods and services tax

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

Commitments and contingencies are disclosed exclusive of GST.

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

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

Borrowing costs

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

Capital charge

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

Revenue

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

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods sold and services rendered

Revenue from goods sold is recognised when the DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to the DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the DHB.

Interest

Interest income is recognised using the effective interest rate method.

Rental income

Rental income from investment property is recognised in the statement of financial performance on a straight-line basis over the term of the lease.

Vested assets

Where a physical asset is gifted to or acquired by the DHB for nil or nominal cost, the fair value of the asset received is recognised as income. Such assets are recognised as income when control over the asset is obtained.

Notes to the financial statements

Significant Accounting Policies

Expenses

Operating lease payments

Payments made under operating leases are recognised as an expense in the statement of financial performance on a straight-line basis over the term of the lease.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of financial performance.

The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.

Cost of Service (Statement of Service Performance)

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

Cost Allocation

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

Cost Allocation Policy

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

Criteria for Direct and Indirect Costs

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

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2008, indirect costs accounted for 1.0% of the DHB's total costs (2007: 1.2%)

Notes to the financial statements

in thousands of New Zealand Dollars

1 Revenue

	2008 Actual	2007 Actual
Ministry of Health Contract Funding	554,439	510,286
Other Government	11,428	9,983
Inter District Flows (Other DHBs)	138,184	126,703
Non Government & Crown Agency Sourced	14,317	19,115
Gain on sale of property, plant and equipment	431	-
Interest Income	1,089	1,085
	719,888	667,172

2 Other operating expenses

	Note	2008 Actual	2007 Actual
Impairment loss on property, plant and equipment	6,7	982	-
Impairment of trade receivables (bad debts)		-	146
Increase in provision of trade receivables (doubtful debts)	10	369	1,615
Loss on disposal of property, plant and equipment		273	18
Audit fees for the audit of the financial statements		161	154
Audit fees for NZ IFRS transition		12	12
Audit fees – Other Audit service		7	-
Directors fees and expenses	21	345	310
Rental and operating lease expenses		2,853	2,796
Litigation Settlement		-	68
		5,002	5,119

3 Employee benefit costs

	2008 Actual	2007 Actual
Direct Staff Costs (excluding increases in employee benefit provisions)	263,980	241,225
Indirect Staff Costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	14,251	11,182
Contributions to defined contribution plans	2,949	2,809
Increase/(decrease) in employee benefit provisions	6,854	5,676
	288,034	260,892

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

Notes to the financial statements

in thousands of New Zealand Dollars

4 Finance costs

	2008 Actual	2007 Actual
Fair value changes in hedge derivatives	-	-
Interest on bank overdraft	511	286
Interest on term borrowings	8,700	7,217
Net loss on derivative classified as Fair Value through Profit & Loss	1,141	-
Financial expenses	10,352	7,503

5 Capital Charge

CCHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2008 was 8 per cent (2007:8 per cent)

in thousands of New Zealand Dollars

6 Property, plant and equipment

	Free-hold land	Freehold buildings	Lease improve ments	Plant & Equip	F, F & E	Work in progress	Total
Cost							
Balance at 1 July 2006	30,850	126,597	2,655	44,602	4,808	79,107	288,619
Additions	-	24,251	5	-	9,163	107,620	141,039
Disposals	-	-	-	(345)	(2,667)	-	(3,012)
Revaluations	-	-	-	-	-	-	-
Transfer to Fixed Assets	-	-	-	-	-	(33,034)	(33,034)
Other Movements	-	-	-	-	3	-	3
Balance at 30 June 2007	30,850	150,848	2,660	44,257	11,307	153,693	393,615
Balance at 1 July 2007	30,850	150,848	2,660	44,257	11,307	153,693	393,615
Additions	-	10,419	22	-	10,351	108,490	129,282
Disposals	-	(3)	-	(412)	(871)	-	(1,286)
Revaluations	-	-	-	-	-	-	-
Transfer to Fixed Assets	-	-	-	-	-	(26,343)	(26,343)
Other Movements	-	11	-	-	(2)	40	49
Balance at 30 June 2008	30,850	161,275	2,682	43,845	20,785	235,880	495,317
Depreciation and impairment losses							
Balance at 1 July 2006	-	(3,533)	(811)	-	(1,800)	-	(6,144)
Depreciation charge for the year	-	(11,979)	(139)	(6,170)	(1,327)	-	(19,615)
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	152	21	-	173
Revaluations	-		-	-	-	-	-
Other Movements	-	-	-	-	(96)	-	(96)
Balance at 30 June 2007	-	(15,512)	(950)	(6,018)	(3,202)	-	(25,682)

in thousands of New Zealand Dollars

6 Property, plant and equipment (continued)

	Free-hold land	Freehold buildings	Lease Improve ments	Plant & Equip	F, F & E	Work in progress	Total
Depreciation and impairment losses							
Balance at 1 July 2007	-	(15,512)	(950)	(6,018)	(3,202)	-	(25,682)
Depreciation charge for the year	-	(11,050)	(131)	(5,113)	(2,428)	-	(18,722)
Impairment losses	-	(982)	-	-	-	-	(982)
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	124	32	-	156
Transfer to investment property	-	-	-	-	-	-	-
Transfer to non-current assets held for sale	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Other Movements	-	-	-	-	(63)	-	(63)
Balance at 30 June 2008	-	(27,544)	(1,081)	(11,007)	(5,661)	-	(45,293)
Carrying amounts							
At 1 July 2006	30,850	123,064	1,844	44,602	3,008	79,107	282,475
At 30 June 2007	30,850	135,336	1,710	38,239	8,105	153,693	367,933
At 1 July 2007	30,850	135,336	1,710	38,239	8,105	153,693	367,933
At 30 June 2008	30,850	133,731	1,601	32,838	15,124	235,880	450,024

6 Property, plant and equipment (continued)

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land was carried out as at 30 June 2006 by M J Bevin, MPA, SNZPI, an independent registered valuer with DTZ New Zealand Ltd. The valuation conforms to International Valuation Standards and was determined by reference to its highest and best use. The valuer was contracted as an independent valuer. The valuer has advised the valuation as at 30 June 2006 remains valid.

The revaluation of buildings was carried out as at 30 June 2006 by M J Bevin, MPA, SNZPI, an independent registered valuer with DTZ New Zealand Ltd. The valuation conforms to International Valuation Standards and was based on depreciated replacement cost methodology. The valuer was contracted as an independent valuer.

The revaluation of plant and equipment was carried out as at 30 June 2006 by E A Forbes, Dip QS, SNZPI, an independent registered valuer with DTZ New Zealand Ltd. The valuation conforms to International Valuation Standards and was determined by reference to market value where available, or depreciated replacement cost where a market value was unavailable. The valuer was contracted as an independent valuer.

The total fair value of land valued by the valuer amounted to $25.1m.

The total fair value of buildings valued by the valuer amounted to $116.9m.

The total fair value of plant and equipment valued by the valuer amounted to $44.6m.

Restrictions

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

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

Leased assets

The DHB leases Radiology equipment under a number of finance lease agreements. At 30 June 2008, the net carrying amount of leased Radiology equipment was $Nil (2007: $Nil). The leased Radiology equipment secures the DHB's lease obligations.

Property, plant and equipment under construction

During the year ended 30 June 2008 the New Regional Hospital project neared completion, with some large components of the project having been transferred from Work in Progress to buildings within Property, plant and Equipment. The project cost currently in work in progress totalled $227.8m (2007: $137m).

Impairment

An impairment of $1.0m (2007 $nil) was recognised for an alarm system that no longer functions at an adequate level for the DHB. The alarm is to be replaced within the next financial year and has been written down to a value to recognise the limited remaining life.

in thousands of New Zealand Dollars

7 Intangible assets

	Software	Licences	Total
Cost			
Balance at 1 July 2006	140	1,177	1,317
Additions	43	-	43
Disposals	-	-	-
Balance at 30 June 2007	183	1,177	1,360
Balance at 1 July 2007	183	1,177	1,360
Additions	5,365	185	5,550
Disposals	(4,954)	-	(4,954)
Balance at 30 June 2008	594	1,362	1,956
Amortisation and impairment losses			
Balance at 1 July 2006	(98)	(859)	(957)
Amortisation charge for the year	(11)	(143)	(154)
Impairment losses	-	-	-
Reversal of impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2007	(109)	(1,002)	(1,111)
Balance at 1 July 2007	(109)	(1,002)	(1,111)
Amortisation charge for the year	(453)	(47)	(500)
Impairment losses	-	-	-
Reversal of impairment losses	-	-	-
Disposals	419	-	419
Balance at 30 June 2008	(143)	(1,049)	(1,192)
Carrying amounts			
At 1 July 2006	42	318	360
At 30 June 2007	74	175	249
At 1 July 2007	74	175	249
At 30 June 2008	451	313	764

There are no restrictions over the title of Capital & Coast District Health Board's intangible assets, nor are any intangible assets pledged as security for liabilities.

In thousands of New Zealand Dollars

8 Inventories

	2008 Actual	2007 Actual
Pharmaceuticals	1,085	1,252
Surgical & Medical Supplies	4,591	4,271
Other supplies	188	109
	5,864	5,632

The amount of inventories recognised as an expense during the year ended 30 June 2008 was $25.6m (2007: $15.4m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2007 $nil). There have been no reversals of write-downs.

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

9a Investments in associates

The DHB has the following investments in associates:

a) General information

Name of entity	Principal activities	Interest held at 30 June 2008	Interest held at 30 June 2007	Balance Date
HIQ Limited	Owns and manages information systems	50%	50%	30 June

HIQ Limited was jointly created with Taranaki DHB in October 2004 and has a balance date of 30 June. The DHB and TDHB share information services through HIQ Limited. The board of HIQ Limited has an equal representation from both DHB's.

b) Summary of financial information on associate entities

2008 Actual	Assets	Liabilities	Equity	Revenues	Profit / (loss)
HIQ Limited	38,871	11,391	27,481	19,349	(221)
	38,871	11,391	27,481	19,349	(221)

2007 Actual	Assets	Liabilities	Equity	Revenues	Profit / (loss)
HIQ Limited	26,278	14,992	11,286	15,062	(370)
	26,278	14,992	11,286	15,062	(370)

c) Share of profit of associate entities

	2008 Actual	2007 Actual
Share of profit/(loss)	(319)	-

HIQ Ltd is a Public Authority in terms of the Income Tax Act 2004 and consequently is exempt from income tax. The share of loss in 2008 is for the cumulative result from incorporation. In prior years the Financial Statements of HIQ Ltd were not available to enable inclusion in the Financial Statements of the DHB.
The share of profit or loss from HIQ Ltd is dependant upon activities performed for the DHB and does not necessarily reflect the percentage shareholding.

In thousands of New Zealand Dollars

d) Investment in associate entities

	2008 Actual	2007 Actual
Carrying amount at beginning of year	6,862	6,862
Acquisition of new investments	-	-
Disposal of investments	-	-
Share of total recognised revenue and expenses	(319)	-
Dividends	-	-
Issue of shares	13,489	-
Carrying amount at end of year	20,032	6,862

e) Share of associates' contingent liabilities and commitments

	2008 Actual	2007 Actual
Contingent liabilities	-	-
Contracted capital commitments	776	-
Other contracted commitments	-	90

The DHB is not jointly or severally liable for the liabilities owing at balance date by the associates.

9b Investments in joint ventures

a) Carrying amount of investments in joint ventures

	2008 Actual	2007 Actual
Central Region TAS	-	-
	-	-

Owing to the minor nature of the Joint Venture no carrying value is recorded the DHB's financial statements

b) Summary of the DHB's interests in Central TAS joint venture (16.67%)

	2008 Actual	2007 Actual
Non-current assets	31	41
Current assets	103	109
Non-current liabilities	-	-
Current liabilities	66	68
Net assets/(liabilities)	68	82
Income	492	446
Expense	507	433
	(15)	13

c) The DHB's share in contingent liabilities

Central Region TAS has no contingent liabilities.

In thousands of New Zealand Dollars

9b Investments in joint ventures (continued)

d) The DHB's share in commitments

The DHB share of Capital Commitments for CR TAS is $0.01m in 2008 (2007:$nil).

10 Trade and other receivables

	2008 Actual	2007 Actual
Trade receivables due from associates	7,577	13,227
Trade receivables from non-related parties	15,544	16,465
Ministry of Health receivables	31,817	10,434
	54,938	40,126
Accrued income	3,494	3,089
Prepayments	633	254
Crown Equity Receivable	21,482	86,000
	80,547	129,469

Trade receivables are shown net of provision for doubtful debts amounting to $1.7m (2007: $3.5) The carrying value of receivables approximates their fair value.

As at 30 June 2008 and 2007, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2008			2007		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	50,620	-	50,620	36,049	-	36,049
Past due 1-30 days	925	-	925	985	-	985
Past due 31-60 days	458	-	458	416	-	416
Past due 61-90 days	267	-	267	377	-	377
Past due > 91 days	4,324	1,656	2,668	5,808	3,509	2,299
Total	**56,594**	**1,656**	**54,938**	**43,635**	**3,509**	**40,126**

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

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

	2008 Actual	2007 Actual
Balance at 1 July	3,509	1,894
Additional provisions made during the year	369	1,615
Receivables written-off during period	(2,222)	-
Balance at 30 June	1,656	3,509

In thousands of New Zealand Dollars

11 Cash and cash equivalents

	2008 Actual	2007 Actual
Petty Cash	14	13
Bank Accounts	-	-
Call deposits	-	-
Cash and cash equivalents	14	13
Bank overdrafts	(18,859)	(1,553)
Cash and cash equivalents in the statement of cash flows	(18,845)	(1,540)

The DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and interest earned is allocated to the individual patients.

Working capital facility

The DHB has a working capital facility supplied by ASB Bank Limited, which was established in October 2004. The facility consists of a bank overdraft. The facility utilisation was $18.9m as at 30 June 2008.

The ASB working capital facility is secured by a negative pledge. Without ASB's prior written consent, The DHB cannot perform the following actions:

* create any security over its assets except in certain circumstances,
* lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
* make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
* dispose of any of its assets except disposals at full value in the ordinary course of business.

The DHB must also meet a cash flow cover covenant, under which operating cash flow must be greater than zero. At all times since the facility was established the covenant has been met, when tested. Unless a waiver has been granted the covenant is tested at 31 December and 30 June each year. The ASB facility has a limit of $40m. A waiver was granted for December 07 and June 08.

In thousands of New Zealand Dollars

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

	Note	2008 Actual	2007 Actual
Surplus for the period	18	(40,676)	(13,019)
Add back non-cash items:			
Depreciation		19,222	19,769
Share of (profit)/loss from associate companies	9a	319	-
Impairment Loss on Property, Plant & Equipment	2	982	-
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		273	18
Add back items classified as financing activity:			
Movements in working capital:			
(Increase)/decrease in trade and other receivables	10	(14,613)	(5,397)
(Increase)/decrease in inventories	8	(232)	(218)
Increase/(decrease) in trade and other Payables	16	1,627	6,133
Increase/(decrease) in employee benefits		7,288	4,147
Increase/(decrease) in provisions		-	50
Net movement in working capital		(5,930)	4,715
Net cash inflow/(outflow) from operating activities		(25,810)	11,483

12 Trust/Special Funds

Trust/ Special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived, and are accounted for separately through the DHB's trust ledger. The revenue and expenditure in respect of these funds is included in the statement of financial performance.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the Statement of Financial Performance, but are recorded in the Statement of Financial Position as both an asset and a liability.

All trust and patient funds are held in bank accounts that are separate from the DHB's normal banking facilities.

In thousands of New Zealand Dollars

Non patient trust funds	2008 Actual	2007 Actual
Balance at beginning of year	5,024	4,692
Monies received	1,467	1,388
Interest received	449	330
Payments made	(1,258)	(1,386)
Balance at end of year	5,682	5,024

Patient funds	2008 Actual	2007 Actual
Balance at beginning of year	159	133
Monies received	270	301
Interest received	6	5
Payments made	(272)	(280)
Balance at end of year	163	159
Total Trust/Special funds	5,845	5,183

13 Interest-bearing loans and borrowings

	2008 Actual	2007 Actual
Non-current		
Secured loans	283,000	217,400
	283,000	217,400
Current		
Current portion of secured loans	28,000	62,000
EECA	-	74
	28,000	62,074

Secured bank loans
TH DHB secured loans are from the Crown Health Financing Agency. The Crown Health Financing Agency is the entity used by the Ministry of Health for the financing requirements of DHBs. The details of terms and conditions are as follows:

Interest rate summary	2008 Actual	2007 Actual
Crown Health Financing Agency	6.075%-7.31%	5.81%-7.31% pa
EECA	-	0.00% pa

Repayable as follows:	2008 Actual	2007 Actual
Within one year	28,000	62,074
One to two years	-	28,000
Two to five years	150,000	80,000
Five to Ten years	133,000	109,400

Term loan facility limits	2008 Actual	2007 Actual
Crown Health Financing Agency	311,000	311,000

in thousands of New Zealand Dollars

13 Interest-bearing loans and borrowings (continued)

Security and terms

The loan facility is provided by the Crown Health Financing Agency, which is aligned with the Ministry of Health. The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent the DHB cannot perform the following actions:

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

The DHB is not required to meet any covenants.
The Government of New Zealand does not guarantee term loans.

14 Employee entitlements

	2008 Actual	2007 Actual
Non-current liabilities		
Liability for long-service leave	1.430	1,586
Liability for sabbatical leave	250	-
Liability for retirement gratuities	690	2,816
	2,370	4,402

	2008 Actual	2007 Actual
Current liabilities		
Liability for long-service leave	2,194	636
Liability for sabbatical leave	208	399
Liability for retirement gratuities	2,806	295
Liability for annual leave	25,265	23,071
Liability for sick leave	1,877	-
Liability for continuing medical education leave	4,559	4,069
Salary and wages accrual	14,476	14,157
	51,385	42,627

Defined Benefit Plans:
The DHB has employees who are members of defined benefit plans. The funding liability of these plans is assumed by central government.
Other Employee Entitlement Liabilities:
-Liability for annual leave and salaries and wages accrued is regarded as at current actual salaries
-Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 3.0%,(2007 3.0%) and a discount rate ranging from 6.95% to 6.33% from 1-10+ years.

in thousands of New Zealand Dollars

15 Provisions

	2008 Actual	2007 Actual
Current Provisions		
Restructure	563	-
ACC Partnership Programme	236	280
	799	280
Non Current Provisions		
ACC Partnership Programme	126	120
Total Provisions	925	400

ACC Partnership Programme	2008 Actual	2007 Actual
Undiscounted amount of claims at balance date	360	390
Discount	34	40
Central estimate of present value of future payments	326	350
Risk margin	36	50
Total Liability	362	400

The movement in provisions is represented by:

	Restructuring	ACC Partnership Programme
2007		
Opening balance	-	350
Additional provisions during the year for the risks borne in current period	-	210
Additional provisions relating to a reassessment of risks in a previous period	-	-
Total expenditure for period	-	560
Amounts used during the year	-	160
Total Liability	-	400
Increase in provision for claims liability	-	50

in thousands of New Zealand Dollars

	Restructuring	ACC Partnership Programme
2008		
Opening balance	-	400
Additional provisions during the year for the risks borne in current period	563	235
Additional provisions relating to a reassessment of risks in a previous period	-	-
Total expenditure for period	563	635
Amounts used during the year	-	273
Total Liability	563	362
Increase in provision	563	(38)

ACC Partnership Programme

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

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

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

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

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

The DHB has chosen a stop loss limit of 350% of the industry premium. The stop loss limit means that the DHB will only carry the total cost of claims up to $3.8m.

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

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

Average inflation has been assumed as 4% for the year ending 30 June 2009, and 4% for the year ending 30 June 2010. A discount rate of 6.8% has been used for the year ended 30 June 2009 and 6.8% for the year ending 30 June 2010.

The value of the liability is not material for the DHB's financial statements; therefore any changes in assumptions will not have a material impact on the financial statements.

Restructuring Provision

The DHB's management approved a detailed and formal restructuring plan which was announced in May 2008. The restructuring plan and associated payments are expected to be completed by October 2008. The provision has been made for the obligation of expected restructuring costs for employee termination benefits.

in thousands of New Zealand Dollars

16 Trade and other payables

	Note	2008 Actual	2007 Actual
Trade payables due to associates		-	-
Trade payables to other related parties	21	981	30
Trade payables to non-related parties		2,091	3,100
GST and other taxes payables		5,957	7,534
Income in advance		215	150
Capital charge due to the Crown		893	2,069
Other non-trade payables and accrued expenses		51,371	39,405
		61,508	52,288

Creditors and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of creditors and other payables approximates their fair value.

17 Patient and Restricted Funds

Patient funds	2008 Actual	2007 Actual
Balance at beginning of year	159	133
Monies received	270	301
Interest received	6	5
Payments made	(272)	(280)
Balance at end of year	163	159

Patient funds are held in a separate bank account,. Any interest earned is allocated to the individual patient balances. Patient fund transactions during the year ended 30 June 2008 are not recognised in the Statement of Financial Performance, but are recorded in the Statement of Financial Position as at 30 June 2008, both as an asset and a liability.

Holiday homes funds	2008 Actual	2007 Actual
Balance at beginning of year	44	37
Monies received	8	11
Interest received	3	3
Payments made	(9)	(7)
Balance at end of year	46	44
Hutt Valley DHB Portion ¼ of Holiday Homes total	12	11
Total Patient and Hutt Valley Portion of Restricted Funds	175	170

The holiday homes were purchased for the benefit of staff from funds bequeathed for the purpose in 1993. The holiday homes are two units at Taupo, which are let to staff of the DHBs, and Hutt Valley District Health Board, at a rate which will cover operating costs. The Holiday Homes transactions are recognised in the Statement of Financial Performance, and in the Statement of Financial Position.

in thousands of New Zealand Dollars

18 Capital and reserves

Reconciliation of movement in capital and reserves

		Other reserves				
	Crown equity	**Revaluation Reserve (Land)**	**Revaluation Reserve (P & E)**	**Total other reserves**	**Retained earnings**	**Total equity**
Balance at 1 July 2006	211,616	24,269	8,925	-	(93,697)	151,113
Total recognised income and expense	-	-	-	-	(13,019)	(13,019)
Repayment of Equity	(3,483)	-	-	-	-	(3,483)
Contribution from the Crown	-	-	-	-	-	-
Movement in revaluation of reserves	-	-	(184)	-	-	(184)
Transfer from retained earnings	-	-	-	-	-	-
Balance at 30 June 2007	208,133	24,269	8,741	-	(106,716)	134,427
Balance at 1 July 2007	208,133	24,269	8,741	-	(106,716)	134,427
Total recognised income and expense	-	-	-	-	(40,676)	(40,676)
Repayment of Equity	(3,483)	-	-	-	-	(3,483)
Contribution from the Crown	26,600	-	-	-	-	26,600
Movement in revaluation of land and buildings	-	-	-	-	-	-
Transfer from retained earnings	-	-	-	-	-	-
Balance at 30 June 2008	231,250	24,269	8,741		(147,392)	116,868

in thousands of New Zealand Dollars

19 Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2008 Actual	2007 Actual
Less than one year	1,882	1,125
Between one and five years	3,059	1,603
More than five years	75	501
	5,016	3,229

The DHB leases a number of buildings, vehicles and items of medical equipment under operating leases.

The leases are on normal commercial terms, and include restrictions on sub-leasing. For leased buildings some leases have ratchet clauses, and most have rights of renewal.

No leases include contingent rentals.

Operating lease payments are recognised as an expense on a straight line basis over the term of the lease.

No leased properties are subleased by the DHB.

During the year ended 30 June 2008, $2.9m was recognised as an expense in the statement of financial performance in respect of operating leases (2007: $2.8m)

Leases as lessor

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

	2008 Actual	2007 Actual
Less than one year	683	662
Between one and five years	1,389	287
More than five years	1,044	-
	3,116	949

During the year ended 30 June 2008, $3.1m was recognised as rental income in the statement financial performance (2007: $3.0m)

The DHB has a long term agreement with the University of Otago for the provision of medical consultancy services and facilities from which they operate these services.
The DHB has long term ground leases on operation where the lessee owns all the improvements.
The DHB has medium term leases (consulting rooms) in two separate health centres.
The DHB has 48 short term commercial leases all subject to 6 month notice of termination. Most are on the surplus land at the Porirua campus.
The DHB has 19 residential leases all subject to the Residential Tenancies Act.

20 Financial instruments

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

Credit risk

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor (approximately 40 per cent). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

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

Interest rate risk

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

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

The net fair value of interest rate hedges swaps at 30 June 2008 was $nil (2007: $nil)

Sensitivity Analysis

If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $0.1m in 2008, (2007 $0.1m).

in thousands of New Zealand Dollars

20 Financial instruments (continued)

Effective interest rates and repricing analysis

In respect of interest-bearing financial liabilities, the following table indicates their effective interest rates at the balance sheet date and the periods in which they reprice.

	Note	2008 Actual							2007 Actual						
		Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Secured bank loans:															
NZD fixed rate loan*		7.31%	28,000	-	28,000	-	-	-	5.94	62,000	62,000	-	-	-	-
NZD fixed rate loan*		6.33%	55,000	-	-	-	55,000	-	7.31	28,000	-	-	28,000	-	-
NZD fixed rate loan*		6.84%	25,000	-	-	-	25,000	-	6.33	55,000	-	-	-	55,000	-
NZD fixed rate loan*		6.075%	70,000	-	-	-	70,000	-	6.84	25,000	-	-	-	25,000	-
NZD fixed rate loan*		6.67%	71,000	-	-	-	-	71,000	6.30	20,000	-	-	-	-	20,000
NZD fixed rate loan*		6.37%	62,000	-	-	-	-	62,000	6.95	19,400	-	-	-	-	19,400
NZD fixed rate loan*		-	-	-	-	-	-	-	6.08	70,000	-	-	-	-	70,000
Bank overdrafts		8.39%	18,859	18,859	-	-	-	-	8.14	1,553	1,553	-	-	-	-
			329,859	18,859	28,000	-	150,000	133,000		280,953	63,500	-	28000	80,000	109,400

* These liabilities bear interest at fixed rates.

in thousands of New Zealand Dollars

Contractual maturity analysis of financial Liabilities

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

	Carrying Amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2008						
Creditors and other payables	61,508	61,508	61,508	-	-	-
Bank Overdraft	18,859	18,859	18,859	-	-	-
Secured Loans	311,000	424,056	48,195	18,129	197,489	160,243
Patient and restricted funds	175	175	175	-	-	-
Total	391,542	504,598	128,737	18,129	197,489	160,243
2007						
Creditors and other payables	52,288	52,288	52,288	-	-	-
Bank Overdraft	1,553	1,553	1,553	-	-	-
Secured Loans	279,400	355,914	77,807	42,194	114,427	121,486
Patient and restricted funds	170	170	170	-	-	-
Total	333,411	409,925	131,818	42,194	114,427	121,486

Contractual maturity analysis of Financial Assets

The table below analyses the DHB's financial assets into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date.

	Carrying Amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2008						
Cash and Cash equivalents	14	14	14	-	-	-
Debtors and other receivables	80,547	80,547	80,547	-	-	-
Trust and Special Funds - Bank	414	414	414	-	-	-
Trust and Special Funds – Term Deposit	5,196	5,213	5,213	-	-	-
Trust and Special Funds – debtors	235	235	235	-	-	-
Total	86,406	86,423	86,423	-	-	-
2007						
Cash and Cash equivalents	13	13	13	-	-	-
Debtors and other receivables	129,469	129,469	129,469	-	-	-
Trust and Special Funds - Bank	600	600	600	-	-	-
Trust and Special Funds – Term Deposit	4,472	4,483	4,483	-	-	-
Trust and Special Funds – debtors	111	111	111	-	-	-
Total	134,665	134,676	134,676	-	-	-

in thousands of New Zealand Dollars

20 Financial instruments (continued)

Maximum exposure to credit risk

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

	2008 Actual	2007 Actual
Cash at bank and petty cash	14	13
Debtors and other receivables	80,547	129,469
Trust and Special Funds – Bank	414	600
Trust and Special Funds – Term Deposit	5,196	4,472
Trust and Special Funds - Debtors	235	111
	86,406	134,665

	2008	2007
Counterparties with Credit Ratings		
Cash at bank and Term Deposits	-	-
AA (Standard & Poors)	5,624	5,085
	5,624	5,085

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

Foreign currency risk

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

The DHB hedges large transactions denominated in a foreign currency. The DHB uses forward exchange contracts to hedge its foreign currency risk. Most of the forward exchange contracts have maturities of less than one year after the balance sheet date. Where necessary, the forward exchange contracts are rolled over at maturity.

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2008 was $nil (2007: $nil), comprising assets of $nil (2007: $nil) and liabilities of $nil (2007: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of financial performance. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as Fair Value through Profit & Loss" (see note 4). The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2008 was $0.03m (2007: nil) recognised in fair value derivatives.

Sensitivity analysis

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

At 30 June 2008, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $1.3m (2007: $1.0m). It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies to which the DHB had direct exposure would have decreased the DHB's surplus before tax by approximately $0.05m for the year ended 30 June 2008 (2007: $nil). The forward exchange contracts have been included in this calculation.

in thousands of New Zealand Dollars

20 Financial instruments (continued)

Fair values

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

	Note	Carrying amount 2008 Actual	Fair value 2008 Actual	Carrying amount 2007 Actual	Fair value 2007 Actual
Trade and other receivables	10	80,547	80,547	129,469	129,469
Cash and cash equivalents	11	14	14	13	13
Secured bank loans	13	(311,000)	(314,081)	(279,400)	(275,770)
Unsecured bank liabilities	16	-	-	-	-
Trade and other payables	16	(61,508)	(61,508)	(52,288)	(52,288)
Bank overdraft	11	(18,859)	(18,859)	(1,553)	(1,553)
		(310,806)	(313,887)	(203,759)	(200,129)
Unrecognised (losses)/gains			(3,081)		3,630

Estimation of fair values analysis

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

in thousands of New Zealand Dollars

20 Financial instruments (continued)

Derivatives

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

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

Interest-bearing loans and borrowings

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

Finance lease liabilities

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

Trade and other receivables/payables

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

Interest rates used for determining fair value

The entity uses the government bond rate as of 30 June 2008 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2008 Actual %	2007 Actual %
Derivatives	N/A	N/A
Loans and borrowings	6.075, 6.295, 6.33, 6.37, 6.39, 6.57,6.84, 6.95, 7.13, 7.31	5.81, 5.99, 6.075, 6.14, 6.295, 6.33, 6.84, 6.95, 7.31

21 Related parties transactions and key management personnel

Identity of related parties

The DHB enters into transactions with government departments, state-owned enterprises and other crown entities. Those transactions that occur within a normal supplier or client relationship on terms and conditions no more or less favourable than those which it is reasonable to expect the DHB would have adopted if dealing with that entity at arm's length in the same circumstances have not been disclosed as related party transactions.

The DHB has a related party relationship with its associate company, its joint venture and with its board members and key management personnel.

In addition the following members of the board have related parties with the DHB suppliers.

Sir John Anderson is a board member of the Commonwealth Bank of Australia who is the banker for the DHB. Sir John Anderson , who was appointed to the Board of CCDHB on 13 December 2007, is also a Board member of Hawkes Bay DHB. Transaction details disclosed relate to the full financial year.

Ian Brown is the Deputy Commissioner of Hawkes Bay DHB

Ken Douglas is a Board member of three suppliers to the DHB, being Air New Zealand, Healthcare of New Zealand Ltd and New Zealand Post Ltd.

Dr Donald Urquhart-Hay has an association with Wakefield Hospital.

Dr Selwyn Katene is the Chairman of Te Roopu Awhina

Judith Aitken is an elected councillor of Greater Wellington Regional Council(GRWC)

Helen Ritchie is a Councillor for Wellington City Council.

The Chairperson of the DHB, the Chief Executive, and the Chief Operating Officer of the DHB are directors on the Board of its associate company, HIQ Ltd.

The following members of the key management personnel have related parties with the DHB suppliers

Liz Maddison is the director of Maddison projects

Jim Wicks wife is an employee of Powerhouse People Ltd.

Cathy O'Malley is the CEO of the following suppliers Wellington Independent Practices Association, The Greater Wellington Health Trust, MATPRO Ltd, Capital PHO, Tumai mo te Iwi, Kapiti PHO and is also a director of MATPRO Ltd

In addition to their salaries, the DHB also provides non-cash benefits to executive officers, and contributes to a post-employment defined benefit plan on their behalf. In accordance with the terms of the plan, executive officers who are members on retiring are entitled to receive annual payments equivalent to a percentage of their salary at the date of retirement. The percentage is dependent on length of service

in thousands of New Zealand Dollars

Remuneration
The key management personnel remuneration is as follows:

	2008 Actual	2007 Actual
Short-term employee benefits	2,781	2,390
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	142	21
	2,923	2,411

	2008 Actual	2007 Actual
Board members	345	310
Executive team	2,578	2,101
	2,923	2,411

Key management personnel include all Board members, the Chief Executive, and the remaining 10 members of the management team.

The Board of the DHB as at 30 June 2008, 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.

in thousands of New Zealand Dollars

Board Members			**2008**	**2007**
Sir John Anderson	Appointed	Board Chair	28	-
Bob Henare	Appointed	Chair resigned Dec 2006	-	18
Judith Aitken	Elected	Chair DSAC	41	47
Brendon Bowkett	Elected		11	25
Ruth Bradwell	Elected		9	26
Ian Brown	Appointed		17	-
Peter Dady	Elected		12	26
Ken Douglas	Appointed	Deputy – Chair, Chair – Risk, Safety & Quality Assurance	33	28
Margaret Faulkner	Elected	Chair – DSAC and Audit Sub Committee	31	30
Ruth Gotlieb	Elected		26	27
Virginia Hope	Elected	Chair - HAC	16	-
Selwyn Katene	Appointed	Chair- CPHAC	14	-
Kiri Parata	Appointed		13	27
Fuimaono Karl Pulotu-Endemann	Appointed		13	27
Helen Ritchie	Elected		27	23
Peter Douglas	Appointed (April 07)		25	6
Peter Roberts	Appointed		14	-
Donald Urquhart-Hay	Elected		15	-
			345	310

Legend:
DSAC – Disability Support Advisory Committee
HAC – Hospital Advisory Committee
CPHAC – Community and Public Health Advisory Committee

Committee Members' (other than Board Members and Employees)	**2008**	**2007**
Community and Public Health Advisory Committee		
Herani Demuth	5	5
Ida Faiumu-Isaako	-	-
Linda Hobman	3	3
Stephen Palmer	-	-
Clive Plucknett	-	-
Puspa Wood	1	1
Disability Support Advisory Committee		
Valerie Bos	3	3
Margaret Guthrie	3	3
Jools Joslin	-	-
Liz Mellish	2	2
Sarah Porter	-	-
Rev Langi Sipeli	-	-
Hospital Advisory Committee		
Hilda Broadhurst	6	5
Marion Bruce	3	3
John Cook	3	3
Lynn McBain	3	3
Rose McEldowney	-	-
Lani Wills	-	-
	32	31

in thousands of New Zealand Dollars

21 Related parties (continued)

Sales to related parties

	2008 Actual	2007 Actual
HIQ (associate)	2,243	3,000
CRTAS (joint venture)	12	-
Wakefield Hospital	42	-
Capital PHO	96	-
Tumai mo te Iwi	38	-
Hawkes Bay DHB	793	-
	3,224	3,000

Purchases from related parties

	2008 Actual	2007 Actual
HIQ (associate)	19,146	11,458
CRTAS (joint venture)	763	617
Air New Zealand	-	3
New Zealand Post	363	201
Healthcare of New Zealand Ltd	5,750	4,519
Te Roopu Awhina	111	-
Wakefield Hospital	3,864	1,921
Maddison Projects	432	302
PowerHouse People Ltd	550	177
Wellington Independent Practices Association	277	227
The Greater Wellington Health Trust	4,905	-
MATPRO Ltd	83	-
Capital PHO	20,446	-
Tumai mo te Iwi	7,805	-
Wellington City Council	560	391
Hawkes Bay DHB	129	-
	65,184	19,816

Outstanding balances to related parties

	2008 Actual	2007 Actual
HIQ (associate)	-	-
CRTAS (joint venture)	10	-
New Zealand Post	-	30
Te Roopu Awhina	21	-
Wakefield Hospital	96	-
The Greater Wellington Health Trust	746	-
MATPRO Ltd	11	-
Capital PHO	44	-
Tumai mo te Iwi	53	-
Hawkes Bay DHB	821	-
	1,802	30

in thousands of New Zealand Dollars

21 Related parties (continued)

Auckland Savings Bank Ltd
ASB Bank Ltd is the DHB's banker and is a member of the Commonwealth Bank of Australia Group. During the year $0.6m of interest and Bank fees where charged to the DHB and the DHB earned $0.2m of interest. The ASB Bank Ltd provides a working capital facility of $40m to the DHB. The facility Utilisation as at 30 June 2008 was $18.9m.

Outstanding balances from related parties

	2008 Actual	2007 Actual
HIQ (associate)	7,577	13,227
CRTAS (joint venture)	14	-
Wakefield Hospital	6	-
	7,597	13,227

Transactions with associates and joint ventures are priced on an arm's length basis.

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2007 $nil).

Ownership
The DHB is a crown entity in terms of the Crown Entities Act 2004, and is owned by the Crown.

Associate Company
The DHB has a 70.82% shareholding in HIQ Ltd (2007 59.65%). HIQ Ltd was jointly created with Taranaki District Health Board on 18 October 2004, and has a balance date of 30 June. The DHB and TDHB share information services provision through HIQ Ltd. The Board of HIQ Ltd has equal representation from both DHBs. The DHB and TDHB own class A and class B shares in the company.

	THE DHB		TDHB		Shares on Issue	
	2008	2007	2008	2007	2008	2007
Class A shares	1	1	1	1	2	2
Class B shares	27,918,690	6,862,006	11,502,925	4,640,919	39,421,615	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 the DHB and TDHB.

The interest in HIQ Ltd had 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.

Joint ventures
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's share is $100. At balance date all share capital remains uncalled.

Transactions with other entities controlled by the Crown
There have been transactions with other entities controlled by the Crown that have not been separately disclosed because the transactions have been carried out on the same terms as if the transactions had been carried out at arms length.

in thousands of New Zealand Dollars

22 Employee Remuneration

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

	Number of Employees 2008	Number of Employees 2007
100 – 110	71	48
110 – 120	48	40
120 – 130	37	34
130 – 140	22	27
140 – 150	26	20
150 – 160	19	23
160 – 170	16	14
170 – 180	15	15
180 – 190	19	26
190 – 200	19	13
200 – 210	14	15
210 – 220	14	-
220 - 230	6	4
230 – 240	7	5
240 – 250	5	1
250 – 260	7	8
260 – 270	5	3
270 – 280	1	-
280 – 290	4	5
290 – 300	2	3
300 – 310	3	2
310 – 320	2	2
320 – 330	1	3
330 – 340	1	-
340 - 350	1	-
350 – 360	-	2
360 – 370	-	-
380 - 390	1	-
400 – 410	-	1
430 - 440	1	-
	367	314

Of the 367 employees shown above, 286 are or were medical or dental employees and 81 are or were neither medical nor dental employees. This represents an increase of 53 staff in total over the previous year. Of these, 22 are or were medical and dental employees and 31 are or were neither medical nor dental employees.

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 645, compared with the actual total number of 367

in thousands of New Zealand Dollars

23 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	2,000
	1	3,657
	1	4,701
	1	6,792
	1	6,827
	1	8,137
	1	9,702
	1	10,000
	1	10,504
	1	11,547
	1	15,331
	1	17,833
	1	19,341
	1	20,000
	1	20,096
	1	21,200
	1	23,750
	1	25,000
	1	33,800
	1	37,876
	1	45,959
	1	70,000
	1	141,816
	23	565,869

24 Subsequent event

There are no significant events subsequent to balance date.

25 Accounting estimates and judgements

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

Key sources of estimated uncertainty

Recoverability of development costs

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

Property, Plant and Equipment

At each balance date the DHB reviews the useful lives and residual values of its property plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property plant and equipment requires the DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset, and expected disposal proceeds from the future sale of the asset.
An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. The DHB minimises the risk of estimation uncertainty by

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

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

The carrying amounts of property, plant and equipment are disclosed in note 6

Retirement, long service leave, sick leave and continuing education

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

Critical accounting judgements in applying the DHB's accounting policies
Certain critical accounting judgments in applying the DHB's accounting policies are described below.

Leases classification

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

25 Accounting estimates and judgements (continued)

Finance and operating leases

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

26 Borrowing costs

The total amount of borrowing costs capitalised during the period ended 30 June 2008 was $11.2m (2007: $6.1m)
The capitalisation rate used to determine the amount of borrowing costs eligible for capitalisation during the year was 6.5% (2007: 6.5%).

27 Explanation of financial variances from budget

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2008.

Statement of financial performance
The DHB recorded a deficit of $40.7m compared with the budgeted deficit of $10.9m. The variance, $29.8m adverse, was the net of revenue $18.2m over budget and costs $48.0 over budget. The primary reason for increased revenue related to population based funding packages from the Ministry of Health and other targeted Ministry of Health funding.

Cost increases were primarily personnel related, Other major areas were outsourced services and payments to other providers.

- personnel costs were mainly medical and nursing staff shortages, leading to additional relieving staff and recruitment costs. The increased costs were compounded by MECA settlements in excess of budgeted levels
- outsourced services were contracted to reduce waiting times
- above budget payments to non DHB providers were offset by additional revenue

Statement of financial position
Major variances were

- an increase in investment in associates resulted from funding Information technology in the DHB's associate providing IT services to the DHB
- trade and other receivables is significantly under budget owing to a timing difference on drawing down the balance of Equity Receivable
- borrowings at $283m differ from budget owing to a revised borrowing programme for financing the New Regional Hospital
- the favourable bank overdraft reflects reduced capital expenditure, other than the New Regional Hospital, and increased trade payables
- trade payables and other accruals reflects additional accruals, and is partly offset by the reduced bank overdraft

Changes in equity
The variance of $74.6m mainly reflects the adverse result, together with the non receipt of equity budgeted for the New Regional Hospital.

Statement of changes in cash flow
The net cash flow was $16.1m better than budget. The major reasons were

- Operating cash flow, whilst close to budget in total reflects both increased funding and the increased operating costs. Interest paid is favourable owing to drawing down equity in place of loan finance, plus interest costs being capitalised on the New Regional Hospital project
- Investing cash flow, variance $13.0m better than budget reflects from timing differences with the New Regional Hospital, plus reduced capital expenditure on other projects. partially offset by advances to the DHB's associate
- Financing cash flows includes equity receipts to fund the New Regional Hospital, plus equity to support the DHB's financial position caused by the operating deficit.

28 Capital Management

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

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

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

29 Explanation of transition to NZIFRS

These are the DHB's first consolidated financial statements prepared in accordance with NZIFRS.

The accounting policies set out in the notes to the financial statements have been applied in preparing financial statements for the year ended 30 June 2008, the comparative information presented for the year ended 30 June 2007 and in the preparation of an opening NZIFRS Balance Sheet at 1 July 2006 (the DHB's date of transition).

In preparing its opening NZIFRS Balance Sheet and restating the 2007 financial statements, the DHB has adjusted amounts reported previously in financial statements prepared in accordance with its old basis of accounting (previous GAAP). An explanation of how the transition from previous GAAP to NZIFRS has affected the DHB's financial position, financial performance and cash flows is set out in the following tables and the notes that accompany the tables.

in thousands of New Zealand Dollars

29 Explanation of transition to NZIFRS (continued)

Reconciliation of the equity

	Note	Transition Balance Sheet 1 July 2006			Comparative Balance Sheet 30 June 2007		
		Previous GAAP	Effect of transition to NZIFRS	NZIFRS	Previous GAAP	Effect of transition to NZIFRS	NZIFRS
Property, plant and equipment		282,835	-	282,835	368,182	(249)	367,933
Intangible assets		-	-	-	-	249	249
Investments in associates		6,862	-	6,862	6,862	-	6,862
Investments in joint ventures		-	-	-	-	-	-
Total non-current assets		289,697	-	289,697	375,044	-	375,044
Inventories		5,414	-	5,414	5,632	-	5,632
Trade and other receivables		119,648	-	119,648	129,469	-	129,469
Cash and cash equivalents		13	-	13	13	-	13
Trust/special funds		4,825	-	4,825	5,183	-	5,183
Assets classified as held for sale		-	-	-	-	-	-
Total current assets		129,900	-	129,900	140,297	-	140,297
Total assets		419,597	-	419,597	515,341	-	515,341
Equity							
Crown equity		211,616	-	211,616	208,133	-	208,133
Other reserves		33,194	-	33,194	33,010	-	33,010
Retained earning/(losses)		(93,856)	159	(93,697)	(106,716)	-	(106,716)
Total equity		150,954	159	151,113	134,427	-	134,427
Liabilities							
Financial liabilities measured at amortised cost		117,074	-	117,074	217,400	-	217,400
Employee benefits		4,314	-	4,314	4,402	-	4,402
Provisions		142	-	142	-	120	120
Total non-current liabilities		121,530	-	121,530	221,802	120	221,922

in thousands of New Zealand Dollars

29 Explanation of transition to NZIFRS (continued)

Reconciliation of the equity (continued)

	Note	Transition Balance Sheet 1 July 2006			Comparative Balance Sheet 30 June 2007		
		Previous GAAP	Effect of transition to NZIFRS	NZIFRS	Previous GAAP	Effect of transition to NZIFRS	NZIFRS
Bank overdraft		17,038	-	17,038	1,553	-	1,553
Financial liabilities measured at amortised cost		53,074	-	53,074	62,074	-	62,074
Trade and other payables		38,433	(159)	38,274	52,688	(400)	52,288
Employee benefits		38,568	-	38,568	42,627	-	42,627
Provisions		-	-	-	-	280	280
Patient and restricted funds		-	-	-	170	-	170
Total current liabilities		147,113	(159)	146,954	159,112	(120)	158,992
Total liabilities		268,643	(159)	268,484	380,914	-	380,914
Total equity and liabilities		419,597	-	419,597	515,341	-	515,341

in thousands of New Zealand Dollars

29 Explanation of transition to NZIFRS (continued)

Reconciliation of the surplus for the year ended 30 June 2007

	Note	Previous GAAP	Effect of transition to NZIFRS	NZIFRS
Revenue		667,172	-	667,172
Total income		**667,172**	**-**	**667,172**
Employee benefit costs		260,892	-	260,892
Depreciation and amortisation expense		19,769	-	19,769
Outsourced services		16,999	-	16,999
Clinical supplies		70,799	-	70,799
Infrastructure and non-clinical expenses		47,359	-	47,359
Payments to non-health board providers		246,846	-	246,846
Other operating expenses		5,119	-	5,119
Finance costs		7,344	159	7,503
Capital charge		4,905	-	4,905
Total expenses		**680,032**	**159**	**680,191**
Share of profit of associates		-	-	-
Surplus for the period		**(12,860)**	**(159)**	**(13,019)**

in thousands of New Zealand Dollars

29 Explanation of transition to NZIFRS (continued)

Reconciliation of cash flows for the year ended 30 June 2007

	Note	Previous GAAP	Effect of transition to NZIFRS	NZIFRS
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		638,269	-	638,269
Other receipts		22,246	-	22,246
Cash paid to suppliers		(390,612)	-	(390,612)
Cash paid to employees		(250,339)	-	(250,339)
Cash generated from operations		19,564	-	19,564
Interest received		1,085	-	1,085
Interest paid		(6,330)	-	(6,330)
Goods &Services Tax (net) (a)		705	-	705
Capital charge paid		(3,541)	-	(3,541)
Net cash flows from operating activities		**11,483**	**-**	**11,483**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		10	-	10
Proceeds from sale of investments		-	-	-
Dividend received		-	-	-
Disposal of subsidiary, net of cash disposed of		-	-	-
Acquisition of subsidiary, net of cash acquired		-	-	-
Acquisition of property, plant and equipment		(93,773)	-	(93,773)
Acquisition of investment property		-	-	-
Acquisition of other investments		(4,424)	-	(4,424)
Acquisition of intangible assets		(3,296)	-	(3,296)
Net appropriation from trust funds		(358)	-	(358)
Net cash flows from investing activities		**(101,841)**	**-**	**(101,841)**
Cash flows from financing activities				
Proceeds from equity injection		-	-	-
Borrowings raised		162,400	-	162,400
Repayment of borrowings		(53,074)	-	(53,074)
Payment of finance lease liabilities		(3,483)	-	(3,483)
Net cash flows from financing activities		**105,843**	**-**	**105,843**
Net increase in cash and cash equivalents		15,485	-	15,485
Cash and cash equivalents at beginning of year		(17,025)	-	(17,025)
Effect of exchange rate fluctuations on cash held		-	-	-
Cash and cash equivalents at end of year		**(1,540)**	**-**	**(1,540)**

Notes to the reconciliation of previous GAAP

29 Explanation of transition to NZIFS (continued)

a) Derivative financial instruments

Under previous GAAP derivative financial instruments (e.g. foreign exchange forward contracts or interest rate swaps) were not recognised in its financial statements until the underlying cashflow occurred.

In accordance with NZIAS 39, derivative financial instruments are always classified as a financial instrument at fair value through profit or loss with changes in fair value recognised in net profit unless hedging accounting is applied.

1 July 2006 adjustments

In accordance with NZIAS 39, no derivative (foreign exchange contracts and interest rate swaps) was held as at 1 July 2006. Accordingly no adjustments in accordance with NZIAS 39 were required.

30 June 2007 adjustments

Similarly at 30 June 2007, no derivatives (foreign exchange contracts and interest rate swaps) were held, and no adjustment was therefore required.

c) ACC liability

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

Under previous GAAP liability resulting from insurance risk was recognised by the DHB, and an actuarial valuation obtained. In accordance with NZIFRS 4, the DHB accounted for its participation in the APP as an insurance contract and recognised the resulting insurance liability.

d) Retained earnings and reserves

The effect of the above adjustments on retained earnings is as follows:

$0.2m – Under NZGAAP a hedge liability of $0.2m was recognised for a derivative that expired in April 2007. The DHB did not adopt hedge accounting under NZIFRS for the hedge liability. This is required to be included in retained earnings under NZIFRS.

30 Summary Revenues and Expenses by Output Class and Reconciliation to Retained Earnings

	Funding	Governance and Funding Administration	DHB Hospital Provider	Elimination $000	Total DHB
Revenue					
Crown	666,866	6,647	420,861	(388,508)	705,866
Other	155	-	13,867	-	14,022
Total Revenue	**667,021**	**6,647**	**434,728**	**(388,508)**	**719,888**
Expenditure					
Personnel	-	2,853	285,181	-	288,034
Depreciation	-	6	19,216	-	19,222
Capital Charge	-	-	6,264	-	6,264
Other	662,997	5,037	167,518	(388,508)	447,044
Total Expenditure	**662,997**	**7,896**	**478,179**	**(388,508)**	**760,564**
Net Surplus/(Deficit)	**4,024**	**(1,249)**	**(43,451)**	**-**	**(40,676)**

	Funding	Governance and Funding Administration	DHB Hospital Provider	Elimination	Total DHB
Opening Retained Earnings	4,707	(4,598)	(106,825)	-	(106,716)
Surplus/(deficit) for the year	4,024	(1,249)	(43,451)	-	(40,676)
Closing Retained Earnings	**8,731**	**(5,847)**	**(150,276)**	**-**	**(147,392)**

31 Statement of Going Concern

The going concern principle has been adopted in the preparation of these financial statements.
The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future.

The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2007/08 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of Comfort

The Board has received a letter of comfort, dated 22 September 2008 from the Ministers of Health and Finance. That letter applies from the date of receipt of the letter until twelve months from the date of the signed audit opinion.

Operating and cash flow forecasts

1 The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that subject to deficit support, there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent. The Board is confident that the equity injections in the 2009/10 and 2010/11 years related to operating cash flows will eventuate but there is uncertainty as to the amount of the additional costs associated with the new facilities at Kapiti, Kenepuru and Wellington will be fully covered under the Ministry of Health's policy guidelines for deficit support. It is estimated that the likely impact is $40 million over the three years of the SOI or 1.65% of total revenue. The Board currently has the support of the Ministry of Health to make application to the National Capital Committee for funding to support its minor capital replacement programme and cash flow the shortfall in deficit support. The projections for minor capital asset replacement is $63 million over the same period.

Borrowing covenants and forecast borrowing requirements

2 The forecasts for the next 3 years prepared by the Board show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of the DHB to continue as a going concern if the forecast information relating to operational viability and cash flow requirements is not achieved or the deficit support is not provided, there would be significant uncertainty as to whether the DHB would be able to continue as a going concern.

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

32 Compliance with the Crown Entities Act 2004

The DHB has breached the Crown Entities Act 2004 in that the audited financial statements were not available within 4 months of the 30 June 2008 balance date required under section 156(2). The Audit Opinion was delayed due to fundamental uncertainty of the going concern assumption