ANNUAL REPORT 2008/2009

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

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ABOUT OUR ANNUAL REPORT

This report presents Capital and Coast District Health Board's (C&C DHB) performance for the year 1 July 2008 to 30 June 2009. It provides an overview of what the DHB committed to deliver in that year and how it met that commitment.

The Annual Report outlines progress against our Statement of Intent (SOI) 2008/09, and provides a detailed account of how the health funding received by C&C DHB has been managed. The SOI is an annual statutory document which determines our course of activities for the financial year including milestones and measures. It includes long-term goals and annual accountability objectives and is the formal accountability document between the Government and C&C DHB.

The Board's long-term strategic objectives (over 10 years) are outlined in its District Strategic Plan and each year, the Board reviews how it has performed according to those objectives in its District Annual Plan.

A DAY IN THE LIFE

- Over 120 patients are admitted to our hospitals. About 38 of these are 'day patients', receiving treatment or surgery which is not expected to require an overnight stay.
- About 55 patients undergo surgery
- 950 outpatients are seen
- About 350 patients are examined in radiology
- 240 patients are seen by our mental health community teams
- About 1100 lab tests are performed in the hospital labs
- 100 patients have their vision checked
- About 130 people are assessed at Wellington Hospital Emergency Department, and more than 90 are assessed at Kenepuru Community Hospital's Accident & Medical Clinic
- 4 patients are admitted to the Intensive Care Unit at Wellington Hospital
- 7 patients are flown to, or from Wellington Hospital
- 10 babies are born
- 34 infants are cared for in Wellington Hospital's neonatal unit
- More than 650 medical records are processed
- 8,000 phone calls are answered by telephonists
- 5,000 letters are processed in the mailroom
- 1,300 clean sheets are sent out from the hospital's own laundry
- 1,900 meals are prepared and distributed (1,150 at Wellington Hospital, and 750 at Kenepuru Community Hospital).

MESSAGE FROM THE CHAIR

The 2008/09 year was a turning point for Capital and Coast DHB. The previous few years were not easy and some areas felt at times detached from the wider organisation. A number of staff had to cope with temporary, and in some cases cramped conditions while the new flagship facility was built on the Newtown site.

It was clear that the organisation needed a fresh set of directions and the migration to the new regional hospital provided the impetus for this. The high level of commitment by staff was demonstrated by the success of the migration. This was a complex and potentially disruptive process, throughout which staff embraced change and worked to ensure patient care remained at the forefront.

A fresh – and refreshingly pragmatic - management team, ably led by CEO Ken Whelan, has reinvigorated the organisation. Ken and his team have embraced the challenge of bringing this DHB back within budget over the next few years, as we address the funding and holding costs of the new regional hospital while simultaneously addressing the gaps which exist in some aspects of our performance. They have done so in an inclusive manner, which truly values the insight of clinicians, other health professionals and the groups which work in the community alongside our organisation.

At the funding end of the business, our staff worked hard to build on our relationships with external and primary providers – to improve the range and efficacy of services delivered in the community.

The entire DHB, including our hospitals, has rounded an important corner and all concerned are invigorated with a fresh sense of optimism. Part of this can be credited to the fact that a robust recovery plan for this DHB is now in place – based on principles which have attracted widespread support and approval from all stakeholders.

One of these principles is including clinicians and those in the clinical frontlines in a much more direct say in how services are funded and delivered. Much of our decision making will be decentralised – and a layer of management has been removed in a significant organisational realignment. Many key decisions for each service will be made by a team led by a doctor and a nurse who are experts in that specialty area.

The relationship with our neighbouring DHBs has also grown closer than ever before – with all central region DHBs now collaborating on a Regional Clinical Services Plan which will see them adopt a more rational and equitable approach to where and how services will be delivered in

the central region of New Zealand.

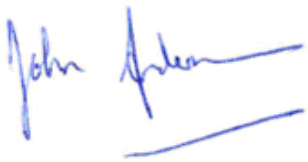
The final, but perhaps most vital, ingredient in this organisation developing a strong sense of purpose and direction is our communities. From individual GPs to PHOs, from local bodies to professional bodies to the Disabled Peoples Assembly – the indisputable reality is that this organisation does not operate in a vacuum.

When those external partners succeed then we, as an organisation, also succeed. Conversely, when we attempt to act in isolation then we, as an organisation become isolated.

My thanks go to my fellow directors on the Board for their contribution and guidance in the governance of the DHB and its future direction.

I also acknowledge and thank Ken Whelan and the management team, a number of them having assumed new roles this year, for the positive progress they have achieved this year.

Overall, my warmest thanks also go to those many individuals and groups outside our organisation who share with us in the goal of improving health and disability support services for the people of this district. Our direction as an organisation is aligned with their direction as health professionals – and I truly believe that together we can make the differences that matter.



Sir John Anderson
Chair

Board members Margaret Faulkner and Judith Aitken, (second from right and far right, respectively) presented this year's Hutt Valley, Capital & Coast DHBs Team of the Year Award at the Wellington Sports Awards. This year the award went to Te Aroha Hutt Valley Premier Womens Softball Team.

A second C&CDHB and HVDHB sponsored award for Sports Team of the Year, went to the Vodafone Wellington Lions.

MESSAGE FROM THE CEO

The 2008/09 year was my first full year as chief executive, and as Sir John rightly notes it was a time when reinvention and reinvigoration were needed.

Hence it is with some satisfaction that we can reflect on the past year as not only the year in which a splendid new hospital was opened in this district, but also the year in which we charted a five-year journey to recovery for the organisation as a whole.

This organisation still faces many challenges and operational issues, not least of which is a financial path which will see us operating at a deficit in the immediate out-years. But I am confident that we will make a full recovery within our five-year target.

One of our greatest assets in this regard is the talented and dedicated people who work in health in this region. I may be a relative newcomer to this district, but I can say with hand-on-heart that its health workforce is an exceptional group of people.

In my first year I have already met untold numbers of doctors committed to going the extra mile for each patient, nurses wholeheartedly supporting people as they battle illness and injury, and allied health staff who achieve so much to improve the quality of life for those we serve.

I am pleased that we are now on a course which will give those clinicians a much stronger say in the decision making over how budgets are used to deliver services.

It is those staff who achieve the real positive differences for this organisation. For example, the success of our migration to the new hospital is a tribute to our clinical and support staff.

Those same staff achieved a 13% increase in surgical throughput in 2008/09 – which equates to around 1,600 extra people receiving surgery. That is quite a spectacular achievement, especially during such a challenging year, and the credit is all theirs.

As Sir John has also noted, our hospitals do not act in isolation, and tribute must also be paid to the thousands of people who work in the community in the field of health – who it has been our pleasure to work alongside and in many instances fund.

Collaboration is a key aspect of our future success, and we are building partnerships across many and various sectors which will endure into the years ahead.

One significant example is the Health Education and Research Collaborative (or HERC) – a new initiative which will see us partner with a range of education and health agencies, including Victoria University and Otago School of Medicine and Health Sciences.

The HERC – which will be established in 2010 – will occupy an 8,000 square metre site on our Newtown campus in Wellington, and represents a commitment to all C&C DHB staff to promote continuing education and foster it at both under-graduate and post-graduate levels.

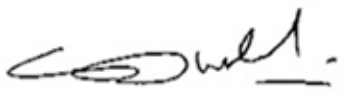
The HERC centre will be unique in Australasia, in that the teaching of nurses and clinicians alongside cutting edge research – from the discovery and pre-clinical stage through to clinical trial activity – will all be located within the campus of a leading public hospital.

This is a truly exciting initiative and we believe that having research and education capability will ensure we're going to be an employer of first choice. This kind of dedicated research facility will also help us to retain the right mix of staff, and will become an important component to support staff in the future.

Lastly, but by no means least, I would like to thank the Board, and in particular Sir John, for their outstanding contribution in the past year.

Without their guidance and direction we could not have arrived at such an optimistic position, looking to the future with the assurance of a robust Recovery Plan to guide our journey.

By working together – with one-another and with the community – I have no doubt that we will reach that destination.



Ken Whelan
Chief Executive

ABOUT C&C DHB

C&C DHB receives funding to improve, promote and protect the health of the people in our communities and ensure health services are available, either by contracting with external providers (such as PHOs, GPs, primary care practices/services, Non-Government Organisations, rest homes, dentists, pharmacists, and Māori and mental health providers) or providing the services directly (such as hospital services).

Currently almost 270,000 people live within the Capital and Coast district, with two thirds of the population in Wellington City, 18% in Porirua and 14% on the Kapiti Coast.

C&C DHB assesses the health status of the population and determines 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, which includes a population of about 900,000.

In all, C&C 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 over 5,000 staff working on a permanent, part-time, casual and temporary basis.

A brand new, state of the art Wellington Regional Hospital was officially opened on 6 March 2009. Care is now delivered in a purpose-built facility with an innovative design for improved connectivity between services. The new hospital is not only a place for the ill and injured, but has become a building icon of our region.

THE HEALTH OF OUR POPULATION

Our DHB spans three territories; Wellington City, Porirua City and part of Kapiti Coast District. The actual combined population of these three districts at the time of the 2006 Census was 266,658.

The people of the Wellington region enjoy, on average, better health and longer life spans and lower rates of morbidity and mortality than many other parts of the country.

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

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

We have fewer than average Māori (10%) and a higher than average Pacific population (7%). The Māori and Pacific populations are younger than other groups in the district, and comprise more children and fewer elderly people.

Overall our district is relatively advantaged in terms of socioeconomic deprivation, with nearly a quarter of the population living in the least deprived areas (NZDep2006 decile 1). However, there are pockets of deprivation in Porirua and south east Wellington and those communities experience poorer health outcomes. Māori and Pacific people are more likely to live in a deprived neighbourhood and have significantly higher rates of avoidable morbidity and mortality than other ethnic groups.

The district population is predicted to increase 15% by 2026 with the highest growth in Wellington and Kapiti. The proportion of Māori and Pacific will increase. Like the country as a whole, the population will age over the next 20 years with the number aged over 65 years to grow 78% and an expected two-fold increase in the population aged over 85 years.

Key health issues for this DHB include:

- Reducing the incidence of long term conditions (such as cardiovascular disease, diabetes and respiratory conditions) and minimising the impact on people's daily lives. Māori and Pacific tend to have earlier onset of long term conditions than other groups.
- The burden of cancer and reducing disparities in survival.
- Experience of mental illness and its unequal impact on younger, disadvantaged population groups.
- Addressing issues for children and youth, including oral health, respiratory, skin infections and injuries, mental health and youth suicide, as well as sexual health.
- Health of older people, including management of long term conditions, cancer, musculoskeletal disease (e.g. arthritis, osteoporosis), injury from falls, the impact of dementia, and home and community support needs.
- Responding to the needs of the 15 percent of the district population estimated to have a disability.

For more detail on the health needs of our population see the *2009/10 – 2011/12 District Annual Plan.*

OUR VISION

BETTER HEALTH AND INDEPENDENCE FOR PEOPLE, FAMILIES AND COMMUNITIES

We understand that the DHB must work with our communities to help:

reduce disparities in health status and *reduce the incidence of chronic conditions amongst our population*.

To achieve our health goals, we have developed a range of specific strategies which include:

- Focusing on people through integrated care
- Supporting and promoting healthy lifestyles
- Working with our communities
- Developing our workforce
- Updating our hospitals
- Managing our money

OUR VALUES

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

- Focusing on people and patients
- Innovation
- Living the Treaty
- Professionalism
- Action and excellence

CHIEF MEDICAL OFFICER

DR GEOFFREY ROBINSON

C&C DHB currently enjoys a stable and experienced medical leadership with 10 Clinical Directors and over 40 Clinical Leaders in departments.

Overall, 60 of our 325 senior doctors are in leadership or quality improvements roles. I think the training provided in past years to enhance clinical leadership and develop individuals came to fruition with the successful and safe transition to the new hospital. The clinicians are much appreciating the new facilities and the wards and clinics environments.

We now have challenges of consolidating the new Clinical Governance structures within the hospitals and more so, with Governance linkages with primary and community care.

The Primary/Secondary Interface Governance Group is providing a vibrant committee overseeing the interface issues around referral processes, discharge planning, IT systems and important clinical issues including optimal medication management.

The C&C DHB is fortunate to have secured nearly a full complement of junior doctors and there are few senior doctor position unfilled.

The DHB continues its successful tradition of providing a strong commitment to post graduate medical training in conjunction with the Medical Colleges. There continues to be sound relations with the University of Otago Wellington School of Medicine and Health Sciences, and the joint library is an excellent facility.

The weekly Grand Rounds are a successful forum for departments, providing updates and case studies.

The Health Education Research Collaborative (HERC) is a joint venture between a number of organisations, including Capital & Coast DHB, Victoria University of Wellington and the Medical Research Institute of NZ, and has involved a lot of planning. The expected benefits are around collaborative research and skills training in particular.

There is still a journey to be travelled around better integration of primary and community with hospital services, and chronic disease management. Dr Adrian Gilliland, C&C DHB Clinical Advisor Primary and Integrated Care, has already assisted greatly in this area.

Perhaps one of the most difficult areas travelled in the past year was the Ministry of Health Review of the cardiac surgery waiting list. Pleasingly the recommendations were enacted and the waiting list has reduced to consistently fewer than 50.

DIRECTOR OF NURSING & MIDWIFERY

KERRIE HAYES

This year has seen some significant changes in the way we deliver nursing to our patients, with more emphasis being placed on *person-centred care* and *team work*.

We have aimed to incorporate a greater nursing skill mix, including the introduction of Health Care Assistants (HCAs) to work with Registered Nurses to support the provision of direct patient care. Patients and their family take a greater role in their care through bedside handover and care planning.

NZQA-accredited training was established with an industry provider and gave *"on the job" training for HCAs* to support their transition into a direct patient care support role. To date, 40 HCAs have undertaken training.

Preparatory work for extending this care model into other departments has now been done.

Nursing leadership roles were also reviewed and adjusted to ensure clinical leadership was available to support consistent and safe patient care across a larger period of the day, evenings and over the weekend, and to reflect the requirements and the changes to wards/service layouts in the new regional hospital.

Nurse leaders from the top down, including myself, will be spending more time out talking to and getting input from our nurses on the ground.

We want to take a more integrated approach, learning from our "grass roots" nursing clinicians about how they believe we can improve patient care. It is the people who work hard every day, doing the – at times challenging – job that we will be closely working with.

With over 2000 nurses currently employed by C&C DHB, we know they are one of the most important links in patient care. We value their commitment, dedication and hands-on knowledge hugely.

An external Midwifery review was also carried out and a *Midwifery Model of Care* was developed, with midwife-led teams implementing the principles of the new model in Women's Health.

The Nursing and Midwifery workforce was bolstered by the largest intake of around 100 graduate nurses and midwives to date and nursing and midwifery vacancies and turnover rates have decreased markedly over the last 12 months.

The leadership of the DONM office and the Nursing Development Unit worked beside service teams to *move patients into the new hospital*.

Other achievements include:

- Support with the implementation of the '6 hour rule' for patients in ED
- Development and trial of a Workload Screening Tool to support nursing decision making around safe staffing
- Supporting Registered Nurses to complete 72 post graduate nursing papers at Masters level and supporting nurses on the professional clinical nursing pathway
- Development of the Nurse Practitioner Candidacy Programme
- Representing the DHB and region on various National Quality, workforce and regional service planning initiatives.

Finally, I would like to pay tribute to my predecessor, Cheyne Chalmers, and the outstanding contribution she made to C&C DHB. Cheyne worked during a challenging time in our history, leaving behind a legacy that included the new Model of Care structure for nurses as well as playing a key role in the migration to the new hospital.

YEAR IN REVIEW

WHERE THE MONEY WENT

2008/2009 SPENDING ($M)

32.02
Other Services

44.02
Aged Residential Care

57.48
Community Pharmaceuticals

14.12
Community Laboratories
(Paid to Hutt DHB)

25.43
Mental Health Services
(Including inter-district)

43.40
Primary Health Organisations & GP Services

17.24
Other Elderly & Disability Support Services

62.27
Hospital - Mental Health Services

108.89
Hospital - Surgical & Anaesthesia

66.46
Hospital - Women's & Children

42.68
Hospital - Clinical Support Services

19.37
Other Hospital Services

2008/2009 REVENUE ($M)

42.16
Inter-District Outflows

17.29
Care Coordination & Home-Based Services for the Elderly

114.35
Hospital - Medicine & Cancer

1.80
Other Revenue

560.02
Ministry of Health

143.78
Other DHB

OUR NEW HOSPITAL





March 6, 2009 will go down in history as a landmark event in this region, with the *official opening of the new Wellington Regional Hospital in Newtown*.

Dignitaries included his Excellency the Governor General, Anand Satyanand PCNZM, QSO, and the Minister of Health, the Hon Tony Ryall.

The 350 invited guests and over 200 staff in attendance were treated to a cultural spectacle as the official party was welcomed into the new Wellington Regional Hospital atrium by DHB Māori and Pacific officials.

The 80 strong C&C DHB Waiata Group filled the atrium with pitch perfect song and together the Governor General, the Health Minister and the C&C DHB Board Chair, Sir John Anderson, unveiled the plaque to signify that the massive effort involved in planning, designing and building New Zealand's newest hospital had reached completion.

Two days after the official opening, to coincide with the Newtown Festival, C&C DHB in partnership with the Wellington Hospitals & Health Foundation, invited members of the public to visit their new hospital and participate in a tour of some areas of the building.

A crowd of almost 10,000 took the opportunity to take the 45 minute tour to see the great new facility where some of their health dollars were spent.

The tour included the main entrance Atrium, the Timeline Corridor depicting the history of Wellington Hospital since 1847, C&C DHB's new Patient Services Coordination Unit (PSCU)/Transit Lounge, PACU (Post Anaesthesia Care Unit), Theatres (2 displays), Surgical Admissions, Blood and Cancer waiting room (with display), across both Atrium Bridges, the Intensive Care Unit (ICU) (with display), the Royal Doulton Tile Gallery, Radiology (including a CT machine, Fluoroscopy Machine, Angiography Machine and Recovery area), and outside to the original hospital arches.

Over 130 staff and volunteers gave up their time to "show off" their new home and the public feedback in forms of letters and cards directly to the DHB, in addition to the Letters to the Editor, clearly indicated how positively received this event was from the local communities.

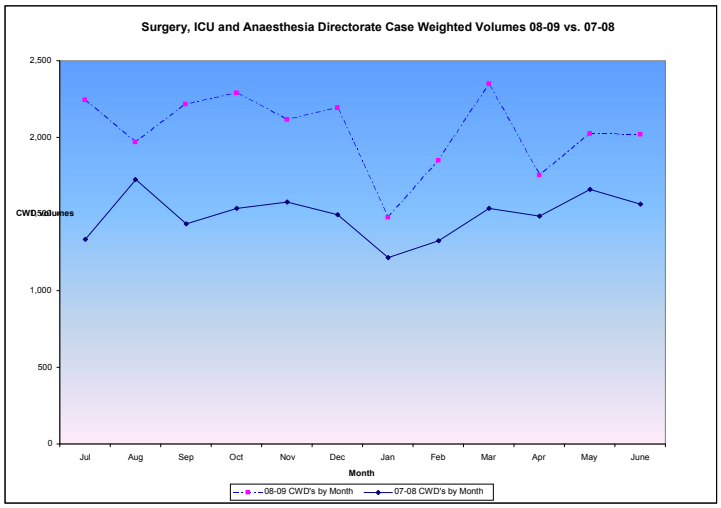
SURGERY, ANAESTHESIA & INTENSIVE CARE

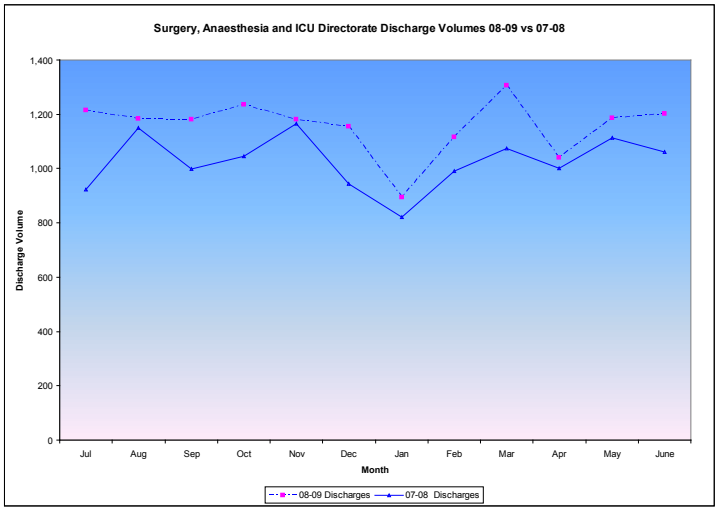
Key priorities for the past year in the Surgery, Anaesthesia and ICU teams were the move into the new regional hospital building, cardiothoracic wait times and increased surgical activity.

In every month of the year, the directorate delivered higher volumes of case weight and discharges than in any month of the previous year.

The number of patients on the surgical waiting list that received surgery in 2008/09 totalled 9714, with patient discharges in surgery in 2008/09 totalling 13,898 – *a 13% increase on 2007/08, or 1600 additional surgeries*.

This resulted in increased case weighted volumes of 36.84% – equivalent to additional revenue of $22,271,599 compared to the previous year.





THE MOVE TO THE NEW BUILDING

We moved the *Intensive Care Unit and Theatres* on 1 April, 2009 to their new locations with much celebration. A week prior to this, the first surgical list was undertaken in the new theatre suite by Professor Geoff Horne (pictured below), to test the new environment and the patient flow arrangements.

Staff and patients celebrated the day and Prof Horne said: "It was a triumph for everyone. If it runs as smoothly as this for the rest of the year it will be just splendid. The thing that distinguishes these theatres from the old block is the geography – there's a seamless transition from theatres to outpatients".

After months and months of planning, the various moves went off without a hitch and three wards, several outpatient areas, Theatres and ICU settled rapidly into their new state-of-the-art facilities.

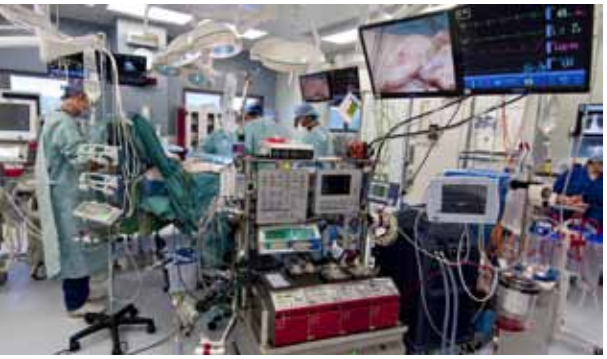
This move was underpinned by months of planning by all staff to realise the patient benefits of a new build and improved facilities. The particular benefits of this new facility include:

- *Modern standardised equipment*, which offers new scope for patient treatment and enhanced safety features.
- The move from two disparate theatre and associated recovery areas to one *comprehensive perioperative environment*.
- Surgical Admissions Unit catering for *Day, and Day of Surgery Admissions collocated with theatres* to improve access.
- *Theatres closely linked with the ICU* all located on one "hot" floor improving the timeliness and safety of patient movement.
- The move from five small specialist wards to three *36 bed pods* with the added benefit of *additional orthopaedic capacity* on one floor.
- *Integrated Urology facility* with colocated procedural space.
- The opportunity to *structure workforce to better to meet the requirements of both secondary and tertiary activity* and also re-align clinical and non clinical staff to required functions.

CARDIOTHORACIC

In 2007, C&C DHB had 300 patients on the Cardiothoracic surgical waiting list, of which 150 had waited longer than six months. This had led to some deaths on the waiting list and it was deemed that a few of these may have been prevented by more timely intervention.

Since then, *a focussed initiative has reduced these numbers, with a total of 629 patients receiving cardiac surgery in 2008/9* – 427 of which were at Wellington Hospital. Since January 2009, all patients have been managed well within the indicators relevant to this case group and the waiting list currently remains below 50.



OTHER ACHIEVEMENTS

A restructure of the directorate in 2008 meant the amalgamation of *two pre-existing programmes, Surgery and Anaesthesia*, into one service. This has provided a renewed focus on surgery and throughput with improved access for patients on the waiting list.

Other developments include:

»The introduction of *two orthopaedic Operating Rooms* to accommodate acute and elective flows

» Relocation of Cardiothoracic Operating Rooms to a *purpose-built, two-theatre suite*

» *Fully established ICU with an increased bed base* to accommodate increased surgical throughput whilst continuing to meet increasing acute demand

» *Increased General Surgical cases* at Kenepuru and the appointment of a *Clinical Coordinator* to facilitate even further increased throughput

» *Ophthalmology* planning for its *new location in the Grace Neill building*.

» Consolidation of *Clinical Leader appointments* to all specialties in Surgery

» *ENT relocated* from the Riddiford Building to new facilities in Outpatients.

» An *additional locum surgeon in Vascular* has stabilised the workforce in this specialty

» *New patient streaming model* being developed for Short Stay Recovery

» *New Urology Department* has provided new procedural opportunities

» *The introduction of awake craniotomies in Neurosurgery including a multidisciplinary focus*

» Department of Anaesthesia and Pain Management *successfully moved to a new department*

» A *fully established Anaesthesia Service* with two recently made appointments

» *Registered Nursing graduate numbers increased* from 21 last year to 40 this year, and a number of Registered Nurses are now undertaking advance study (50+).

MEDICINE & CANCER SERVICES

MOVING IN

A brand *new Medical & Cancer Directorate* combining 10 Medical services, and Cancer, Palliative Care and the Haematology Service was established on 1 July 2008 and its initial focus after developing the directorate, was on safely moving to the new Wellington Regional Hospital.

After moving the entrance of the Cancer Service to the main hospital atrium, interventional cardiology services moved into the new building along with Radiology in November 2008.

The whole *transition to the new building* was very successful and considerable efforts across teams and the directorate meant a safe move for all of the five Medical and Cancer wards (renal, oncology, Coronary Care Unit (CCU), and two medical wards) to four 36 bed wards over a period of two and a half weeks.

Gastroenterology and the Diabetes and Endocrine Service began the planning and design phase for their respective refurbishment and relocation, which is scheduled for completion in late 2009.

The most challenging part of the move was the *amalgamation of medical sub-specialities and medical and surgical specialities*. Two new wards comprising oncology, renal and internal medicine patients in one, and the CCU and the Cardiothoracic surgical ward in the other, now form *a new specialist Cardiac Unit providing tertiary level care to patients from the lower half of the North Island and top of the South Island*.

The *integration and multi-skilling* of the clinical teams is progressing well through strong leadership and will continue into the coming year.

In preparation for the move to the new hospital, the *senior nursing leadership* team for the inpatient wards was redesigned and this led to the development of strong nursing leadership teams.

One significant benefit has been the achievement of a full nursing staff. Recruitment of skilled and experienced staff has increased and turnover has reduced.

MOVING IN

In the new year, the *Clinical Measurement Unit (CMU)* opened its doors and established for the first time, a shared clinical space for Cardiology, Respiratory, Immunology, Cardiothoracic and Neurology's outpatient, research and technical services. Ambulatory care for these services is now easily accessible for patients on Level 2 of the new hospital.

Internal Medicine began to see the planning for the Medical Redesign Project come to life with the current development of a *24-bed Medical Assessment and Planning Unit (MAPU)* adjacent to the Emergency Department, Radiology and Clinical Measurement Unit.

The MAPU will create a dedicated space for acute medical patients to receive rapid access to appropriate multidisciplinary assessment and treatment 24 hours a day. In preparation for the changed model of care MAPU requires, Internal Medicine undertook a major redesign of medical staff rosters and practises. The changes included the closure of acute admissions of medical patients to Kenepuru Hospital.

It is expected that MAPU will be opened in mid November 2009.

SWINE FLU

The rapid presentation and spread of *H1N1 influenza (Swine Flu)* in the Wellington region in May, June and July 2009 created challenges for all services, including testing the limits of the new hospital facilities for management of widespread isolation procedures.

Despite limited time to plan and prepare for the management of patients with the H1N1 influenza, all services coped well and have improved practices as a result.

OTHER ACHIEVEMENTS

A milestone was achieved by the Renal Service in December 2008 with the completion of *seven renal transplants in six days*, including four within a 24-hour period. Multiple services and departments across the hospital pulled together with significant input from surgery, theatre, laboratory, renal nursing and medical staff to achieve this major logistical exercise (the usual number of transplants per month is 1 – 2).

The new *cardiology intervention suite* at Wellington Hospital has

enabled a number of patients to have cardiac devices implanted in Wellington, avoiding travel to Auckland.

This year also saw the consultation and development of the C&C DHB Cancer Control Plan, which was developed after extensive engagement with staff and stakeholders. The plan is due to be completed towards the end of 2009.

Feeding into the plan is the Kaiwhakatere (patient navigator) project, the objective of which is to document the journey and experiences of Māori and Pacific patients with cancer. The findings of this project will support a range of recommendations within the cancer plan. Both projects have resulted in increased engagement with our stakeholders in primary care and the community.

In January 2009, after many years of preparation and planning by key staff, the *third Linear Accelarator (Linac)* was installed and commissioned (pictured below).

The additional Linac ensured that timely radiation therapy treatment is delivered to patients and has reduced wait times for radiation therapy to within Ministry of Health guidelines.

The installation of the Linac was associated with a major software upgrade for the service and this project was conducted in conjunction with ICT (previously HIQ). It was delivered on time and with minimal disruption to service delivery, which is a reflection of the high level of co-operation across the two services.

The *High Dose Rate (HDR) brachytherapy service* continued to provide a high quality gynaecology cancer treatment service and was *expanded to include treatment for prostate cancer.*

WOMEN'S & CHILD HEALTH

WOMEN'S HEALTH SERVICES

The Move

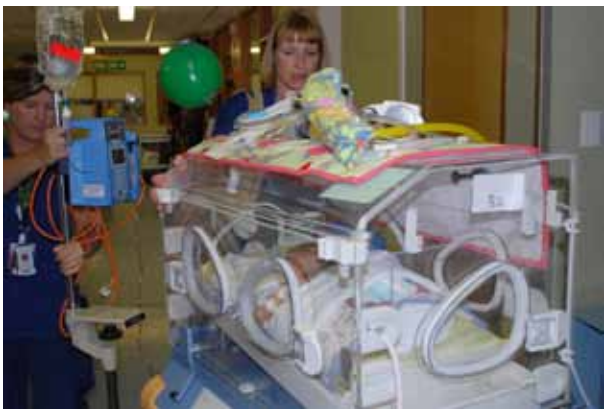
The first of the directorates to move into the new hospital, Women's Health services provided a great example of excellent planning and a seamless transition for other services to follow.

The move in January 2009 *brought together women's outpatients, ultrasound, women's acute assessment and Te Mahoe unit,* and is located in much better proximity to the rest of women's health services and other support services. Three ultrasound machines were upgraded and a new invasive ultrasound room provided in the new facility.

Women's *inpatients and delivery suite moved* in February 2009. The total number of women's inpatient beds was unaltered by the move however the configuration of beds with 50% of the rooms being single is hugely improved from the old wards.

Although delivery suite reduced in total room numbers, all rooms are multipurpose and women are no longer required to move between labour and delivery rooms.

A significant amount of equipment, including all delivery beds, was upgraded as part of the move. The feedback from women using the service has been extremely positive.



With the move to the new building, Associate Charge Midwife Manager positions for the antenatal and postnatal ward were established to provide *midwifery leadership* and support to midwives across all shifts. Overall there has been *improvement in midwifery retention and the number of midwives employed in the service is now significantly improved* on previous years.

Maternity Services

A programme to provide *HIV Screening in pregnancy* was also introduced towards the end of the financial year and is aimed at reducing the incidence of neonatal HIV infection by screening all pregnant women for HIV routinely as part of the first antenatal blood test. A key component of the programme is aimed at educating maternity practitioners around the need to move from a 'high risk' screening base to a 'universal offer' for HIV testing. Women who are diagnosed as positive are then able to receive appropriate treatment to minimise the risk of transmitting the infection to their newborn.

Maternity services have had another busy year with 3988 women giving birth to a total of 4072 babies in the year.

The average age of women giving birth in Wellington has historically been higher than the national average and this seems to be continuing with 60% of the women giving birth being aged 30 or older. Only 5.6% of women giving birth were less than 20-years-old.

The caesarean section rate was 26.8 % which was down from 29% in the previous year.

In April 2009 the *Maternal Fetal Medicine* Subspecialist Committee approved our application as a training unit with the first trainee expected to start in December 2009.

Weighing in at 3.28kg (7lb 4oz) Luca Philip Buckley (right) was the first baby to be born in the new Wellington Regional Hospital building - arriving just after 1.30pm, February 12, 2009. His delivery, by C-Section, was also the first surgery to be performed in the new Hospital.

Other Services

In August 2008 a new *colposcopy database* was implemented to facilitate clinical outcomes monitoring and to provide data for monthly reporting to the National Screening Unit.

CHILD HEALTH SERVICES

Neonatal

The *Neonatal Intensive Care Unit (NICU) moved* into a new purpose-built area in February 2009, the design of which was based on research and international practise that supported the concept of caring for premature babies in environments that best suit their gestational age rather than acuity, and this model of care was introduced with the move.

The number of physical cots also increased to 40 and the number of resourced cots will increase to 36 in 2009-10.

A significant amount of other equipment was also upgraded at the time of the move.

The unit has successfully recruited two additional Nurse Specialists, who will be working on the same roster as the junior doctors, but unlike these doctors, they will work only in NICU so will provide valuable continuity of care within the unit.

The *Newborn Hearing Screening programme* began recently with the aim of screening all newborns to detect early those that may have a hearing impairment. The babies that do not pass the screening test are referred to audiology for full testing and interventions as required.

Early detection and intervention is aimed at minimising the impact of hearing loss on the child's development and minimising the impact on the family.

Children

The new *Children's Outpatients area* in the Grace Neill Block is on track and planned to be finished by the end of 2009. The number of consulting rooms will increase and enable all paediatric outpatients to be held in a paediatric facility, while other support and allied health space is also improved in the new design.

The *reconfigure of the existing Childrens' Wards* is well underway and work is planned to occur during the summer months. The changes include a *24-hour acute assessment unit* as part of the ward, *designated adolescent space*, *better parent facilities*, *more single rooms*, *enhanced paediatric oncology space with both negative and positive pressure isolation rooms*, and the *removal of the six bedded cubicles*.

This reconfigure will allow us to adopt new models of care where children will be admitted to wards according to length of stay, not age, which is in keeping with national and international care models.

Improved access to and utilisation of theatre has resulted in an *increase in the number of children accessing elective surgical procedures*. The total number of children discharged (acute and elective paediatric surgery) increased by 21% from 07-08 to 08-09. The *significant increase was in elective cases*, both local and from other districts. This has seen a reduction in the total number of children on the waiting list and reduced time spent waiting for surgery. We would expect to see further improvements in 2009-10.

Genetic Services have this year trialled and purchased microarray equipment, which makes our DHB the first diagnostic genetics laboratory in New Zealand and one of only a handful of centres within Australasia to offer microarray testing as a diagnostic service.

This fully automated technology will enable up to a million genetic features to be analysed in a single assay and provide a high resolution genome wide-screen for genetic imbalance essential for those patients with idiopathic mental retardation or cancer.

The service has promoted its achievements and is raising its profile nationwide as the only provider of this innovative technology, use of which can be purchased by private providers.

MENTAL HEALTH SERVICES

This year we have launched a new service for our clients that provides access to a *physical health check from a GP* while they are receiving mental health care on-site.

Clients can see a GP on our site at a special clinic where they can get checked for their other health issues, such as diabetes, high blood pressure, cholesterol measuring or women's health issues. This GP service initiative allows for a truly holistic approach to our clients' health needs.

Meanwhile, our *Intellectual Disability Service* clients now have the opportunity to really get their hands dirty with the development of a gardening project based at the old Porirua Hospital Bowling Club ground and clubrooms.

Clients in Te Maara project can get involved in all aspects of gardening and plans are in place for it to become a commercial enterprise in coming years. The clubrooms are used as a social club for clients and a separate area has been set aside for Tautoko – a Whitireia Polytech service catering to clients' educational needs.

Te Haika, a special group of clinicians set up to process referrals to the general adult mental health service, will soon be joined by other services including Māori Mental Health, CAMHS and Drug & Alcohol.

The service has already been successful in increasing referrals, increasing the number of people being seen through the Choice Appointments system, decreasing waiting times and decreasing the handling of referrals.

The *Child & Adult Mental Health Service (CAMHS)* Service has now been further developed to include bases in Wellington, Porirua and Kapiti, while also integrating services for all those aged between 0 – 19. The new arrangement allows for easier access for clients and whanau.

Two new staff roles have been designated to specifically focus on improving access and developing service delivery to better manage flow through the Service and this has already resulted in the waiting list for CAMHS decreasing from around six months to approximately two weeks. The programmes, *7 Helpful Habits* and *Choice and Partnership Approach*, are now well embedded in the service.

Detailed architectural plans for *refurbishment of Ward 27* are now underway and many changes are expected in the coming year. Plans are in place for the temporary relocation of clients and staff during the alterations.

In partnership with the Wellington Hospitals' & Health Foundation, Te Korowai-Whāriki were able to utilise bequest monies to relocate a house onto the Ratonga Rua campus. *Saunders House* now offers another step in the transition to the community for inpatient clients.

A system of video conferencing facilities between seven sites within the Central region has been established to enhance integrated working across the sector, increase information sharing and encouragement for local innovations which improve consumer access and reduce people having to travel to access the Mental Health Service.

WorkFirst, an employment service guided by the principles of the Individual Placement and Support (IPS) model of supported employment, has gained national and international recognition with the Silver Achievement award at The Mental Health Services Conference in Auckland, September 2008.

CLINICAL SUPPORT SERVICES

Radiology

Radiology services had a big year, with the move into the new building and the purchase of *$8m worth of new equipment* – including a new MRI, new digital mammography and a plain film room. A new gamma camera with CT has been installed and is the first of its kind in the Southern Hemisphere, and will be only the fourth of its kind in the world. This has improved the working environment and will support recruitment of radiologist and radiographers.

The service has also established a new *Interventional Recovery Ward* (IRW) which is a designated area where patients can recover. This has reduced the number of cancellations for angiography. We have also increased the number of examinations by 8% and now do approximately 350 per day.

Emergency Department

The department has had the clinical treatment area renovated to support patient safety. The *new-look Emergency Department* area with its panoptic view makes it easier for all staff to provide safer care and enables them to achieve this in a more supportive environment.

The Emergency Department saw a total of 47,118 presentations over the past financial year – an increase of 2544 since 2005/06.

Laboratory

Although the laboratory didn't move this year, moving clinical services to the new building meant the installation of the *Pneumatic Tube System* throughout the new facility. This has led to services reporting improved receipt of results.

Phlebotomy

The Phlebotomy Service is now being delivered from a *purpose-built suite* in the new Outpatient Department. A recent survey of Outpatient clients demonstrated high levels of satisfaction with both the facility and service, and there has been a 15% increase in the number of people attending our new rooms which are now much more accessible.

Pharmacy

With the introduction of the *automated dispensing system, Pyxis*, and the *outsourcing of production services*, pharmacy has made some good changes to their clinical pharmacy service, now spending greater time on direct patient-related care (75% compared with 25% in the old model).

Pyxis has allowed improved medicine management through profiling and has meant a reduction in some types of medication errors.

Emergency management service

On ANZAC day, 2009 general practitioners in Auckland treating students who had returned from a trip to Mexico, alerted Public Health staff to the first New Zealand cases of '*Swine Flu*' – or as it came to be known 'Novel Influenza A (H1N1) 09'.

C&C DHB, along with the rest of the health sector, swung into action immediately, implementing pandemic plans developed and exercised in response to the Avian Influenza threat in 2005.

The immediate focus was on the 'keep it out' phase of the planning – C&C DHB supported Public Health staff in the region to do everything possible to prevent any further spread of the virus and to provide the laboratory testing of all suspect cases.

As more cases emerged across the country, 'stamp it out' measures were implemented and the demands for public information grew significantly. A wide range of C&C DHB staff were engaged in infection control measures, assessing suspect cases, processing laboratory tests, supporting the Regional Public Health Team, providing treatment and advice to staff with flu like symptoms, and of course caring for patients with H1N1. While for most people the illness was relatively mild, some children, pregnant women, and people with underlying medical conditions became seriously ill.

In mid-June it was evident that the virus was spreading quickly through the Wellington Region, and the decision was made to move to the 'manage it' phase of the national plan.

Our Laboratory staff, Accident & Medical service at Kenepuru, the Emergency Department and inpatient staff continued to work hard and are to be commended for their dedication and outstanding efforts under difficult circumstances.

The pressure also came on primary health and community pharmacies, with some practices recording record numbers of attendances during the peak.

Our Community services also supported this effort by assisting in the initial phase of the pandemic with swabbing patients in the community.

Assessment, Treatment and Rehabilitation and Therapies

The *Speech Language Therapy (SLT) team* has developed a *new Dysphagia Nurse Screening tool* for stroke patients, which provides a clearer method of determining when it is appropriate to allow patients to begin eating and drinking again.

Prior to development of the tool, there was no clear process and patients could remain on a nil-by-mouth diet unnecessarily, or could be started unsafely on an oral diet.

The SLT team worked with the stroke service to come up with a tool to screen for patients with dysphagia (difficulty swallowing), that was based on best practice guidelines. Nurses undergo a one-day training course and all stroke patients are now screened.

A review of the tool showed that no patient who passed the screen test needed later referral to SLT, which indicates the tool is being used appropriately. There are plans to train more nurses in its use across other services.

Meanwhile, the *Community Rehabilitation team* has established a *new Falls Screening Tool* that is used during initial assessment, based on best practice guidelines for those aged 80 or over, at risk of falling. There are five standards with the tool that are now completed with each patient.

An audit of how effective this tool is being applied will be completed shortly, while there is considerable interest in seeing how the tool might have an effect on hospital admissions over the long-term.

The *Inpatient Rehabilitation team* has now been trained for the *implementation of the Functional Independence Measure* – an outcome measure which all rehabilitation patients now receive.

The information from this is provided to the Australian Rehab Outcome Centre, which will give us the opportunity to compare ourselves with others and identify where improvements can be made.

Meanwhile, numerous activities have gone on throughout the year as a result of the *Patient Journey Project*, such as all patients being introduced to all members of their team within 48 hours of arrival, improved goal setting standards, improved working relationships and more focussed multi-disciplinary team meetings.

Patient Administration Services

With a *redesign of administration services* as part of the move to the new hospital, it now has a greater focus on *administration best practice*, customer service and professionalism, data collection – "Do it once and do it right ", standardised processes and equity of workloads.

Medical Improvements include a *centralised records department*, *a new trolley system* which streamlines the process for medical record delivery to Outpatients Clinics and *improved record delivery for Outpatients to 99%*.

Changes in Referrals Management include *improving the "one point entry" for referrals*, introducing patient focussed booking, reducing DNA rates and planning a trial for phone "text" reminders of appointments.

Additional Community Services

We have *increased provision of IV* in the community for those patients needing this.

HEALTH EDUCATION & RESEARCH COLLABORATION

Capital & Coast DHB is establishing a *Health, Education and Research Collaborative (HERC) centre* as a one-stop-shop for research and education, planning for which has now begun.

The 8000 square metre site, housed in the Clinical Services Block and Ward Support Block of Wellington Hospital, is a commitment to all C&C DHB staff to promote continuing education and foster it at both the under-graduate and post-graduate level.

Expected to open in 2010, the HERC will involve a number of organisations, including Capital & Coast DHB, Victoria University of Wellington, the Medical Research Institute of NZ and the University of Otago School of Medicine & Health Sciences.

"Modern medicine is based on education and research and New Zealand has a proud record in this area. To continue this tradition and to enhance our performance as a tertiary hospital, we need to have a strong teaching and research base for our staff."

- HERC advisor Professor Richard Beasley.

The HERC Centre will provide major opportunities for the teaching of nurses, doctors and allied health professionals, to be undertaken alongside cutting edge research, from basic biomedical science through to clinical trial activity.

After nine months of planning, the Stage One parties confirmed as coming into the Centre next year include Victoria University of Wellington, University of Otago School of Medicine & Health Sciences, Whitireia Community Polytechnic College Faculty of Health Education and Social Sciences, Massey University School of Health Sciences, Medical Research Institute of New Zealand and Wellington Free Ambulance. In addition there are five private organisations which will also be joining as commercial partners.

The HERC facilities will include:

- A Clinical Trials unit – a 10-bed facility that all partners in HERC will have access to
- A new national patient simulation centre
- A large lecture theatre and smaller seminar rooms.

> "This kind of dedicated research facility will help us attract and retain the right mix of staff and will become an important component to support staff in the future."
>
> *- C&C DHB Chief Operating Officer Shaun Drummond*

By fostering the sharing of knowledge, skills and expertise across the scientific, academic and health services, we can improve health outcomes in New Zealand.

PRIMARY, INTEGRATED & COMMUNITY CARE

Director Primary Care Nursing & Integrated Care

A key feature of the primary and integrated care team's work over the last year has been a concentrated focus on *workforce development and integration.*

Having the person and their family/whanau at the centre of the work has enabled developments that will contribute to a whole of system continuum of care.

This has been facilitated by all projects and work having a DHB-wide workforce focus. Examples of this focus include expanding the new graduate programme to include primary care and the scoping of advanced nursing roles that support and enhance existing service, and effect improvements not only in the hospital but within the community as well.

Some other highlights of the past year, include:

- Appointing a *Nurse Leader for Primary and Integrated Care*.
- Along with the Director of Nursing & Midwifery in our hospital services, establishing a *nursing professional development and career pathway* that encompasses all levels of education, integrates education and establishes a framework for workforce planning and a tool for recruitment and retention.
- A *Nurse Entry To Practice (NETP) Expansion programme* for primary health care/general practice nurses to link with the hospital programme accredited with the Nursing Council of New Zealand. This will attract Clinical Training Agency funding, which will support workforce development in the primary health care (including NGO) sector.
- Rolling out *C&C DHB's Professional Development and Recognition programme (PDRP) to primary health care*. This means that registered nurses from primary/secondary and tertiary services will all have access to the same career pathway framework.

» Identifying areas where advanced nursing practice roles can have a significant impact on patient outcomes through *development of nurse practitioner candidacy positions*. Examples include development of an Older Person Specialist Nurse working towards a nurse practitioner role (supporting aged and residential care in building capacity and capability within the sector as well as aiming to minimise hospital admissions); scoping a nurse practitioner role in primary mental health to support GPs and NGOs – particularly those serving Māori and Pacific mental health consumers; further development of a paediatric nurse practitioner role working across hospital and community, providing specialist support to not only hospital clinicians but also GPs and primary care/ general practice nurses into the area of allergy/eczema management.

» *Strengthening the C&C DHB immunisation programme* through the consolidation of primary care immunisation coordinator relationships. The coordinators have chosen to work collaboratively with the C&C DHB Immunisation Facilitator, sharing the strengths of their individual programmes and resulting in an increase in the uptake of immunisation.

» Piloted a *management of adult cellulitis treatment programme* in a location of established high incidence, with the intention of reducing avoidable admissions.

Clinical Advisor Primary and Integrated Care

A new role of *Clinical Advisor Primary and Integrated Care* was established In March 2009.

This appointment has taken a lead in many initiatives including the development of a new electronic framework for regular communication with primary care stakeholders on a monthly basis; and development of a number of new After Hours initiatives after extensive consultation and input into planning with primary care stakeholders across the Kapiti, Porirua and Wellington region.

Other work has included the formation of a new Working Group on Anticoagulation, including Primary and Secondary Clinicians from multiple disciplines including GPs, haematologists, specialist nursing and pharmacists. This group is in the process of developing a safe and effective means of initiating, monitoring and dosing complex anticoagulant therapy in both Primary and Secondary Care settings.

Further input has also been made in cooperation with the Booking Centre into improving the quality processes and feedback to referrers for elective First Specialist Appointments and also into referral and discharge processes involving the new Medical Assessment and Planning Unit, due to open soon.

Primary Care

During 2008/09 a key focus was to *enhance integration between primary and secondary services*.

The appointment of the Clinical Advisor Primary Health Care has made significant inroads towards this goal and has provided a primary care voice on the DHB's executive management team and the primary secondary clinical governance group.

This group includes clinical representatives from both the primary and secondary services and as it evolves, it is now well placed to assist work in the coming year to support the shift of some services from hospital, to primary care settings.

Highlights for the past year include:

- *Ambulatory Sensitive Hospitalisations (ASH)* targets have been exceeded and we are one of the leading DHBs in the country
- *Immunisation targets were achieved* and our rates are well above the national average
- *CarePlus targets were exceeded* and all of our PHOs are above the national target of 70%.

Funding for after hours services has also been increased during the past year through after hours funding from central government. In Wellington this has translated into a reduction in fees at after hours services for high needs groups, *increased GP hours at the Kenepuru Accident and Medical clinic at peak times*, as well as primary care training for triage nurses.

In Kapiti, there has been a *proactive discharge planning process* at practice level and a one-off standing orders project in rest homes to manage people better in the community.

We are also working on a district-wide service at the Wellington Hospital Emergency Department for *triage and assessment for primary care appropriate presentations*, and a communications plan.

Improving the health of children and youth

We have collaborated with community stakeholders to successfully develop a *Child Health Strategy* for C&C DHB.

We have established a cohesive and collegial C&C DHB Immunisation Stakeholder group, where there is transparency in sharing best practice models of Immunisation Co-ordination and Outreach Immunisation Services (OIS). We have also offered clinical training, support and guidance to new OIS providers.

We have increase linkages with C&C DHB midwives and Lead Maternity Carers and made this a priority.

Immunisation education for midwives is offered twice yearly, with additional contact and education delivered through delivery suites, team meetings, and individual contacts.

The *Before School Check programme* has been implemented and checks are underway. A contract is in place with Plunket to provide the service.

Through Regional Public Health, the *HPV programme* (cervical cancer vaccine) has been established for girls in Year 8 and coverage of 54.2% has already been achieved. It is hoped this will increase over time.

In the C&C DHB area two schools, with our support, have received a Gold *School Food programme award* from the Heart Foundation and one is working towards a Silver award. These schools have also enhanced their healthy food policies and a total of eight schools have now implemented or improved a healthy food policy.

C&C DHB are currently supporting training for a *Māori and a Pacific lactation consultant*.

We have also contracted a provider to undertake *childbirth education classes* each year in Wellington and Porirua, specifically aimed at teens and priority groups, while also developing a community lactation consultant/breastfeeding advocacy role.

As a result of this, C&C DHB breastfeeding rates at six weeks have shown a significant improvement across the DHB, rates at three months surpassed the national goal by 5.3%, and 8.1% at six months. C&C DHB are one of the leaders nationally for exclusively breast-fed babies.

Improving Oral health

The funding for *improving oral health services* in our region has now been approved by the Ministry of Health and we will be developing these services in the next year.

Implementing the Health of Older People Strategy

Services to older people has been a key focus during 2008/09 and we evaluated our community care service model including Care Coordination Centre services, the home based packages of care we offer in the community and the role of care managers.

This has led to a *refinement of our approach to home based services* and we now have a fully integrated assessment, care planning and service delivery process for home based care and support.

A *review of mental health services for older people* was completed and will allow us to develop an appropriate model of care for this high needs client group this year.

An *approach to end of life care* has been developed and will be gradually implemented in the district, with the first step being put in place for inpatients in Mary Potter Hospice.

Initiatives are also being put in place to *prevent and reduce the impacts of long term conditions, cancer and mental health,* along with *the provision of palliative care*.

Long Term Conditions

The *tobacco control plan* has now been submitted to the Ministry of Health and implementation is underway. We have put in place a smoking dependence record form in hospital, which will allow us to measure the number of patients who currently smoke and who have been given advice or referral to smoking cessation services.

We have increased the number of people enrolled in the *diabetes Get Checked programme*, improved the number of diabetics with good blood sugar levels and achieved the Diabetes Detection targets for all population groups in the past year.

We have also supported a new model of diabetes care, which is to be done through collaboration between the hospital diabetes team and a primary care provider.

Through a focus on long term conditions management, we have increased the percentage of people enrolled in Care Plus, with all PHOs in the DHB achieving the national goal of 70% enrolment.

In addition, PHOs were also resourced with flexible "Enhanced Care Plus" funding to allow for further support for long term conditions in line with Care Plus.

We have also provided workforce development for evidence based self management training for those working with people with long term conditions.

Throughout the past year, we have assisted all our PHOs to carry out *systematic cardiovascular screening* of targeted higher needs population. As a result of this, all PHOs are making progress in cardiovascular screening.

We have now developed a *community dietician service* to support long term condition management in primary care.

This position will focus on work with populations that will benefit from specialist dietetic support. In the first instance the role will have a focus on the management of diabetes and cardiovascular disease and obesity.

We have also extended a shared and collaborative care approach in the management of diabetes to a Cannons Creek primary care service. The intention is to evaluate this work in such a way as to provide local clinical evidence of the efficacy of this model.

Community Action

We have maintained *strong linkages with our high needs communities* via ongoing support for the Kapiti Community Health Group Trust and Porirua Healthlinks Trust.

Both these groups have been working on coordinating local transport initiatives to enable easier access for residents to C&C DHB services.

This has led to the Red Cross supporting a community shuttle service between the Kapiti Coast and C&C DHB, and coordinating volunteer transport services.

Progressing the NZ Disability Strategy

A major advancement in progressing the NZ disability strategy has been the appointment of a *Disability Advisor* based in the hospital.

This newly established role has a core purpose to provide expert advice in policy and practices consistent with the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons With Disabilities, promoting a health care environment supportive of people living with disabilities.

The role provides leadership and advice, reviews access, develops policy and practice on disability issues, and contributes to wider teams across the DHB. Current pieces of work include:

- Access, way finding and orientation
- Connecting with communities and supporting the establishment of consumer advisory processes
- Incorporating and structuring a disability perspective into clinical governance
- Quality improvement and patient safety
- Collecting information on the experience of disabled people in the DHB
- Better connecting hospital services with support in the community
- Exploring new ways to enter into the Under 65 disability support system

It's believed C&C DHB is leading the way for other DHBs by developing this role.

ALLIED HEALTH, TECHNICAL & SCIENTIFIC

The DHB last year established the new role of *Director Allied Health Technical and Scientific*, which works to support all directorates in achieving the provision of effective services and development of the Allied Health, Technical and Scientific workforce within the Hospital and Health Service.

It provides a *point of contact for internal and external stakeholders* and creates a link across the continuum of care. Establishing this role has also resulted in a *collective voice across the organisation* for consultation, development and involvement in the creation of models.

This enables a holistic approach to health, promotes a multidisciplinary model, builds organisational identity, builds capability, and builds/ contributes to clinical governance activity.

Having this effective voice at executive management and Board level, and across the Hospital & Health Services, has raised the profile of particular health services and has led to successes including:

- Molecular biology (laboratory service and their training development and responses to coping with the demand during the H1N1 pandemic)
- Ensuring allied health are involved in developments such as the new Medical Assessment & Planning Unit and family violence strategies
- The Genetics Laboratory now being accredited to provide testing that was previously not available in New Zealand
- Increased echo services at Kenepuru Hospital
- Development of Allied Health Technical and Scientific Forums and raising the profile of particular professions, such as Orthoptists and Clinical Physiology
- Inclusion and representation in clinical governance structures at all levels within the Hospital & Health Services, and representation in the primary secondary clinical interface group
- Piloting allied health assistant core competency training within the nursing assistant model (interdisciplinary training)
- Consistency of roll out of a national process for MECA requirements and this has been an example for other DHBs
- Development of a regional allied health clinical network to work towards regional collaboration.

MĀORI HEALTH

The Māori Health Directorate continues to drive the implementation of C&C DHB's Māori Health Strategy – Te Plan II. The directorate has focussed on a *number of key initiatives* over the past year.

Encouraging healthier living for Māori has been a key focus, with a new service being launched which aims to implement a healthy lifestyle programme for Tangata Whaiora.

Another initiative involves the implementation of an *intensive physical activity/healthy lifestyle programme* for Nga Mokai tamariki and rangatahi. A particular emphasis of this programme is to support individuals/whanau to overcome the barriers to accessing services.

The directorate has also funded *additional youth services resources* in the community.

Provision of *Māori breastfeeding services* has been an important step, with the aim to support Māori mothers as a priority group and enable exclusive breastfeeding to children to around six months, continuing after this period in combination with introducing solid food.

Community cardiac services have been expanded in the three Porirua PHOs to deliver *Cardio-Vascular Disease risk assessment services* targeting Māori and Pacific populations over the age of 35 years.

Increasing the capacity and capability of our *Māori health workforce* remains a priority for C&C DHB and achievements include:

- working with Māori health providers to identify their capability and potential areas for development
- the provision of cultural awareness training for the C&C DHB board and staff
- a career progression project for Māori health workers in primary care
- supporting a forum for Māori staff at C&C DHB.

C&C DHB continues to lead a regional project on behalf of the DHBs in the Central Region, which included completing a *stocktake of workforce initiatives* within the region, developing a social marketing framework aimed at *encouraging Māori into the health sector* and implementing a *strengths-based conference for Māori health providers*.

A *Māori Health Coordinator* has been established in Kapiti to develop an overview of Māori Health in Kapiti using key indicators, strengthen relationships with key stakeholders and address access issues for Māori within the Kapiti district.

Mary Potter Hospice has been supported to *improve access and information for Māori providers, patients and communities*. The project also aims to identify workforce development needs to support palliative care services for Māori.

C&C DHB continues to provide *effective bicultural training opportunities* for our staff. The feedback received about our Treaty of Waitangi, Māori Health Disparities and Tikanga Best Practice training suggests that all staff who have participated are finding it to be of significant value.

The concept for a five-year marketing campaign to improve Māori health has also been completed, with the initial phase concentrating on *promoting images and messages that capture Māori strengths* and links these to whanau and Whanau Ora.

PACIFIC HEALTH

Early in 2009, C&C DHB carried out the *Pacific Stocktake Project*, which presented an opportunity to reconfigure the current investment in Pacific Health at a time where change is inevitable and the global economy is placing a strong emphasis on ensuring crown funding is well targeted, effective and outcome-focussed.

Excellent results have been achieved in *immunisation rates* in the Pacific community, which have come about through a collaborative approach to addressing Pacific health.

The use of Community Health Workers from Pacific Health Service has contributed to the overall Immunisation Outreach approach being a success, with 87% of the Pacific target of 90% being achieved.

Pacific Community Health Workers set up Pacific families on a particular day ensuring the Outreach team have access to these groups. Pacific health providers believe this type of community mobilisation ensures services are well targeted by a collaborative community approach.

A range of community-driven initiatives ranging from active health lifestyle programmes targeted to elderly, children and young people, to competitive Pacific sports-type activities like Kilikiti for those in middle-age, have proven to be a huge success in *mobilising the Pacific community*.

These initiatives continue to see large numbers of Pacific people congregate per event, promoting key themes in relation to health prevention, coordination and rehabilitation. C&C DHB investment in such programmes has been through the utilisation of HEHA Pacific resources.

The significance of these events is the change in the way Pacific people prepare and provide food that is more nutritious than food previously made available to people who attended these events.

These changes signal a philosophical shift in thinking by Pacific health providers and promoters and the communities they target, where Pacific people are more likely to eat healthier and exercise more. It is a reflection that the key health messages are impacting on the Pacific community.

In 2009 the Ministry of Health signalled a change to the way *Pacific Provider Development Funding (PPDF)* will be administered. C&C DHB has the second largest Pacific population in the country, second to Auckland. In 08/09 PPDF funding has focussed on provider development, however the new *Serau Pacific Provider and Leadership Development Funding plan 2009/10* will focus on investment in the development of Pacific workforce from the PPDF.

HUMAN RESOURCES

A key focus for Human Resources in the past year has been on *capability building* – supporting managers through the Wellington Regional Hospital change programme, getting "the basics right" by improving systems and processes, running various training and education programmes for managers, building the capability of the HR Team and reducing reliance on external agencies and advisors.

We have rebuilt the recruitment function within the DHB and improved marketing of our organisation, targeting reducing the cost per hire from $3,600 to $1,700 over two years (a saving of $1.5M) and improving candidate care.

The 18 nurse graduates who took part in the Post-Graduate Certificate in Nursing (Mental Health).

By year end savings were on target, phase one of the website enhancement had been completed, preferred supplier agreements established, recruitment and candidate care processes improved and a number of successful marketing campaigns completed under new branding. Graduate recruitment has been a particular highlight.

Another area that has received focus is the HR Systems and Payroll – a *Human Resource Information Centre* has been established and a *Payroll Systems Accountant* appointed. Some quick-wins have been implemented to clean up the HR data and provide managers with basic HR reporting to help them manage their workforce.

A comprehensive programme of work is in place for the next year to re-implement HR systems and processes to support administrative requirements as well as longer term workforce planning.

Permanent employees	4133
Full time	*2726*
Part time	*1670*
Casual employees	774
Temporary employees	270
Part time	*108*
Full time	*162*
Total number of employees	5177

There has been a pleasing downward trend in turnover from over 16% last year, to 14%.

INFORMATION & COMMUNICATION TECHNOLOGY

The DHB's IT services, formerly delivered by an external provider, have now *successfully been brought in-house* – a move that is expected to provide significant savings.

We can now tailor the service to suit our own specific clinical and organisational Information Technology needs and goals.

The return of our ICT services to within the DHB is something to be celebrated.

There's no denying there are challenges ahead, as we firm up the performance of our electronic health record and address shortfalls in many of our other systems. But there's also no denying the comfort that comes in tackling those challenges together, as parts of one organisation.

The change has seen around two dozen highly skilled and capable staff make the shift from the external provider to our own ICT Directorate.

ORGANISATIONAL DEVELOPMENT & PATIENT SAFETY

This *new directorate* was established this year to lead and inform the organisation about people development, capability and capacity, and to develop and/or implement best practise methodology, systems and frameworks and tools.

It also seeks to achieve *safe, people-focused health care*, through patient safety and quality of health service delivery.

Key achievements in the past year include supporting the development and implementation of the *new Clinical Governance structure* across the hospital and health services – as strengthening the Clinical Governance within C&C DHB is a key priority.

A review of the structure was needed to ensure that we are able to strengthen clinician/management partnerships, improve efficiencies, improve communication, support the devolution of decision making to the lowest level, support staff to deliver safe, quality health care and to ensure we work to quality standards. Two workshops have now been held with senior clinicians and managers.

Another milestone has been the implementation of the *new Risk Management Policy and Guidelines*, which has been supported by training provided to senior staff and first line managers.

A Risk Reporting framework is now in place supported by the Quality & Risk Unit and the training has also been offered to other DHBs following a number of expressions of interest.

The directorate also led the *development of the process documentation* for processes which were changing in the services as a result of the move to the new hospital.

The team also worked with the services to identify training and orientation requirements, developed the training material and supported the delivery of this to staff affected by the move. Simulation training was provided prior to the move for areas including ICU, Theatres and Delivery Suite.

In addition, the directorate *led the Audit process* with the services to ensure patient and staff safety were maintained and that the services were ready and able to move.

The moves were all completed within the scheduled timeframes with no significant clinical or patient/staff safety issues arising. The success of the overall migration to the new hospital resulted from the detailed planning driven by the directorates and the new hospital project team, and the commitment of all staff to ensure patients were moved safely into the new hospital. This was all achieved whilst continuing to provide access to all services.

A new *Patient Safety Officer role* was established to support patient safety across the organisation. This key role aims to improve serious and sentinel event management and reporting, supporting implementation of the national Incident Management System, and implementing our Open Disclosure Policy.

Meanwhile, a review has been carried out and framework developed for the *credentialing policy* which supports Senior Doctor Professional Development Review and credentialing.

In other professional development issues, the Professional Development Unit has continued to work with Victoria University to ensure the *Post Graduate programmes are planned and aligned to organisational requirements* with 73 passes achieved by the nurses completing post graduate papers. The core competency programme for nurses was reviewed and recommendations implemented to support improved compliance with achieving these.

There has been development and implementation of a *post graduate year two training programme for RMOs*, which includes a mentoring programme, and a *new Professional Development Programme* for RMOs aligned to RACP and RCS Physician/Surgeon training.

A 'just in time' *programme for Charge Nurse Managers* in the new inpatient areas in the new hospital was also established.

NON-CLINICAL SUPPORT SERVICES

After undergoing a full review and restructure in the past year, non-clinical support services has now moved towards a model of *greater efficiency* for the organisation.

One of the key achievements so far, has been the *rationalisation of the supply of clinical products*, moving from a model of holding excess stock to one where we get products when we need them. This involved reviewing our supply chain methods, reviewing our contractual arrangements with Suppliers and determining the right stock levels to be held at our warehousing and in ward store areas.

In liaison with wards and departments, we have been able to successfully reduce our stock holding on site by at least one third of the volume traditionally held, resulting in better cashflow management and greater transparency around supply routes.

As part of our ongoing commitment to an improved supply chain process, a quarterly review is done with the various wards and departments to identify any further efficiencies that can be gained.

The directorate has also redesigned the way it provides additional services to bring them together under *one provider*, which has delivered greater cost savings and improved service.

The integrated service model, managed by one external organisation, delivers a seamless service including cleaning, internal and external waste management, washroom supplies, patient food, retail food and meals on wheels service, pest control, and support to the nursing model of care.

This single management structure has enabled C&C DHB to reap the benefits of single point accountability, improved management resource and reduced cost.

This model has delivered many great improvements, including introducing *new state of the art cleaning technology* to a *new electronic auditing system* for the immediate reporting of cleaning results, a *24/7 single point of contact support centre* for all related services and an *integrated electronic food management system*, all

focused on the quality of care we provide to our patients and clients.

Non-Clinical Support Services has also actively *supported the new nursing model of care* as we moved into the new building, with the alignment of resources and scope to the activity and demands of the new ward configuration.

The result has seen many duties previously undertaken by either nursing or health care assistants transferred to the integrated service model and being performed by ward-based food service assistants and dedicated cleaning staff. This has released valuable nursing resources and assistance to provide increased direct patient care.

The blending of traditional distinctions between non-clinical staff functions has brought a hospitality concept to the patient's bedside.

Staff Holiday Programme

The Wellington Regional Hospital's commitment to be an employer of choice has led to a number of initiatives being undertaken to *support a work/family balance for staff*.

A pilot WRH *School Holiday Programme* for children aged 5 – 12 years was conducted from the January 5 – February 4, 2009, in partnership with a local child care provider, and was held at nearby Berhampore School.

A total of 36 staff took the opportunity to access the programme, with a total of 52 children participating.

Staff who took part in the pilot were involved in the evaluation and the response was overwhelming support from staff and management.

Minor improvements to the School Holiday programme have been implemented, including moving it to a venue adjacent to the Hospital Campus and adjusting hours to best meet staff requirements. The programme is now well entrenched in the C&C DHB culture, with programmes running every school holidays and there are plans to expand to an additional programme for 12 – 15-year-old children.

KENEPURU HOSPITAL & KAPITI HEALTH CENTRE

We are committed to the *Kenepuru/Kapiti project*, which aims to illustrate the current utilisation of facilities and services at Kenepuru Community Hospital and Kapiti Health Clinic.

A plan has been developed that suggests directions and an overall model for future services at Kenepuru and Kapiti, based on the needs of both the local population and the whole DHB. The project was commissioned by the CEO under request from the Capital and Coast District Health Board.

Over previous years, a number of attempts to structure services at the two sites have led to changes to a number of individual services but not to the overall model of service delivery.

With the completion of the new Wellington Regional Hospital in Newtown it was timely to address the future service delivery model for the entire district.

This will allow for planning for utilisation of DHB facilities and resources that best meets the needs of the local communities and develops capacity for future health service growth.

The key objectives for Kenepuru include:

- Having a coherent, endorsed service model for Kenepuru which provides some services for the local community and some 'centre of excellence' services (such as rehabilitation and elective surgery) for the entire district.
- Efficient use of facilities:
  - Theatre capacity utilised to at least 85%, to provide the majority of ambulatory elective surgical provision for the district
  - High utilisation of outpatient facilities to deliver at least 35% of total outpatient attendances
- Services that have been designed and equipped to be 'fit for purpose' and are insulated from resource surges occurring at Wellington Regional Hospital
- Sufficient clinical and management autonomy to be able to operate Kenepuru Hospital effectively.

To achieve this, an 18 month timeframe was implemented and significant progress has already been made, with a number of initiatives close to implementation in the new financial year.

The project has already made a number of achievements to date, including:

- A *public awareness campaign* implemented to keep stakeholders and the community up to date with progress achieved
- The *upskilling of clinical staff* to care for post-surgical patients
- Developing a *High Observation area* on the surgical ward
- Developing an *improved Orthopaedic surgical patient selection process*
- A review of *patient transfer protocols*
- A review of *Blood, Allied Health and Radiology* to support a proposed increase in surgical activity
- A *new theatre template* established
- 51% (67% of all elective) of all *ophthalmology surgery* now conducted at Kenepuru
- 67% of total *dental surgery* now performed at Kenepuru
- *Additional surgery* introduced in the first six months of 2009 included two extra half-day Gastroenterology sessions per week with further increase expected in the upcoming months
- *Additional outpatient's activity* introduced to Kenepuru in the first six months of 2009 included two additional Gastroenterology clinics per month, introduction of two Neurology clinics per week, increase of renal clinics by four new per month and an additional Infectious Diseases clinic per month. There have also been increased respiratory and sleep clinics.

As part of the Committed to Kenepuru and Kapiti project, *community engagement and communication* were identified as critical success factors and as such, feedback/input from those currently accessing the wide range of services would be of ongoing value for the evaluation and planning of health service delivery.

Utilising the skills and enthusiasm of the Kenepuru Community Hospital Advisory Group, along with other interested stakeholders, the frameworks for a cross-section of *Kenepuru Community Hospital Consumers* has been established and endorsed across a number of forums. The platform is set for the nomination and appointment of consumers to take place in the first half of the next financial year.

The **vision** of the group is to *enable consumers to participate in the development of services* provided by the C&C DHB.

To do this, the **aims** of the group are:

- To contribute to a quality health service
- To assist in the identification of unmet needs
- To facilitate representation from the community

C&C DHB already has robust consumer input across a number of services/facilities and plans to have this structured across all facilities within the next 12 months.

Kenepuru Accident and Medical Clinic

Last year the A&M saw approximately 34,000 patients, which is an average of 93 patients per day.

The clinic is available for one-off visits from patients requiring urgent accident and medical primary medical and nursing services, but who do not have their own GP, or are unable to be seen by a GP.

It was reopened to 24-hour-a-day service in August 2008 after a period of being closed overnight and was reaccredited by ACC.

The clinic has recently also been granted some extra funding to improve access to primary services in the Porirua area after hours.

The recent swine flu pandemic was a testing time for the team, with record numbers of patients seen on a daily basis, however the team's worked well together and continued to provide quality care under such pressure.

Radiology Services

A *new ultrasound service* at Kenepuru has also been set up in conjunction with Pacific Radiology, which has made a difference for inpatients at Kenepuru and again means fewer patients travelling to Wellington for Radiology.

Cardiology Services

The delivery of *four echocardiography scanners* for Cardiology means we have started echo testing on-site at Kenepuru Hospital for both inpatient and outpatients. This means a reduced need to transfer inpatients to Wellington Hospital and reduced travel for outpatients from the Porirua and the Kapiti Coast. The Wellington Hospital Foundation contributed $80,000 towards the purchase of one of the echo machines.

Porirua Transport Cluster

Following on from the success of the Kapiti Community Transport Steering Group, a number of key organisations within Porirua joined together to form a local *Health Transport Cluster*.

The purpose of this cluster is to *develop a directory of transport providers within the local community* who can assist with transport to and from health and hospital appointments. DNA (Do Not Attend) rates for certain groups within the Porirua area were disproportionately higher than the average and transport has been identified as a significant contributor.

To date, 22 transport providers within Porirua, who each have individual criteria for those who they can transport, have been added to the service directory.

The DHB, along with other community partners, are developing the communication strategies to best assist the community to access this information.

Kapiti

During the last year we have worked closely with Wellington Free Ambulance and the Kapiti community to address the need for *urgent care in the community*.

This has led to a new pilot service being introduced from July 2009 that is aimed at reducing the number people needing to be transferred to Wellington Regional Hospital from the Kapiti Coast.

GOVERNANCE OF C&C DHB

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; Surgery, Intensive Care Unit 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 New Zealand Public Health and Disability Act 2000. 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 (last held in October 2007) and four are appointed by the Minister of Health. A Crown Monitor was appointed in the 2007/08 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.

During 2008/09 the Mental Health sub-committee of CPHAC was disestablished.

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.

Other Committees

The Board has established one Committee called the Finance Risk and Audit Committee (FRAC) with responsibility for the overview of the Risk Management Processes, External and Internal Audit processes, and financial matters.

During 2008 the Risk Management Policy Framework was revised, and the Board adopted a risk assessment methodology based on the SAC (Severity Assessment Code).

To ensure the cohesiveness of the governance function during 2008/09, the Board Chair and Committee Chairs met regularly.

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/Meetings/Meetings.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.

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2009:

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 2009, fairly reflect the financial position and operations of Capital & Coast District Health Board.

Sir John Anderson Chair	Ken Douglas Deputy Chair
Ken Whelan Chief Executive Officer	Theo Koenders Director of Finance

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 2008 to 30 June 2009. Whilst our forecast performance targets are expressed in specific terms, actual performance is likely to vary, positively or negatively, in each case.

Highlights:

- Ambulatory Sensitive Hospital (ASH) admissions are potentially preventable by appropriate primary care and provide an indication of access to and effectiveness of primary care in our district. We exceeded our targets for ASH and are one of the leading DHBs in the country on this performance measure.
- Immunisation rates for 2 years olds are a key government priority, we achieved our targets and our rates are well above the national average.
- The Care Plus programme aims to improve long term condition management, reduce inequalities, improve primary care teamwork and reduce the cost of services for high-need primary health users. We exceeded our targets for participation in this programme and all of our PHOs are above the national target of 70%.
- Movement into the Wellington Regional Hospital has been completed successfully, on time and on budget.

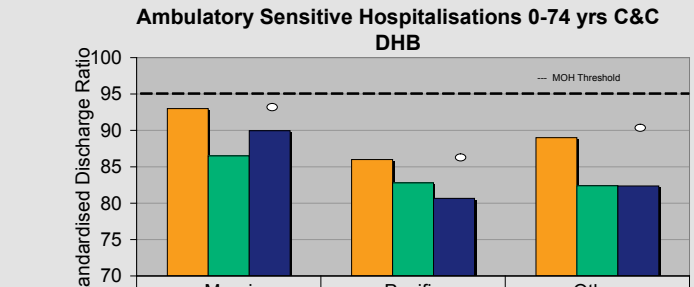
The criteria for rating our performance are shown below:

Rating	Criteria
Achieved	Where the work has been completed within the timeframe or target reached.
Partially Achieved	Where the work has been completed within the 2008/09 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.

One of the functions of the Statement of Intent and in particular Statement of Service Performance, as stated in the Crown Entities Act (s142), is to show how we measure what we did in 2008/09. These performance measures, targets and milestones are subject to annual audit by auditors appointed by the Office of the Auditor General.

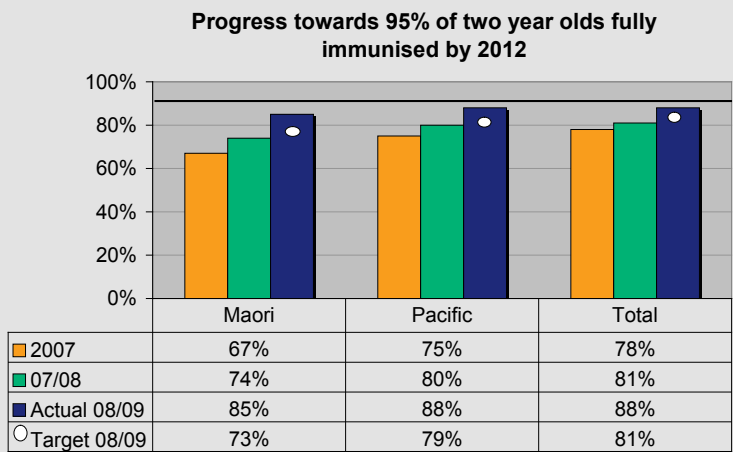
REDUCED DISPARITY IN HEALTH STATUS

Overall Assessment	Achieved
Long term Outcome	Reduce illness and disease among high health need populations such as Māori, Pacific peoples, refugees and new migrants, by reducing barriers to access and by encouraging access and healthy lifestyles, so that there is are fewer differences in the health of people across the district
Medium Outcome	Embedding primary care strategy Improving health of Māori and Pacific people Improving health of children and young people Improving oral health
Why is this an important priority for C&C DHB?	Our Health Needs Assessment shows that the district has a significant group of people living with low health status.

Key Performance Measure	Ambulatory Sensitive Hospitalisations (ASH)	Year End Rating
Output class: Funder Ambulatory sensitive hospital (ASH) admissions are potentially preventable by appropriate primary care (including outpatient services), and provide an indication of access to, and the effectiveness of, primary care in our district.	**Health target**  Comment: This measure is based on our performance relative to other DHBs – a rate of 100 would be the same as the national average. C&C DHB aims to stay below 95% of the national average. Note positive performance is indicated by a decrease in the ratio, so we have exceeded our targets for ASH.	Achieved

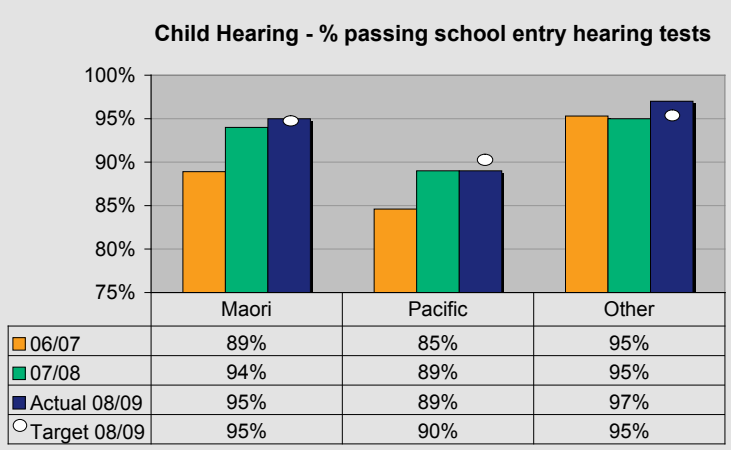
	Maori	Pacific	Other
06/07	93	86	89
07/08	86.5	82.8	82.4
Actual 08/09	90.0	80.7	82.4
Target 08/09	94	86	90

Objectives for ASH			
Output Class and timeframes for 2008/09	Objectives		
Funder June 2009	Action	Trial acute medical clinics in selected specialties.	
	Target/ Milestone	Health Target for admissions to hospital that are avoidable or preventable by primary health care achieved.	Achieved
	Progress	We have had workshops with local GPs to discuss the Medical Redesign Project and acute access clinics have been part of the discussion. It is planned that the trial acute medical clinics will be developed after the Medical Assessment and Planning Unit (MAPU) is opened (Nov 09). We have met our targets for ambulatory sensitive hospitalisations	
Funder June 2009	Action	Establish community based treatment (including intravenous treatment) of cellulitis.	
	Target/ Milestone	Evidence of community based treatment.	Achieved
	Progress	Community based treatment of cellulitis was piloted from January to June 2009 and an evaluation is underway. Data has been collected on treatments provided and funding has been allocated for roll-out of the pilot in 2009/10.	
Funder June 2009	Action	Invest with other partners in interventions such as healthy housing, smoke-free promotion.	
	Target/ Milestone	Reduced respiratory related admissions in children.	Not achieved
	Progress	Respiratory admissions for 0-14 year olds increased from 17.0/1000 in 2007/08 to 21.4/1000 in 2008/09	
Funder June 2009	Action	Implementation of advanced directives established in Aged Residential Care facilities.	
	Target/ Milestone	Evidence of advanced directives established in two Aged Residential Care facilities.	Not achieved
	Progress	We have changed our approach in this area. The current view amongst clinicians and service providers is for improved communication and understanding of patients/family wishes throughout episodes of care rather than a clear written decision on a patient's file regarding the action to be taken in the event of life threatening event. We are working to ensure improved communications occur between patients, families and clinicians.	

Key Performance Measure	Immunisation Coverage at age two years	Year End Rating
Output class: Funder Immunisation is one of the most cost-effective and successful preventative health interventions known. Improving immunisation coverage is a key component of the New Zealand health strategy: "to improve child health."	**Health target**  Comment: As a DHB we consistently achieve our immunisation targets and are one of the leaders in increasing immunisation rates.	Achieved

	Maori	Pacific	Total
2007	67%	75%	78%
07/08	74%	80%	81%
Actual 08/09	85%	88%	88%
Target 08/09	73%	79%	81%

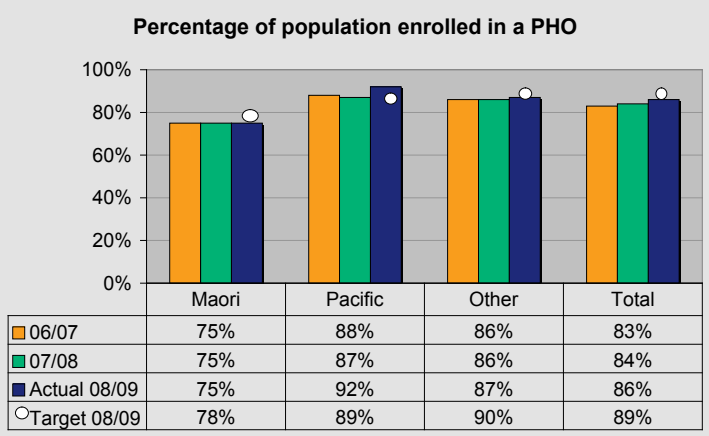
Objectives for immunisation			
Output Class and timeframes for 2008/09	**Objectives**		
Funder June 2009	Action	Support good data quality on the National Immunisation Register and work actively with the community and providers to meet coverage targets for child hood immunisations.	
	Target/ Milestone	Progress towards the target of 95% 2 years olds fully immunised by 2012.	Achieved
	Progress	Key linkages, education, promotion of key immunisation messages, clinical support, advice and guidance are ongoing across primary and secondary services. Regional and national linkages with key immunisation stakeholders has been grown and maintained.	
Funder June 2009	Action	Increased outreach immunisation service.	
	Target/ Milestone	Improved immunisation coverage for Māori and Pacific children at 2 years.	Achieved
	Progress	We have met our immunisation coverage targets for Māori and Pacific children.	

Key Performance Measure	School Entrant Hearing Loss	Year End Rating
Output class: Funder This performance measure seeks to monitor the improvement in the percentage of children passing the school entrant hearing test. Collecting data on the hearing tests carried out will help to identify hearing disparities between populations and allow for improved service planning and targeting	 Comment: In 2008/09 we have achieved our targets for the majority of our population.	Partially achieved

	Maori	Pacific	Other
06/07	89%	85%	95%
07/08	94%	89%	95%
Actual 08/09	95%	89%	97%
Target 08/09	95%	90%	95%

Objectives for hearing

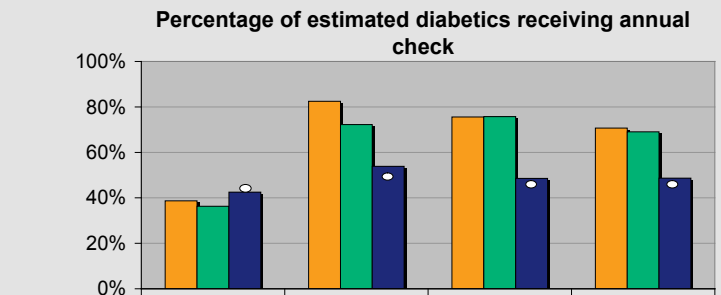
Output Class and timeframes for 2008/09	Objectives		
Funder June 2009	Action	A Mobile Community Ear Clinic service will be provided 4 days a week in areas of high deprivation in Porirua.	
	Target/ Milestone	The Porirua Mobile Ear Clinic will show evidence of visits to Pacific Language Nests and Te Kohanga Reo in Porirua.	Partially Achieved
	Progress	Regional Public Health (RPH) has held clinics in areas such as Porirua East, Titahi Bay, Waitangirua in both the community and PHO practices. The clinics are run Monday to Friday and have high Māori and Pacific attendance.	
Funder June 2009	Action	Implement the before school check programme with an emphasis on Māori, Pacific.	
	Target/ Milestone	Before School Check programme implemented.	Achieved
	Progress	The Before School Check programme has been implemented and checks are underway. A contract is in place with Plunket to provide the service.	

Key Performance Measure	Eligible Māori enrolled in PHO	Year End Rating
Output class: Funder This measure seeks to identify the improvements we are making in access by Māori to primary health care. It measures the local Māori population enrolled in local DHB PHOs	 Maori / Pacific / Other / Total 06/07: 75% / 88% / 86% / 83% 07/08: 75% / 87% / 86% / 84% Actual 08/09: 75% / 92% / 87% / 86% Target 08/09: 78% / 89% / 90% / 89% Comment: Although we have not achieved for the majority of our targets the changes in calculation needs to be accounted for, as the targets were set previous to these changes. In this case, the apparent decrease in the PHO coverage percentages by ethnicity can be largely explained by the uneven changes in geocoding completion and partly by changes between the two series of population projections based on 2001 Census and 2006 Census respectively. *(The underlying data up to June 2008 for PHO coverage calculation was based on the meshblocks and population projections derived from Census 2001. From July 2008 onwards, Ministry of Health has changed over to Census 2006 meshblock for the geocoding of area boundaries to determine the DHB boundaries. Hence, the actual PHO coverage for 2007/08, which is based on July 2008 PHO register has used Census 2006 data.* *The MoH transition from Census 2001 to Census 2006 has also resulted in a lower percentage completion of geocodes when compared with the earlier registers (see table below). This geocoding difference is not evenly distributed with different ethnicities: Pacific percentage of geocodes completion dropped 2% followed by Other at 4% and Māori at 5%. These differences have largely contributed to the apparent decreases in PHO coverage.)* **Percentage of Geocoding Completion by Ethnicity** Quarter start date / Māori / Pacific / Other 01/Apr/2008: 99% / 99% / 98% 01/Jul/2008: 95% / 97% / 94% 01/Oct/2008: 94% / 97% / 94%	Partially achieved

Objectives for hearing			
Output Class and timeframes for 2008/09	Objectives		
Funder June 2009	Action	Continue to monitor trends in primary care access (utilisation) as a whole and with respect to gender, age groups, ethnicity and, where feasible, NZDep.	
	Target/ Milestone	A 2.5% increase in Māori enrolment in PHOs over December 2007 baseline.	Partially Achieved
	Progress	We continue to monitor trends in primary care access. We have not had a 2.5% increase in Māori enrolment but we have maintained level from previous year. As explained above this means an increase in overall numbers although not evident in the actual percentages for 08/09.	

IMPROVED HEALTH AND INDEPENDENCE OF OUR PEOPLE, FAMILIES AND COMMUNITIES

Overall Assessment	Achieved
Long term Outcome	Reducing the number of people who develop an ongoing illness or disease, and reducing the impact of disease on people's lives. The aim is to maximise opportunities for independence and maintain or improve quality of life, particularly for high need populations.
Medium Outcome	» Reducing incidence and impact of diabetes on people » Reducing cancer wait times » Developing mental health service pathways » Reducing childhood obesity » Improving nutrition and increasing physical activity in children and adults
Why is this an important priority for C&C DHB?	This is important to allow people of our district to maximise opportunities for independence, and maintain or improve quality of life. Empowering people with information and support can have a positive influence on their ability to motivate to make lifestyle changes.

Key Performance Measure	Diabetes – Proportion of DHB population estimated to have diabetes accessing annual checks and the proportion on the diabetes register who have good management	Year End Rating
Output class: Funder Long Term Conditions such as Cardiovascular disease (CVD) and diabetes are leading causes of death in New Zealand and disproportionately affect Māori and Pacific people and people of low socio-economic status. They are both priorities within the New Zealand Health Strategy Service coordination to improve the management of illnesses associated with diabetes complications will improve the patient experience, provide safer and more efficient service, reduce avoidable admissions and improve health outcomes Early recognition of diabetes supports the opportunity for better self-management and reduced complications.	**Health target**  		Maori	Pacific	Other	Total
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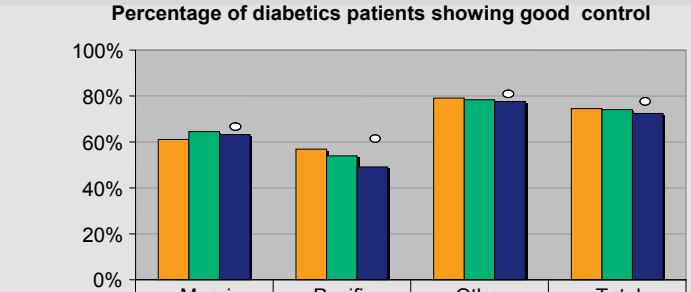
2006	39%	83%	76%	71%
07/08	36%	72%	76%	69%
Actual 08/09	43%	54%	49%	49%
Target 08/09	42%	47%	44%	45% |  |	Maori	Pacific	Other	Total
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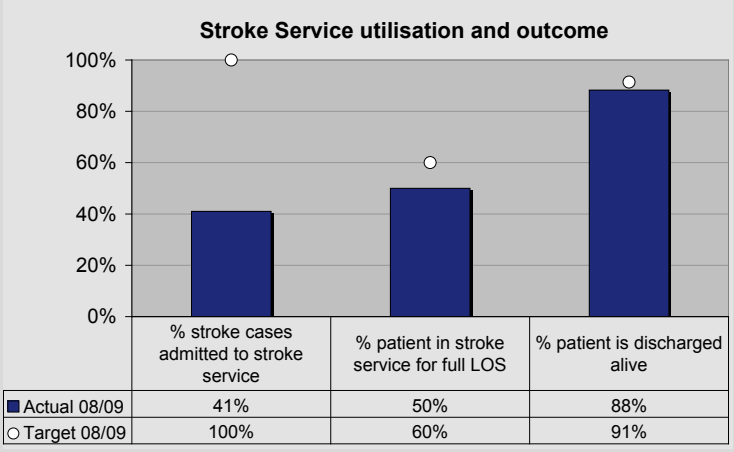
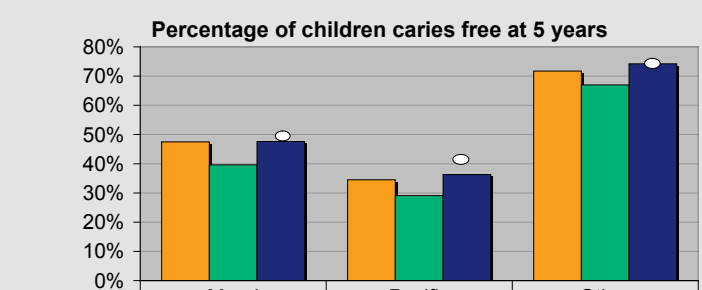
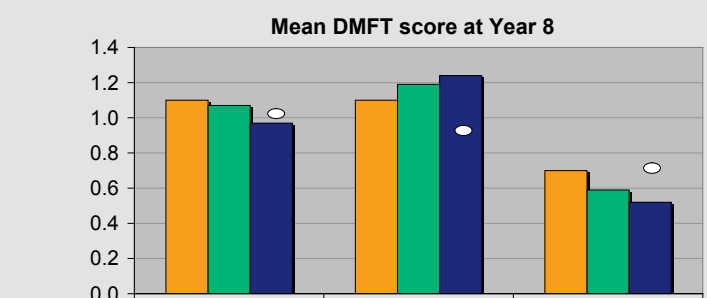
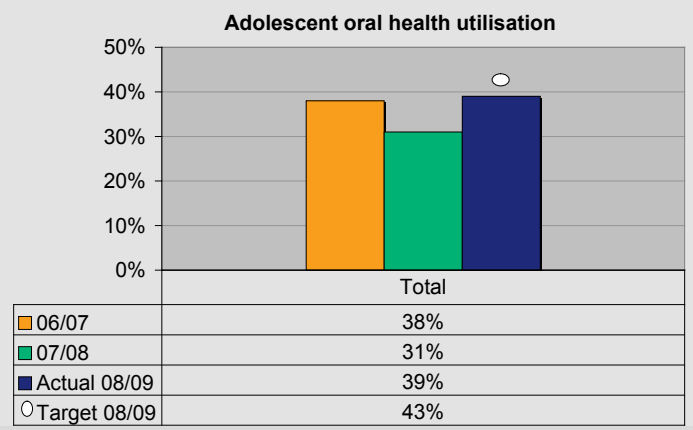
2006	61%	57%	79%	75%
07/08	64%	54%	78%	74%
Actual 08/09	63%	49%	78%	72%
Target 08/09	65%	60%	80%	76%	 Comment: In 2008/09 we have achieved all of our targets for annual checks. Targets for 2008/09 were set on an updated model of diabetes prevalence, which assumes a higher number of diabetics in the community compared to previous years. This means that although the number of checks has increased, the proportion of estimated diabetics is lower. We have not achieved our targets for 2008/09 for diabetes management but continue to have diabetes management as a key focus in 2009/10.	Achieved Not achieved

Key Performance Measure	Stroke service utilisation	Year End Rating
Output class: Provider Organised stroke services cover from the acute stroke event to the eventual discharge from rehabilitation services. Long-term, the ideal is that 100% of people, who suffer a stroke event, are admitted to an organised stroke unit or service, and at least 50% spend most of their stay there. It can be used as a proxy measure of how well we are managing the care of patients with long term conditions such as CVD.	 Comment: The service is working towards ensuring all acute stroke patients are admitted to Wellington Regional Hospital and to improve patient flow between the acute service and rehabilitation. This will reduce the length of stay and ensure a timely and smooth transfer to rehabilitation.	Not achieved

Objectives for long term conditions			
Output Class and timeframes for 2008/09	**Objectives**		
Funder June 2009	Action	Promotion of free annual checks (Diabetes - Get Checked Aotearoa) in the community and linkage with the cardiovascular risk assessment programme.	
	Target/ Milestone	Achieve Targets for Diabetes Annual Checks: Māori (42%) Pacific (47%) and Others (44%)	Achieved
	Progress	We have achieved our targets for diabetes annual checks in all populations. PHOs have been resourced to target Cardiovascular Risk screening for priority groups. People with diabetes have been specified as one of the target groups.	

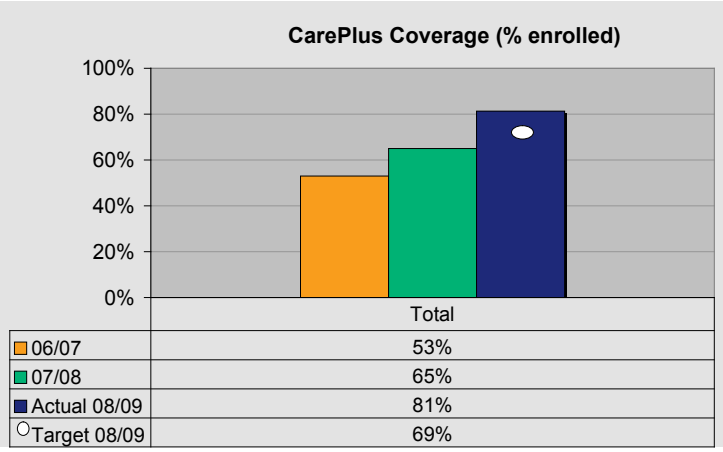
Funder June 2009	Action	Monitor access of high risk groups and related long term conditions to health services. Trial additional service coordination across HHS diabetes/cardiology/renal and other services for patients with complex needs.	
	Target/ Milestone	Health Target for diabetes management met for Māori (65%), Pacific (60%) and others (80%)	Not Achieved
	Progress	Access to diabetes checks has been monitored quarterly. We have not met our targets for diabetes management.	
Funder June 2009	Action	Support PHOs with resources to prioritise eligible Māori and Pacific populations for cardiovascular risk assessment.	
	Target/ Milestone	Establish baseline for recording uptake of cardiovascular risk assessment in primary care and develop PHO and District targets.	Achieved
	Progress	A baseline indicator for cardiovascular risk has been monitored as part of the Ministry of Health reporting process. All PHOs have been resourced to target higher need populations for systematic cardiovascular risk assessments	

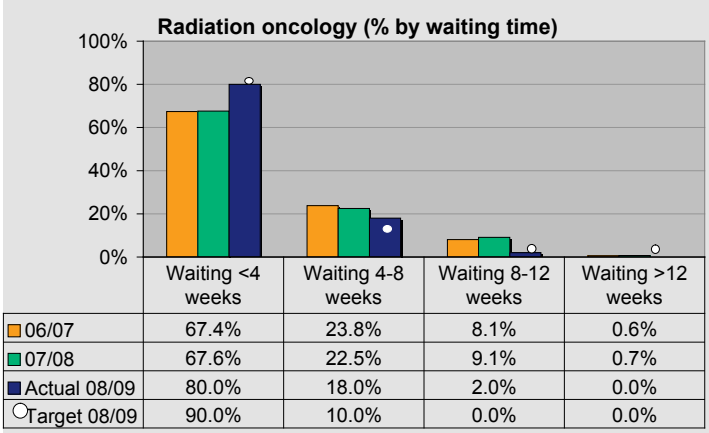
Key Performance Measure	Oral Health – The percentage of children caries free at age five years, the Diseased Missing and Filled Teeth (DMFT) score at year eight (12 years) and progress towards 85% adolescent oral health utilisation	Year End Rating
Output class: Funder Oral health status allows us to evaluate how our health promotion programmes, and services such as the DHB School Dental Service and other child health providers, are influencing the oral health status of children.	 Maori / Pacific / Other 2006: 47.5% / 34.5% / 71.7% 2007: 39.6% / 29.1% / 67.0% Actual 2008: 47.6% / 36.3% / 74.2% Target 2008: 50.0% / 42.0% / 75.0% Comment: We have not achieved our targets for 2008/09 but have made improvement on 2007/08 results across all ethnicities.  Maori / Pacific / Other 2006: 1.10 / 1.10 / 0.70 2007: 1.07 / 1.19 / 0.59 Actual 2008: 0.97 / 1.24 / 0.52 Target 2008: 1.00 / 0.90 / 0.68 Comment: The aim for the DMFT is to have the score decreasing this indicates a positive result. In 2008/09 we achieved this for the majority of our population but not for Pacific children.	Partially achieved Partially achieved

	Health target  Comment: We have not achieved our targets for 2008/09 but have made improvement on 2007/08 results across all ethnicities.	Not achieved

Objectives for health promotion			
Output Class and timeframes for 2008/09	**Objectives**		
Funder June 2009	Action	Establish a Māori breastfeeding service Fund a part-time DHB lactation coordination role.	
	Target/ Milestone	Interim measure: Increase in the proportion of Māori and Pacific women exclusively breastfeeding at discharge over the December 07 baseline.	Achieved
	Progress	We have developed a community lactation consultant/breastfeeding advocacy role C&C DHB breastfeeding (BF) rates for 6 weeks are under the national target by 4.6%, but have shown large improvement at DHB level. For 3 month olds C&C DHB surpassed the national goal by 5.3%, and 8.1% for 6 months	

Funder June 2009	Action	Implement Tobacco Control Plan.	
	Target/ Milestone	Increase smoking cessation attempts as referred by DHB services by 10%.	Achieved
	Progress	Tobacco control plan has been signed off / submitted to Ministry of Health and implementation is underway 103 people have been referred to Smoking cessation coordinator in the Jan - Jul period. We have implemented a smoking dependence record form in the Wellington Regional Hospital which will allow us to measure the number of patients who currently smoke who have been given advice or referral to smoking cessation services.	

Key Performance Measure	CarePlus – The proportion of each PHOs expected CarePlus enrolled population enrolled in the CarePlus programme	Year End Rating
Output class: Funder The Care Plus programme aims to improve long term conditions management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users. If we can get patients with high need to access service at a primary level where their condition is at a manageable stage it gives the patient better outcomes as well as making the DHB service more efficient, sustainable and effective. Care Plus has been designed to give PHOs extra funding to provide additional services to improve care for individuals with known high health needs.	 Comment: We have exceeded our target for Care Plus enrolment in 2008/09 and all our PHOs are above the national target of 70%.	Achieved

Key Performance Measure	Cancer Waiting Times – All patients receive radiation oncology treatment within 6 weeks of their first specialist assessment	Year End Rating
Output class: Provider Radiotherapy reduces the impact of a range of cancers and delays to treatment are likely to lead to poorer outcomes. Our performance target relates to high priority people, and the aim is to begin radiation treatment of an increasing number of these people within a four-week period and all high priority people within six weeks.	**Health target**  		Waiting <4 weeks	Waiting 4-8 weeks	Waiting 8-12 weeks	Waiting >12 weeks
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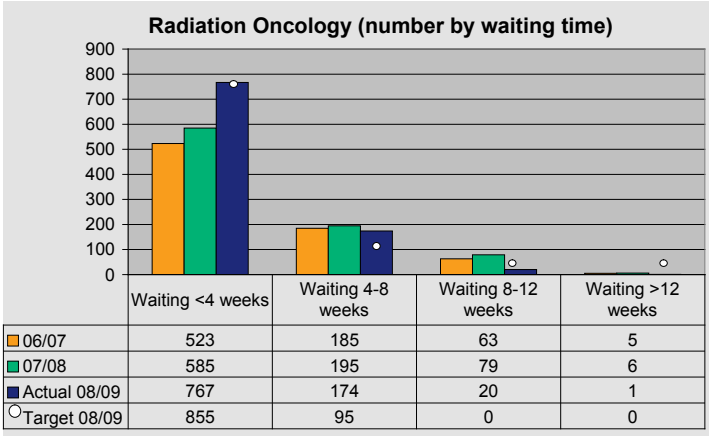
06/07	67.4%	23.8%	8.1%	0.6%
07/08	67.6%	22.5%	9.1%	0.7%
Actual 08/09	80.0%	18.0%	2.0%	0.0%
Target 08/09	90.0%	10.0%	0.0%	0.0% |  |	Waiting <4 weeks	Waiting 4-8 weeks	Waiting 8-12 weeks	Waiting >12 weeks
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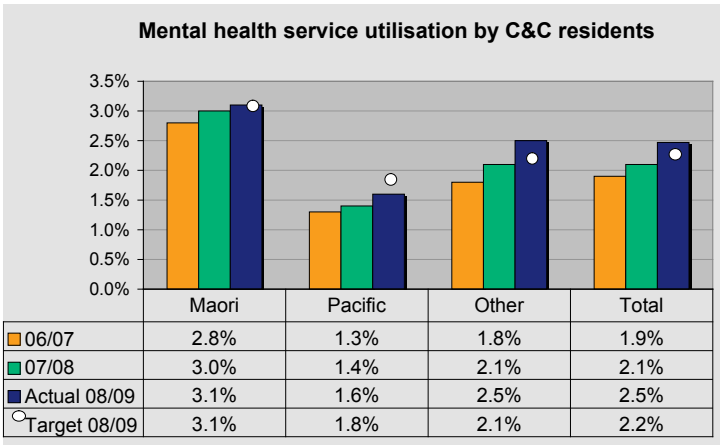
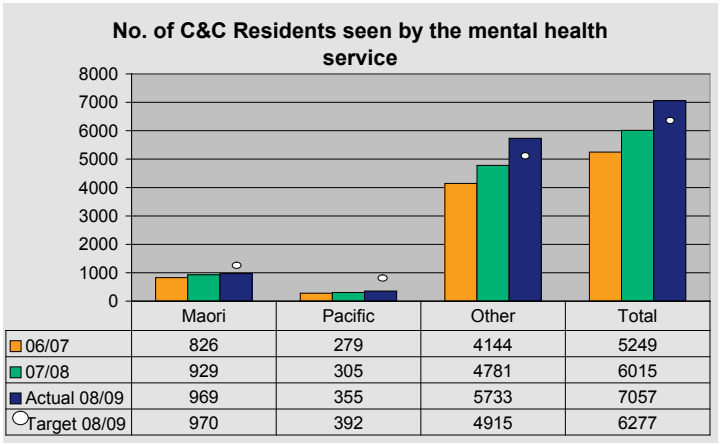
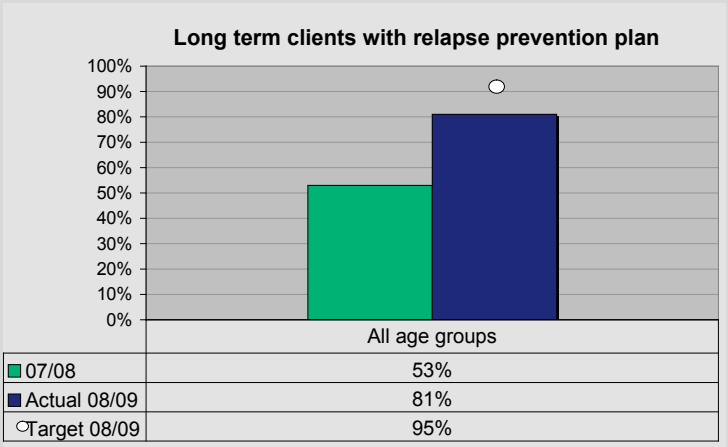
06/07	523	185	63	5
07/08	585	195	79	6
Actual 08/09	767	174	20	1
Target 08/09	855	95	0	0	 Comment: Although we have not achieved all of our targets we have made improvement on 2007/08. In quarter four following the commissioning of a new, additional cancer treatment machine no patients waited longer than the Health Target of six weeks.	Partially achieved

Objectives for cancer services			
Output Class and timeframes for 2008/09	Objectives		
Funder June 2009	Action	Actively engage with the Central Cancer Network (CCN) and Local Cancer Network (LCN)'s framework and workplan	
	Target/ Milestone	Narrative report on DHB participation on CCN governance and workstreams completed.	Achieved
	Progress	We have actively participated in the Central Cancer Network. Our Clinical Director and Operations Manager for cancer services are both on the network steering group. In late 2008 we established a local Hutt and Capital and Coast Cancer Network that has been meeting successfully every 1-2 months.	

Key Performance Measure	Mental Health Service Utilisation by C&C residents	Year End Rating
Output class: Provider The number of people who are seen by the mental health service is an indicator of the extent to which we are meeting mental health needs.	 Mental health service utilisation by C&C residents Maori / Pacific / Other / Total 06/07: 2.8% / 1.3% / 1.8% / 1.9% 07/08: 3.0% / 1.4% / 2.1% / 2.1% Actual 08/09: 3.1% / 1.6% / 2.5% / 2.5% Target 08/09: 3.1% / 1.8% / 2.1% / 2.2%  No. of C&C Residents seen by the mental health service Maori / Pacific / Other / Total 06/07: 826 / 279 / 4144 / 5249 07/08: 929 / 305 / 4781 / 6015 Actual 08/09: 969 / 355 / 5733 / 7057 Target 08/09: 970 / 392 / 4915 / 6277 Comment: Although the percentage of people accessing services across all ethnicities did not increase in 2008/09, we did achieve our targets for Māori and Pacific who are part of our high needs population. To improve access we have established Te Haika, a single point of access process, that has had an immediate effect of significantly reducing waiting times and by expediting internal referrals. With this establishment, the capacity of teams to attend to more referrals has been increased. This will increase overall access rates over the next year.	Partially achieved

	Health target  Comment: We showed a large improvement in this indicator in 2008/09 and expect to achieve this target in 2009/10.		Not achieved

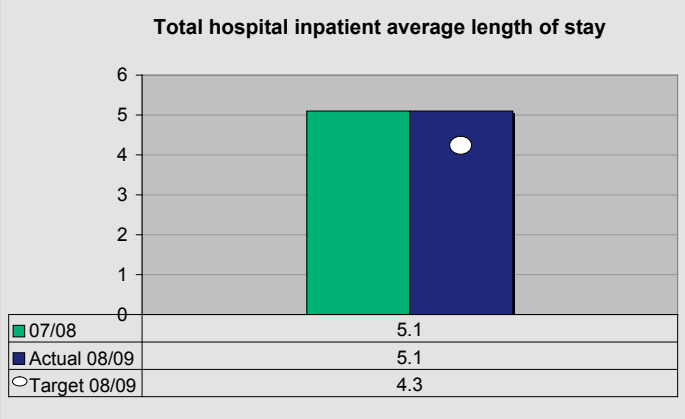
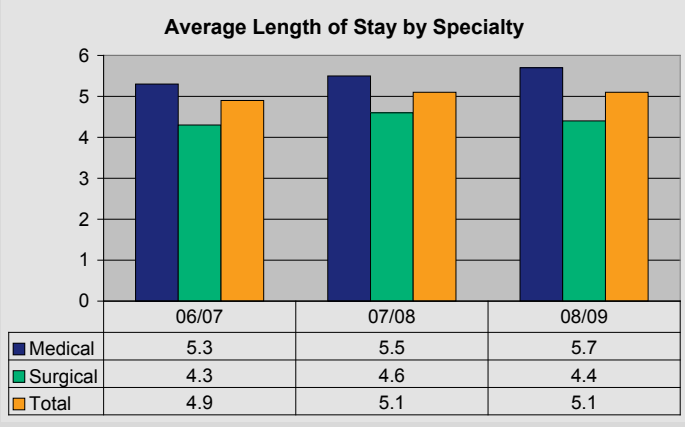
Objectives for the mental health service			
Output Class and timeframes for 2008/09	**Objectives**		
Funder June 2009	Action	Develop service specifications and negotiate contract for the first Short Term Assessment and Recovery Service (STARS).	
	Target/ Milestone	STARS implemented and early evaluation completed.	Not achieved
	Progress	The Short Term Assessment and Recovery Service (STARs) was planned to open in November 2008 but a deferment was called due to concerns about the clinical and financial viability of the service design. A joint working group (including representatives from the C&C DHB and Wellink Trust) undertook a review of the model, its assumptions and analysis of the clinical and financial sustainability. The new model is to be named Te Whetu Marama.	

Funder June 2009	Action	Develop appropriate integrated services for people aged 65 or over with mental illness and physical health problems (in conjunction with Health of Older People Team).	
	Target/ Milestone	Mental Health 'graduates' review completed and approach planned.	Achieved
	Progress	A review of mental health services for older people was completed and will allow us to develop an appropriate model of care for this high needs client group in 2009/10.	
Provider June 2009	Action	Improve service responsiveness to Māori tangata whaiora and whanau and encourage more Māori into the mental health workforce.	
	Target/ Milestone	300 clinicians participate in Whakapai/He Whakarito education.	Partially Achieved
	Progress	Mauri Ora Total staff completed = 132 Graduated Te Ara Reo Total to complete 2009 intake = 19 enrolled Whakapai Cultural 2 Day Launch Total staff attended = 80 Whakapai Cultural Coaching mentoring supervision Total staff = 26 Grand Total = 257	

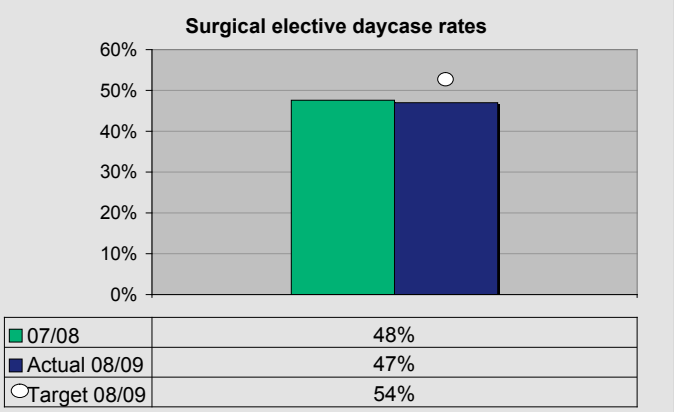
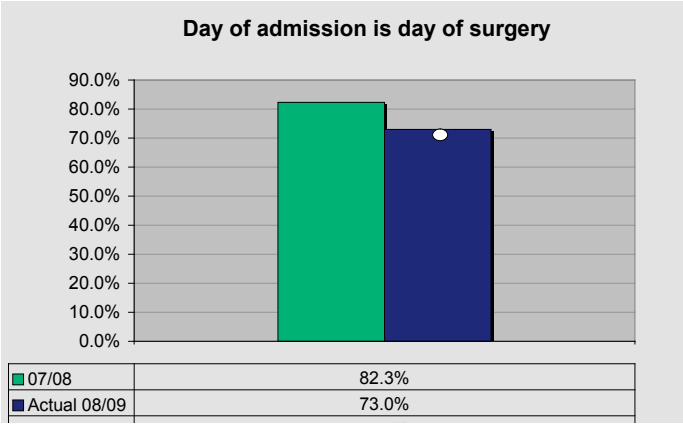
Funder /Provider June 2009	Action	Project for the integration of mental health data across DHB and NGOs implemented.	
	Target/ Milestone	Business Case for Stage I of the NGO Strategic Development project completed	Achieved
	Progress	The three District Health Boards (DHBs), in the "sub-region" covered by Wellington, Porirua, the Kapiti Coast, Hutt Valley and Wairarapa, purchase a range of services to meet the mental health and addiction needs of local people. Some of these arrangements involve contracts with Non Governmental Organisations (NGOs). Services are procured against a set of nationally defined purchase unit codes. Central Region Mental Health Portfolio Managers have identified projects in three phases designed to rationalise mental health and addiction services: » Phase 1: focussed on high cost, high risk services across the C&C DHB, Hutt Valley DHB and Wairarapa DHB areas » Phase 2: focussed on the remainder of local and sub-regional services » Regional services covering the 6 DHBs in the lower North Island. » The project(s) are pursuing the triple aim of: › Improving the health of the population › Enhancing the patient experience › Reducing (or controlling) the per capita cost of care.	
Provider June 2009	Action	Human Factors Training – Te Korowai Whariki and the Local Mental Health Services, will develop and implement a comprehensive training that focuses on patient safety (the Human Error and Patient Safety (HEAPS) programme).	
	Target/ Milestone	Progress towards 90% of mental health services personnel completing training by June 2010.	Not Achieved
	Progress	The new Mental Health Directorate decided not to pursue the human factors training	

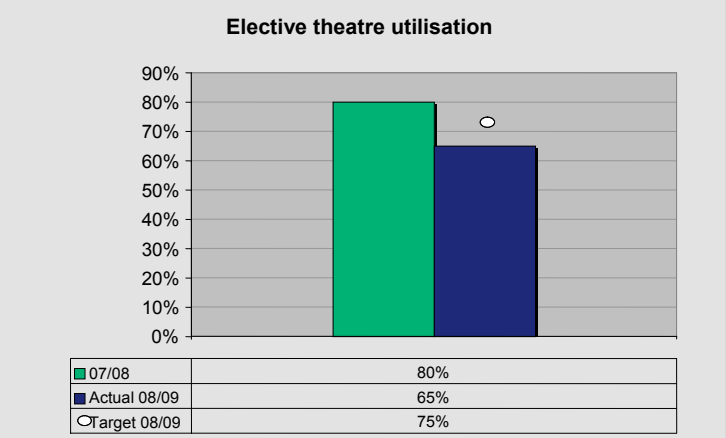
IMPROVEMENT IN OUR PERFORMANCE

Overall Assessment	Achieved
Long term Outcome	To recruit and retain our workforce, implement new models of care, develop our leadership, and improve people information and infrastructure
Medium Outcome	» Strengthen clinical governance and quality » Information systems developments » Safe migration to the New Regional Hospital
Why is this an important priority for C&C DHB?	Our overriding purpose as a DHB is to provide safe good quality services that restore health and improve quality of life, by improving our performance we can achieve this for our district.

Key Performance Measure	Total hospital inpatient length of stay	Year End Rating
Output class: Provider This indicator measures the average number of days (measured at midnight) spent in hospital by inpatients.	 07/08 5.1 Actual 08/09 5.1 Target 08/09 4.3 	Not achieved

	06/07	07/08	08/09
Medical	5.3	5.5	5.7
Surgical	4.3	4.6	4.4
Total	4.9	5.1	5.1

	Comment: We have not achieved our target for 2008/09 but with increased capacity and new models of care (e.g. introduction of the Medical Assessment and Planning Unit in the Wellington Regional Hospital) we expect to meet these targets in 2009/10. Medical Average Length of Stay has increased slightly on 2008/09 and Surgical has decreased. The net result is the same average length of stay over the total service.	
Key Performance Measure	Elective daycase rates	Year End Rating
Output class: Provider This indicator measures the number of elective daycases as a percentage of all elective procedures.	 Comment: We have not achieved our target but the number of daycases have been maintained. The move to Wellington Regional Hospital on 1st April has provided improved facilities for day cases and we look to build on the 2008/09 progress in 2009/10.	Not achieved
Key Performance Measure	Day of Admission is day of surgery	Year End Rating
Output Class: Provider This indicator measures the frequency of inpatient surgery on the day of admission as a percentage of all inpatient elective surgery	 Comment: There has been a slight decrease in the cancellation rate - from 11% in 2007/08 to 10% in 2008/ 09, which has helped us achieve our target for 2008/09. We aim to make further improvements in 2009/10 to maintain the results of 2007/08.	Achieved

Key Performance Measure	Elective theatre utilisation	Year End Rating
Output class: Provider This indicator measures our progress towards our target of 85% theatre utilisation.	 Comment: Reporting issues in 2007/08 resulted in an over reporting of utilisation. This led to a higher target being set. This has been corrected in the past year and we expect to make progress towards our target in 2009/10.	Not achieved

Key Performance Measure	Elective service patient flow indicators (ESPIs)					Year End Rating
Output class: Provider These are a number of performance indicators that have been established to measure clarity and timeliness. These assess how well a hospital manages the patient flow through the system.	ESPI		Results	Target	Ministry Compliance Threshold	Achieved
	1	Process all patient referrals within 10 working days	100%	95%	> 90%	
	2	Patients waiting less than 6mths for their first specialist assessment	0.5 – 1.3%	<1.6%	< 2%	
	3	Patients without a commitment to treatment whose priorities are higher than actual treatment threshold	1.0 – 1.9%	<4%	< 5%	
	4	Clarity of treatment status	NA	NA	NA	
	5	Patients given a commitment to treatment but not treated within 6 months	1.4 – 2.9%	<4%	<5%	

	6	Patients in active review who have not received a clinical assessment within the last 6 months	3.3 – 10.1%	<12%	<15%	
	7	Patients who have not been managed according to their assigned status and who should have received treatment	1.1 – 2.1%	<4%	<5%	
	8	The proportion of patients treated who were prioritised using nationally recognised processes or tools	99 – 100%	95%	>90%	
	Comment: We have achieved an outstanding rating on all of our ESPIs in 2008/09.					

Objectives for updating our hospital			
Output Class and timeframes for 2008/09	**Objectives**		
Provider Date as stated	Action	Complete the new facility at Newtown.	
	Target/ Milestone	Handover of podium for equipment and training – Sep 2008 Radiology department early migration and operating new building – Dec 2008	Achieved
	Progress	New facility is now fully operational, and was completed on time and within budget. Radiology move, successfully completed in November 2008.	

Provider June 2009	Action	Migrate services to new facility with minimum disruption and maximum patient safety in the physical move.	
	Target/ Milestone	New Regional Hospital fully operational	Achieved
	Progress	The first service to move was radiology, successfully completed in November 2008 with the last service moving in April 2009. Acute services were maintained through the move period with elective services reduced in March / April 2009, to support the surgical, theatres and ICU moves. There were no significant clinical, patient or staff safety issues over the period of the move.	
Provider June 2009	Action	Organisational capability developed by focusing on role clarity, leadership and performance. Role clarity process completed for leadership and priority Hospital and Health Service roles. Role relationships defined across the DHB.	
	Target/ Milestone	Implementation of new management structure and facility- service relationships Clinical leader roles and responsibilities clarified	Achieved
	Progress	The corporate and clinical governance structure was reorganised and introduced during May/ June 2009. This included the reformation of the Clinical Quality Board into the Clinical Governance Executive and the streamlining of the 26 sub committees of the previous Quality Board. The directorate structures for our eight directorates and their governance structures have been completed. Partnership agreements between the clinical and operational directors have been established. A new position description for Clinical Leaders has been developed with the Clinical Directors and a process for establishing job sizing for the time required to perform clinical leader duties.	
Provider/Governance June 2009	Action	Consistent rostering practices implemented through OneStaff implementation and capacity planning info available.	
	Target/ Milestone	Paper timesheets eliminated.	Not Achieved
	Progress	Consistent rostering practices developed and implemented – training ongoing. The One Staff rostering technology has been reviewed and will be replaced in 09/10 year. Paper timesheets have not yet been eliminated	

Provider/Governance June 2009	Action	Improve acute journey	
	Target/ Milestone	Plan in place for Medical Assessment and Planning Unit (MAPU) to reduce medical Average Length of Stay (ALOS) in future years	Achieved
	Progress	The Medical Redesign Project since mid 2008 has delivered the realignment of medical staff rosters with the objective of increasing the availability of senior medical staff to acute medical admissions seven days a week. Junior doctor rosters have been changed to support this new model of working. The MAPU is currently under construction and is on target to open mid November 2009. The MAPU will further increase acute medical patients' access to timely assessment, diagnostics and treatment planning. Medical ALOS (excl day cases) has decreased from 7days in July 08, to 5 days in June 09.	
Provider June 2009	Action	Improve elective patient flow and theatre productivity.	
	Target/ Milestone	Theatre cancellation rate decreased to <07/08 baseline	Partially Achieved
	Progress	Significant progress has been made in increasing elective throughput in 2008/ 09. There has been a slight decrease in the cancellation rate - from 11% in 2007/08 to 10% in 2008/ 09. We have achieved a sustained downward trend with the Cardiothoracic waiting list, the number of patients waiting for cardiac surgery as at 1 July 2009 was 29.	
Provider/Governance June 2009	Action	Develop and implement a performance reporting framework.	
	Target/ Milestone	New clinical governance framework Patient satisfaction improved Increased % of complaints responded to within timeframe	Partially Achieved
	Progress	New clinical governance framework has been implemented. Reporting has been reviewed and strengthened with improved processes for monitoring trends and actions relating to reportable events, complaints, clinical indicators and other Quality activities. The risk management policy has been revised and a robust risk management and reporting framework implemented at the Directorate, HHS and DHB level.	

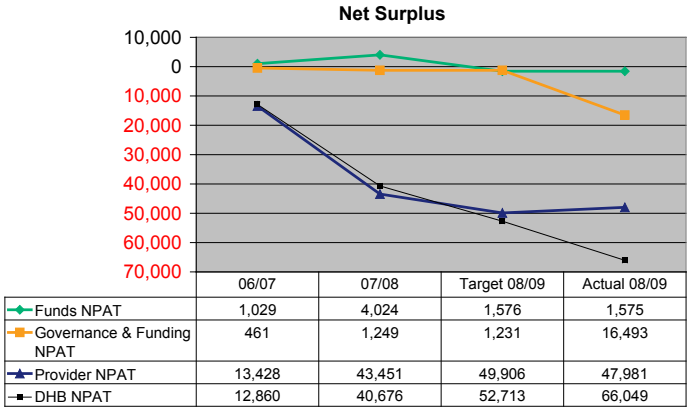
		Patient Satisfaction Survey responses have been low over this past year. This has resulted in no reported improvement in patient satisfaction. Now that migration to the new hospital has been completed work is being undertaken to review our processes, improve the validity of results and identification of areas to focus on for improvement. The annual complaint response compliance rate was 54.81%. This was below the C&C DHB target of 75% and was impacted on by: staff turnover within the Directorates and the complaints office, and the migration to the New Regional Hospital. It is anticipated that this will improve in 2009/10.	
Provider June 2009	Action	Safe medication management.	
	Target/ Milestone	Healthcare associated Staphylococcus bloodstream infections decreased against 07/08 baselines	Achieved
	Progress	Rate in 08/09 was 0.17 compared with 0.20 in 07/08.	
Provider June 2009	Action	Orion clinical record replaces the legacy Allegra system.	
	Target/ Milestone	Electronic Health Record (EHR) implemented.	Not Achieved
	Progress	Due to conflicting pressures, the second phase of the electronic health record (EHR2) has been rolled over to the 09/10 financial year.	
Provider/Governance June 2009	Action	Implement comprehensive disaster recovery capability to support a clinical and business environment increasingly reliant on computer based information.	
	Target/ Milestone	Service Availability for Category 1 Systems 99% or above. Measure rolling 12 months availability by systems aggregated to produce a monthly statistic	Partially Achieved
	Progress	The Disaster Recovery (DR) strategy has been developed and signed off on by the DHB. Because of the cost, this project has been split across four financial years. The first two phases are complete with funding being pursued through external (to C&C DHB) funding mechanisms to continue to deliver on the other phases of the project	
Provider June 2009	Action	Implement robust project and programme governance to ensure successful scoping, budgeting and implementation of ICT projects.	

	Target/ Milestone	Agreed services provided and within Annual Budget +/- 5%.	Not Achieved
	Progress	The governance arrangement of HIQ made accurate costing of services back to individual DHBs problematic. Whilst it is generally felt that this target was not met, it is difficult to determine precisely by what extent. One of the drivers behind C&C DHB ending its joint venture in HIQ was to get a clearer and more controlled understanding of its ICT spend. The 09/10 year will be the first year where there will be a specific ICT budget and team within C&C DHB and the process changes being made will facilitate better conformance with this benchmark.	
Provider/Governance June 2009	Action	Renegotiate service level agreement with outsourced Information Communication Technology provider.	
	Target/ Milestone	Service level agreement redeveloped and executed Monthly reporting of redeveloped agreed metrics. Customer Satisfaction of 90% of customers being satisfied or very satisfied as measured in monthly customer satisfaction survey	Achieved
	Progress	C&C DHB has ceased its joint venture with HIQ and Information Technology services have been brought back within the DHB. It was identified that the tools and processes needed to achieve this did not exist with in the DHB's ICT service provider. As a result a programme of work looking at service delivery processes and tools was commenced. This programme of work is expected to be completed before Christmas 2009, at which point more robust activity collection and reporting will be available.	

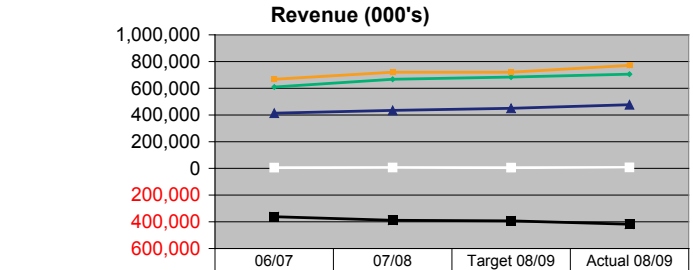
MANAGING OUR FINANCES

Overall Assessment	Achieved
Long term Outcome	Our objective is to have a sound financial base to fund and provide cost effective health services into the future
Medium Outcome	» Investing in systems, processes and our workforce » Influencing national pricing programme » Working with owner to develop a strategy to improve our balance sheet

Key Performance Measure	Net surplus	Year End Rating
Output Class: Governance		Partially achieved



	06/07	07/08	Target 08/09	Actual 08/09
Funds NPAT	1,029	4,024	1,576	1,575
Governance & Funding NPAT	461	1,249	1,231	16,493
Provider NPAT	13,428	43,451	49,906	47,981
DHB NPAT	12,860	40,676	52,713	66,049



	06/07	07/08	Target 08/09	Actual 08/09
Funds	609,565	667,021	683773	705,597
Governance and Funding Admin	5,501	6,647	5888	6,997
Provider	413,728	434,728	449725	476,535
Elimination	361,622	388,508	-393210	418,207
DHB Revenue	667,172	719,888	719888	770,922

Comment:

A significant part of the variance was due to a land sale at Porirua which was budgeted but not finalised.

Objectives for managing our finances			
Output Class and timeframes for 2008/09	Objectives		
Funder/Provider June 2009	Action	Further develop management systems to monitor volume management to contract and within budget allocation.	
	Target/ Milestone	Regular monthly meetings held between provider Arm Group Managers and Funder. Implement clear escalation and risk management processes, including early warning signals to identify risks.	Achieved
	Progress	Regular meetings have been held between Planning & Funding and HHS directorate managers.	
Funder/Provider June 2009	Action	Complete regional and national process to manage IDF flow and monitor adherence to agreed business rules.	
	Target/ Milestone	Elective services reports delivered to other regional DHBs monthly. IDF revenue identified and collected.	Achieved
	Progress	Regional IDF elective reports have been disseminated monthly.	
Funder/Provider June 2009	Action	Participation in DHBNZ work programmes around pricing, workforce etc.	
	Target/ Milestone	Increased funding received. Data requests submitted on a timely basis for all national pricing programmes. Staff contribute to national workstreams.	Achieved
	Progress	Data has been submitted to the National Pricing Programme. DHB staff have participated in the National Pricing Programme 2008/09.	

AUDITOR'S REPORT

FINANCIAL STATEMENTS

Statement of financial performance

For the year ended 30 June 2009
in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Revenue	1	*770,922*	*762,516*	*719,888*
Share of net surplus of joint venture		-	-	-
Total income		**770,922**	**762,516**	**719,888**
Employee benefit costs	3	*321,752*	*304,783*	*288,034*
Depreciation and amortisation expense	6,7	*21,526*	*28,775*	*19,222*
Outsourced services		*30,620*	*11,900*	*22,402*
Clinical supplies		*91,772*	*77,151*	*77,805*
Infrastructure and non-clinical expenses		*58,421*	*43,477*	*56,674*
Payments to non-health board providers		*288,965*	*292,228*	*274,490*
Other operating expenses	2	*5,312*	*24,201*	*5,002*
Finance costs	4	*12,733*	*24,607*	*10,352*
Total expenses		**831,101**	**807,122**	**753,981**
Surplus/(deficit) before Capital Charge		**(60,179)**	**(44,606)**	**(34,093)**
Capital charge	5	*5,915*	*8,108*	*6,264*
Surplus/(deficit) after Capital Charge		**(66,094)**	**(52,714)**	**(40,357)**
Share of profit / (loss) of associates	9a	*45*	-	*(319)*
Surplus /(deficit)	18	**(66,049)**	**(52,714)**	**(40,676)**

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 2009
in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Revaluation of property, plant and equipment	18	-	-	-
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		-	-	-
Surplus for the year	18	**(66,049)**	**(52,714)**	**(40,676)**
Total recognised income and expense for the year		**(66,049)**	**(52,714)**	**(40,676)**

The accompanying notes form part of these financial statements.

Statement of recognised income and expense

As at 30 June 2009

in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Assets				
Non-current assets				
Property, plant and equipment	6	*507,543*	*502,617*	*450,024*
Intangible assets	7	*938*	*521*	*764*
Investments in associates	9a	*27,641*	*40,760*	*20,032*
Investments in joint ventures	9b	-	-	-
Total non-current assets		**536,122**	**543,898**	**470,820**
Current assets				
Inventories	8	*6,807*	*6,000*	*5,864*
Trade and other receivables	10	*58,503*	*61,400*	*80,547*
Cash and cash equivalents	11	*13*	*13*	*14*
Trust/special funds	12	*6,851*	*5,800*	*5,845*
Total current assets		**72,174**	**73,213**	**92,270**
Total assets		**608,296**	**617,111**	**563,090**
Equity				
Crown equity	18	*298,628*	*310,597*	*231,250*
Other reserves	18	*31,850*	*30,618*	*33,010*
Retained earnings/(losses)	18	*(213,441)*	*(199,686)*	*(147,392)*
Total equity		**117,037**	**141,529**	**116,868**
Liabilities				
Non-current liabilities				
Borrowings	13	*311,984*	*313,000*	*283,000*
Employee entitlements	14	*5,675*	*4,750*	*2,370*
Provisions	15	*90*	-	*126*
Patient and restricted funds	17	-	*165*	-
Total non-current liabilities		**317,749**	**317,915**	**285,496**

The accompanying notes form part of these financial statements.

Statement of recognised income and expense - cont'd

Current liabilities				
Bank overdraft	11	*32,727*	*45,321*	*18,859*
Borrowings	13	*24,240*	*-*	*28,000*
Employee entitlements	14	*50,942*	*-*	*51,385*
Provisions	15	*379*	*5,352*	*799*
Trade and other payables	16	*65,068*	*106,994*	*61,508*
Patient and restricted funds	17	*154*	*-*	*175*
Total current liabilities		**173,510**	**157,667**	**160,726**
Total liabilities		**491,259**	**475,582**	**446,222**
Total equity and liabilities		**608,296**	**617,111**	**563,090**

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2009
in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		*726,172*	*742,708*	*674,820*
Other receipts		*41,518*	*19,223*	*22,864*
Cash paid to suppliers		*(439,404)*	*(436,849)*	*(429,418)*
Cash paid to employees		*(319,655)*	*(307,583)*	*(280,744)*
Cash generated from operations		*8,631*	*17,499*	*(12,478)*
Interest received		*1,022*	*834*	*1,089*
Interest paid		*(12,864)*	*(22,403)*	*(8,557)*
Goods and Services Tax (Net) (a)		*(26,839)*	*(18,000)*	*1,576*
Capital charge paid		*(5,956)*	*(8,109)*	*(7,440)*
Net cash flows from operating activities	11	**(36,006)**	**(30,179)**	**(25,810)**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		*12*	*24,972*	*4,404*
Acquisition of property, plant and equipment	6	*(79,942)*	*(72,814)*	*(95,359)*
Acquisition of investment property		-	-	-
Advances to associates		*(9,150)*	-	*(13,489)*
Acquisition of intangible assets	7	*(373)*	*(26,201)*	*(5,550)*
Net appropriation from trust funds	12	*(1,272)*	*834*	*(662)*
Net cash flows from investing activities		**(90,725)**	**(73,209)**	**(110,656)**
Cash flows from financing activities				
Proceeds from equity injection		*92,345*	*98,346*	*91,118*
Borrowings raised		*24,000*	*2,000*	*121,600*
Repayment of borrowings		-	-	*(90,074)*

The accompanying notes form part of these financial statements.

Statement of cash flows - cont'd

Repayment of equity	18	*(3,483)*	-	*(3,483)*
Net cash flows from financing activities		**112,862**	**100,346**	**119,161**
Net increase in cash and cash equivalents		*(13,869)*	*(3,042)*	*(17,305)*
Cash and cash equivalents at beginning of year		*(18,845)*	*(42,266)*	*(1,540)*
Cash and cash equivalents at end of year	**11**	**(32,714)**	**(45,308)**	**(18,845)**

(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 $1,171 (2008: $nil) by means of finance leases.

Statement of contingent liabilities

As at 30 June 2009
in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Legal proceedings against the DHB		*325*	*464*	
		325	*464*	

The DHB has been notified of 3 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2009 (2008: 4).

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 (2008: $nil).

The accompanying notes form part of these financial statements.

Statement of commitments

As at 30 June 2009
in thousands of New Zealand dollars

	Note	2009 Actual	2009 Budget	2008 Actual
Capital commitments		**24,786**	**36,640**	
Non-cancellable commitments – provider commitments				
Not more than one year		*101,797*	*90,045*	
One to two years		*15,622*	*15,156*	
Two to five years		*5,322*	*20,472*	
Over five years		*-*	*131*	
		122,741	**125,804**	
Non-cancellable commitments – operating lease commitments				
Not more than one year		*1,562*	*1,882*	
One to two years		*868*	*2,495*	
Two to five years		*829*	*564*	
Over five years		*36*	*75*	
		3295	**5,016**	

The accompanying notes form part of these financial statements.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2009

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.

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

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.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2009

Basis of preparation

The financial statements have been prepared for the period 1 July 2008 to 30 June 2009. Comparative figures and balances relate to the period 1 July 2007 to 30 June 2008.

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.

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

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 2009

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.

Notes to the financial statements

Statement of accounting policies for the year ended 30 June 2009

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
- work in progress.

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.

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.

Statement of accounting policies for the year ended 30 June 2009

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 75 years	1.3-100%
Building fitouts	1 to 35 years	2.9-100%
Plant and equipment	3 to 40 years	7.5-100%
Leasehold Improvements	1 to 50 years	2-100%

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.

Significant accounting policies

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%
Licenses	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.

Inventories held for distribution are stated at cost, adjusted where applicable for any loss of service potential.

Cash and cash equivalents

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

Significant accounting policies

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.

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.

Significant accounting policies

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.

Significant accounting policies

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

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

Annual leave

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

Provisions

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

Restructuring

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

Trade and other payables

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

Significant accounting policies

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.

Notes to the financial statements

Significant accounting policies

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.

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.

Significant accounting policies

Interest

Interest income is recognised using the effective interest rate method.

Rental income

Rental income from 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.

Borrowing costs

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

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 2009, indirect costs accounted for 1.83% of the DHB's total costs (2008: 1.0%)

Notes to the financial statements

in thousands of New Zealand dollars

1	Revenue	Note	2009 Actual	2008 Actual
	Ministry of Health Contract Funding		*587,378*	*554,439*
	Other Government		*18,159*	*11,428*
	Inter District Flows (Other DHBs)		*147,627*	*138,184*
	Non Government & Crown Agency Sourced		*15,884*	*14,317*
	Gain on sale of property, plant and equipment		*845*	*431*
	Interest Income		*1,022*	*1,089*
	Decrease in provision of trade receivables (doubtful debts)	10	*7*	-
			770,922	**719,888**
2	**Other operating expenses**			
	Impairment loss on property, plant and equipment	*6,7*	-	**982**
	Impairment of trade receivables (bad debts)		*549*	-
	Increase in provision of trade receivables (doubtful debts)	*10*	-	*369*
	Loss on disposal of property, plant and equipment		*685*	*273*
	Audit fees for the audit of the financial statements		*237*	*161*
	Audit fees for NZ IFRS transition		-	*12*
	Audit fees – Other Audit service		*55*	*7*
	Directors fees and expenses	*21*	*391*	*345*
	Rental and operating lease expenses		*3,395*	*2,853*
			5,312	**5,002**

in thousands of New Zealand dollars

3	Employee benefit costs	Note	2009 Actual	2008 Actual
	Direct Staff Costs (excluding increases in employee benefit provisions)		*300,728*	*263,980*
	Indirect Staff Costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)		*14,362*	*14,251*
	Contributions to defined contribution plans		*4,107*	*2,949*
	Increase/(decrease) in employee benefit provisions		*2,555*	*6,854*
			321,752	**288,034**

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

4	Finance costs			
	Interest on bank overdraft		*646*	*511*
	Interest on term borrowings		*12,079*	*8,700*
	Interest on finance leases		*8*	-
	Net loss on derivative classified as Fair Value through Profit & Loss		-	*1,141*
	Financial expenses		**12,733**	**10,352**

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 2009 was 8 per cent (2008:8 per cent)		5,915	6,264

in thousands of New Zealand dollars

6 Cost	Property, plant and equipment						
	Freehold land	Freehold buildings	Lease improve-ments	Plant & equip	F, F & E	Work in progress	Total
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**
Balance at 1 July 2008	*30,850*	*161,275*	*2,682*	*43,845*	*20,785*	*235,880*	*495,317*
Additions	-	*261,965*	*3*	*25,812*	*1,078*	*78,672*	*367,530*
Disposals	-	*(1,212)*	-	*(1,481)*	*(83)*	*(287,380)*	*(290,156)*
Revaluations	-	-	-	-	-	-	-
Transfer to Fixed Assets	-	-	-	-	-	-	-
Other Movements	-	-	-	-	-	*(294)*	*(294)*
Balance at 30 June 2009	**30,850**	**422,028**	**2,685**	**68,176**	**21,780**	**26,878**	**572,397**

in thousands of New Zealand dollars

6 Depreciation and impairment losses	Property, plant and equipment						
	Freehold land	Freehold buildings	Lease improve-ments	Plant & equip	F, F & E	Work in progress	Total
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*
Revaluations	-	-	-	-	-	-	-
Other Movements	-	-	-	-	*(63)*	-	*(63)*
Balance at 30 June 2008	**-**	**(27,544)**	**(1,081)**	**(11,007)**	**(5,661)**	**-**	**(45,293)**

in thousands of New Zealand dollars

6 Depreciation and impairment losses	Property, plant and equipment - cont'ds Freehold land	Freehold buildings	Lease improve-ments	Plant & equip	F, F & E	Work in progress	Total
Balance at 1 July 2008	-	*(27,544)*	*(1,081)*	*(11,007)*	*(5,661)*	-	*(45,293)*
Depreciation charge for the year	-	*(11,316)*	*(130)*	*(4,915)*	*(4,966)*	-	*(21,327)*
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	*208*	-	*546*	*30*	-	*784*
Revaluations	-	-	-	-	-	-	-
Other Movements	-	*982*	-	-	-	-	*982*
Balance at 30 June 2009	**-**	**(37,670)**	**(1,211)**	**(15,376)**	**(10,597)**	**-**	**(64,854)**
Carrying amounts							
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*
At 1 July 2008	*30,850*	*133,731*	*1,601*	*32,838*	*15,124*	*235,880*	*450,024*
At 30 June 2009	**30,850**	**384,358**	**1,474**	**52,800**	**11,183**	**26,878**	**507,543**

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 Māori Protection Mechanisms.

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

Leased assets

The net carrying amount of property, plant and equipment held under finance leases is $1.206m (2008: $nil).

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $26.88m (2008: $227.8m) which includes $15.7m of New Regional Hospital assets.

in thousands of New Zealand dollars

7. Intangible assets

Cost	Software	Licences	Total
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*
Balance at 1 July 2008	*594*	*1,362*	*1,956*
Additions	*329*	*44*	*373*
Disposals	*-*	*-*	*-*
Balance at 30 June 2009	*923*	*1,406*	*2,329*
Amortisation and impairment losses			
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)*
Balance at 1 July 2008	*(143)*	*(1,049)*	*(1,192)*
Amortisation charge for the year	*(134)*	*(65)*	*(199)*
Impairment losses	*-*	*-*	*-*
Reversal of impairment losses	*-*	*-*	*-*
Disposals	*-*	*-*	*-*
Balance at 30 June 2009	*(277)*	*(1,114)*	*(1,391)*
Carrying amounts			
At 1 July 2007	*74*	*175*	*249*
At 30 June 2008	*451*	*313*	*764*
At 1 July 2008	*451*	*313*	*764*
At 30 June 2009	*646*	*292*	*938*

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	2009 Actual	2008 Actual
Pharmaceuticals	*1,269*	*1,085*
Surgical & Medical Supplies	*5,350*	*4,591*
Other supplies	*188*	*188*
	6,807	*5,864*

The amount of inventories recognised as an expense during the year ended 30 June 2009 was $44.82m (2008: $25.6m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2008: $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 2009	Interest held at 30 June 2008	Balance Date
HIQ Limited	Owns and manages information systems	50%	50%	30 June

b) Summary of financial information on associate entities

2009 Actual	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
HIQ Limited	*43,495*	*11,262*	*32,233*	*22,772*	*57*
	43,495	*11,262*	*32,233*	*22,772*	*57*

2008 Actual	Assets	Liabilities	Equity	Revenues	Profit/ (loss)
HIQ Limited	*38,872*	*11,391*	*27,481*	*19,349*	*(221)*
	38,872	*11,391*	*27,481*	*19,349*	*(221)*

in thousands of New Zealand dollars

c) Share of profit of associate entities

	2009 Actual	2008 Actual
Share of profit/(loss)	*45*	*(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 profit or loss from HIQ Ltd is dependant upon activities performed for the DHB and does not necessarily reflect the percentage shareholding.

d) Investment in associate entities

	2009 Actual	2008 Actual
Carrying amount at beginning of year	*20,032*	*6,862*
Acquisition of new investments	-	-
Disposal of investments	-	-
Share of total recognised revenue and expenses	*45*	*(319)*
Dividends	-	-
Issue of shares	*7,564*	*13,489*
Carrying amount at end of year	*27,641*	*20,032*

e) Share of associates' contingent liabilities and commitments

	2009 Actual	2008 Actual
Contingent liabilities	-	-
Contracted capital commitments	-	*776*
Other contracted commitments	-	-

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

in thousands of New Zealand dollars

9b. Investments in joint ventures

a) Carrying amount of investments in joint ventures

	2009 Actual	2008 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%)

	2009 Actual	2008 Actual
Non-current assets	*27*	*31*
Current assets	*124*	*103*
Non-current liabilities	-	-
Current liabilities	*76*	*66*
Net assets/(liabilities)	*75*	*68*
Income	*498*	*492*
Expense	*491*	*507*
	7	*(15)*

c) The DHB's share in contingent liabilities

Central Region TAS has no contingent liabilities. (2008: $nil)

d) The DHB's share in commitments

The DHB share of Capital Commitments for CR TAS is $0.58m in 2009 (2008: $0.01m).

in thousands of New Zealand dollars

10. Trade and other receivables

	2009 Actual	2008 Actual
Trade receivables due from associates	*8,948*	*7,577*
Trade receivables from non-related parties	*13,598*	*15,544*
Ministry of Health receivables	*30,728*	*31,817*
	53,274	*54,938*
Accrued income	*4,479*	*3,494*
Prepayments	*750*	*633*
Crown Equity Receivable	*-*	*21,482*
	58,503	*80,547*

Trade receivables are shown net of provision for doubtful debts amounting to $1.6m (2008: $1.7m)

The carrying value of receivables approximates their fair value.

As at 30 June 2009, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2009			2008		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	*43,987*	*-*	*43,987*	*50,620*	*-*	*50,620*
Past due 1-30 days	*1,661*	*-*	*1,661*	*925*	*-*	*925*
Past due 31-60 days	*683*	*-*	*683*	*458*	*-*	*458*
Past due 61-90 days	*1,624*	*-*	*1,624*	*267*	*-*	*267*
Past due > 91 days	*6,968*	*1,649*	*5,319*	*4,324*	*1,656*	*2,668*
Total	**54,923**	**1,649**	**53,274**	**56,594**	**1,656**	**54,938**

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.

in thousands of New Zealand dollars

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

	2009 Actual	2008 Actual
Balance at 1 July	*1,656*	*3,509*
Additional provisions made during the year	*427*	*369*
Provisions reversed during the year	*(434)*	*-*
Receivables written-off during period	*-*	*(2,222)*
Balance at 30 June	*1,649*	*1,656*

11. Cash and cash equivalents

	2009 Actual	2008 Actual
Petty Cash	*13*	*14*
Bank Accounts	*-*	*-*
Call deposits	*-*	*-*
Cash and cash equivalents	*13*	*14*
Bank overdrafts	*(32,727)*	*(18,859)*
Cash and cash equivalents in the statement of cash flows	*(32,714)*	*(18,845)*

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 $32.7m as at 30 June 2009. (2008: $18.9m)

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 ASB facility has a limit of $40m.

in thousands of New Zealand dollars

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

	Note	2009 Actual	2008 Actual
Surplus for the period	18	*(66,049)*	*(40,676)*
Add back non-cash items:			
Depreciation		*21,526*	*19,222*
Share of (profit)/loss from associate companies		*(45)*	*319*
Impairment Loss on Property, Plant & Equipment		*-*	*982*
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		*(!60)*	*273*
Add back items classified as financing activity:			
Movements in working capital:			
(Increase)/decrease in trade and other receivables		*5,792*	*(14,613)*
(Increase)/decrease in inventories		*(943)*	*(232)*
Increase/(decrease) in trade and other Payables		*1,467*	*1,627*
Increase/(decrease) in employee benefits		*2,862*	*7,288*
Increase/(decrease) in provisions		*(456)*	*-*
Net movement in working capital		**8,722**	**(5,930)**
Net cash inflow/(outflow) from operating activities		**36,006**	**(25,810)**

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	2009 Actual	2008 Actual
Balance at beginning of year	*5,682*	*5,024*
Monies received	*1,823*	*1,467*
Interest received	*357*	*449*
Payments made	*(1,152)*	*(1,258)*
Balance at end of year	*6,710*	*5,682*
Patient funds	**2009 Actual**	**2008 Actual**
Balance at beginning of year	*163*	*159*
Monies received	*825*	*270*
Interest received	*4*	*6*
Payments made	*(851)*	*(272)*
Balance at end of year	*141*	*163*
Total Trust/Special funds	**6,851**	**5,845**

13. Interest-bearing loans and borrowings

	2009 Actual	2008 Actual
Non-current		
Secured CHFA loans	*311,000*	*283,000*
Finance Leases	*984*	-
	311,984	**283,000**
Current		
Secured CHFA loans	-	*28,000*
Secured Bank loans	*24,000*	-
Finance Leases	*240*	-
	24,240	**28,000**

Secured loans

The DHB secured loans are from the Crown Health Financing Agency (CHFA) and bank. 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:

in thousands of New Zealand dollars

Interest rate summary	2009 Actual	2008 Actual
Crown Health Financing Agency	*5.16%-7.31%*	*6.075%-7.31% pa*
Bank loan	*3.22%*	-
Finance Leases	*6.50%*	-

Repayable as follows:	2009 Actual	2008 Actual
Within one year	*24,000*	*28,000*
One to two years	-	-
Two to five years	*150,000*	*150,000*
Later than five years	*161,000*	*133,000*

Analysis of finance leases	2009 Actual	2008 Actual
Minimum lease payments payable		
Within one year	*320*	-
One to two years	*317*	-
Two to five years	*816*	-
Later than five years	*9*	-
Total minimum lease payments	*1,462*	-
Future finance charges	*(238)*	-
Present value of minimum lease payments	*1,224*	-
		-
Present value of minimum lease payments payable		-
Within one year	*300*	-
One to two years	*280*	-
Two to five years	*638*	-
Later than five years	*6*	-
Total Present value of minimum lease payments	**1,224**	**-**

in thousands of New Zealand dollars

Term loan facility limits	2009 Actual	2008 Actual
Crown Health Financing Agency	*311,000*	*311,000*
Bank loan	*28,000*	-

Security and terms

The loan facility is provided by the bank and 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.

in thousands of New Zealand dollars

14. Employee entitlements

Non-current liabilities	2009 Actual	2008 Actual
Liability for long-service leave	*2,773*	*1,430*
Liability for sabbatical leave	*327*	*250*
Liability for retirement gratuities	*2,575*	*690*
	5,675	**2,370**

Current liabilities	2009 Actual	2008 Actual
Liability for long-service leave	*1,694*	*2,194*
Liability for sabbatical leave	*170*	*208*
Liability for retirement gratuities	*414*	*2,806*
Liability for annual leave	*29,979*	*25,265*
Liability for sick leave	*1,744*	*1,877*
Liability for continuing medical education leave and expenses	*5,779*	*4,559*
Salary and wages accrual	*11,162*	*14,476*
	50,942	**51,385**

Defined Benefit Plans:

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

Other Employee Entitlement Liabilities:

- Liability for salaries and wages accrued is regarded as at current actual salaries.
- Liability for annual leave is calculated as the greater of average weekly earnings for the 12 months immediately before the end of the last pay period before the annual holiday is taken or the employees ordinary weekly pay as at the beginning of the annual holiday.
- Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 3.0%,(2008 3.0%) and a discount rate ranging from 3.49% to 6.35% from 1-10+ years.

in thousands of New Zealand dollars

14. Provisions

	2009 Actual	2008 Actual
Current provisions		
Restructure	-	*563*
ACC Partnership Programme	*379*	*236*
	379	**799**
Non Current Provisions		
ACC Partnership Programme	*90*	*126*
Total Provisions	**469**	**925**

ACC partnership programme	2009 Actual	2008 Actual
Undiscounted amount of claims at balance date	*404*	*360*
Discount	*18*	*34*
Central estimate of present value of future payments	*422*	*326*
Risk margin	*47*	*36*
Total Liability	**469**	**362**

The movement in provisions is represented by:

2008	Restructuring	ACC Partnership Programme
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	-	-
Subtotal	**563**	**635**
Amounts used during the year	-	*273*
Total Liability	*563*	*362*
Increase in provision for claims liability	**563**	**(38)**

in thousands of New Zealand dollars

2009	Restructuring	ACC Partnership Programme
Opening balance	*563*	*362*
Additional provisions during the year for the risks borne in current period	-	*405*
Additional provisions relating to a reassessment of risks in a previous period	-	-
Subtotal	**563**	**767**
	-	
Amounts used during the year	*563*	*298*
Total Liability	-	*469*
(Decrease) / Increase in provision	**(563)**	**107**

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

in thousands of New Zealand dollars

- 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 2010, and 4% for the year ending 30 June 2011. A discount rate of 4.8% has been used for the year ended 30 June 2010 and 4.8% for the year ending 30 June 2011.

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.

16. Trade and other payables	Note	2009 Actual	2008 Actual
Trade payables to other related parties	21	*8*	*981*
Trade payables to non-related parties		*4,923*	*2,091*
GST and other taxes payables		*8,178*	*5,957*
Income in advance		*2,718*	*215*
Capital charge due to the Crown		*851*	*893*
Other non-trade payables and accrued expenses		*48,390*	*51,371*
		65,068	**61,508**

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.

in thousands of New Zealand dollars

17. Patient and restricted funds

Patient funds	2009 Actual	2008 Actual
Balance at beginning of year	*163*	*159*
Monies received	*825*	*270*
Interest received	*4*	*6*
Payments made	*(851)*	*(272)*
Balance at end of year	**141**	**163**

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 2009 are not recognised in the statement of financial performance, but are recorded in the statement of financial position as at 30 June 2009, both as an asset and a liability.

Holiday homes funds	2009 Actual	2008 Actual
Balance at beginning of year	*46*	*44*
Monies received	*14*	*8*
Interest received	*2*	*3*
Payments made	*(8)*	*(9)*
Balance at end of year	**54**	**46**
Hutt Valley DHB Portion ¼ of Holiday Homes total	**13**	**12**
Total Patient and Hutt Valley Portion of Restricted Funds	**154**	**175**

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

	Crown equity	Other reserves				Total equity
		Re-valuation reserve (land)	Re-valuation reserve (P & E)	Total other reserves	Retained earnings	
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 reserves	-	-	-	-	-	-
Transfer from retained earnings	-	-	-	-	-	-
Balance at 30 June 2008	**231,250**	**24,269**	**8,741**		**(147,392)**	**116,868**
Balance at 1 July 2008	*231,250*	*24,269*	*8,741*		*(147,392)*	*116,868*
Total recognised income and expense	-	-	-	-	*(66,049)*	*(66,049)*
Repayment of Equity	*(3,484)*	-	-	-	-	*(3,484)*
Contribution from the Crown	*70,862*	-	-	-	-	*70,862*
Movement in revaluation of land and buildings	-	-	*(1,160)*	-	-	*(1,160)*
Transfer from retained earnings	-	-	-	-	-	-
Balance at 30 June 2009	**298,628**	**24,269**	**7,581**	**-**	**(213,441)**	**117,037**

in thousands of New Zealand dollars

19. Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as folows:

	2009 Actual	2008 Actual
Less than one year	*1,562*	*1,882*
Between one and five years	*1,697*	*3,059*
More than five years	*36*	*75*
	3,295	**5,016**

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 2009, $2.5m was recognised as an expense in the statement of financial performance in respect of operating leases (2008: $2.9m)

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:

	2009 Actual	2008 Actual
Less than one year	*2,292*	*683*
Between one and five years	*6,980*	*1,389*
More than five years	*165*	*1,044*
	9,437	**3,116**

During the year ended 30 June 2009, $2.67m was recognised as rental income in the statement financial performance (2008: $3.1m)

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 52 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 13 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 33 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 2009 was $nil (2008: $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 2009, (2008: $0.1m).

Notes to the financial statements

in thousands of New Zealand dollars

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.

	2009 actual							2008 actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 years	2-5 years	More than 5 years
Secured bank loans:														
NZD fixed rate loan*	5.16	28,000					28,000	7.31	28,000	-	28,000	-	-	-
NZD fixed rate loan*	6.33	55,000				55,000		6.33	55,000	-	-	-	55,000	-
NZD fixed rate loan*	6.84	25,000				25,000		6.84	25,000	-	-	-	25,000	-
NZD fixed rate loan*	6.075	70,000				70,000		6.075	70,000	-	-	-	70,000	-
NZD fixed rate loan*	-	-	-	-	-	-	-	6.67	71,000	-	-	-	-	71,000
NZD fixed rate loan*	6.37	62,000					62,000	6.37	62,000	-	-	-	-	62,000
NZD fixed rate loan*	6.295	20,000					20,000	-	-	-	-	-	-	-
NZD fixed rate loan*	7.13	12,000					12,000	-	-	-	-	-	-	-
NZD fixed rate loan*	6.57	11,000					11,000	-	-	-	-	-	-	-
NZD fixed rate loan*	6.95	19,400					19,400	-	-	-	-	-	-	-
NZD fixed rate loan*	6.39	8,600					8,600	-	-	-	-	-	-	-
NZD fixed rate loan*	3.22	24,000	24,000	-	-	-	-	-	-	-	-	-	-	-
Finance leases*	6.50	1,224	150	150	280	638	6	-	-	-	-	-	-	-
Bank overdrafts	3.30	32,727	32,727	-	-	-	-	8.39	18,859	18,859	-	-	-	-
		368,951	56,877	150	280	150,638	161,006		329,859	18,859	28,000	-	150,000	133,000

* 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	Con-tractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2009						
Creditors and other payables	*65,068*	*65,068*	*65,068*	-	-	-
Bank Overdraft	*32,727*	*32,727*	*32,727*	-	-	-
Secured Loans	*335,000*	*438,214*	*43,768*	*19,573*	*192,402*	*182,471*
Finance Leases	*1,224*	*1,462*	*320*	*317*	*816*	*9*
Patient and restricted funds	*154*	*154*	*154*	-	-	-
Total	**434,173**	**537,625**	**142,037**	**19,890**	**193,218**	**182,480**
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**

in thousands of New Zealand dollars

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	Con-tractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2009						
Cash and Cash equivalents	*13*	*13*	*13*	-	-	-
Debtors and other receivables	*58,503*	*58,503*	*58,503*	-	-	-
Trust and Special Funds - Bank	*1,514*	*1,514*	*1,514*	-	-	-
Trust and Special Funds – Term Deposit	*5,100*	*5,148*	*5,148*	-	-	-
Trust and Special Funds – debtors	*237*	*237*	*237*	-	-	-
Total	**65,367**	**65,415**	**65,415**	**-**	**-**	**-**
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**	**-**	**-**	**-**

in thousands of New Zealand dollars

Maximum exposure to credit risk

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

	2009 Actual	2008 Actual
Cash at bank and petty cash	*13*	*14*
Debtors and other receivables	*58,503*	*80,547*
Trust and Special Funds – Bank	*1,514*	*414*
Trust and Special Funds – Term Deposit	*5,100*	*5,196*
Trust and Special Funds – Debtors	*237*	*235*
	65,367	**86,406**
Counterparties with Credit Ratings		
Cash at bank and Term Deposits		
AA (Standard & Poors)	*6,627*	*5,624*
	6,627	**5,624**

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 AUD Dollars.

The DHB hedges large transactions denominated in a foreign currency. The DHB uses forward exchange contracts to hedge its foreign currency risk. The DHB has no forward exchange contracts as at the balance sheet date.

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2009 was $nil (2008: $nil), comprising assets of $nil (2008: $nil) and liabilities of $nil (2008: $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 2009 was $nil (2008: $0.03m) 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 2009, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $3.57m (2008: $1.3m). 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 $0.04m for the year ended 30 June 2009 (2008: $0.05m).

Fair values

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

		Carrying amount	Fair value	Carrying amount	Fair value
	Note	2009 Actual	2009 Actual	2008 Actual	2008 Actual
Trade and other receivables	*10*	*58,503*	*58,503*	*80,547*	*80,547*
Cash and cash equivalents	*11*	*13*	*13*	*14*	*14*
Secured bank loans	*13*	*(335,000)*	*(350,868)*	*(311,000)*	*(314,081)*
Finance Leases	*16*	*(1,224)*	*(1,224)*	-	-
Trade and other payables	*16*	*(65,068)*	*(65,068)*	*(61,508)*	*(61,508)*
Bank overdraft	*11*	*(32,727)*	*(32,727)*	*(18,859)*	*(18,859)*
		(375,503)	**(391,371)**	**(310,806)**	**(313,887)**
Unrecognised (losses)/gains			*15,868*		*3,081*

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.

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 2009 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2009 Actual %	2008 Actual %
Derivatives	*N/A*	*N/A*
Loans and borrowings	*3.22, 5.16, 6.075, 6.295, 6.33, 6.37, 6.39, 6.50, 6.57, 6.84, 6.95, 7.13.*	*6.075, 6.295, 6.33, 6.37, 6.39, 6.57,6.84, 6.95, 7.13, 7.31*

21. Related parties transactions and key management personnel

Identity of related persons

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.

Ian Brown is the Deputy Commissioner of Hawkes Bay DHB

Ken Douglas is a Board member of two suppliers to the DHB, being 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

Helen Ritchie is a Councillor for Wellington City Council.

Dr. Peter Roberts is the Chair of the Workforce Committee for the Royal Australasian College of Physicians.

Dr. Donald Urquhart-Hay is a Senior Urologist in Mid Central Health.

Ken Douglas is a councillor at Porirua 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, Compass Health Wellington Trust.

She is a director of MATPRO Ltd. and is also the trustee of Wellington Free Ambulance.

Adrian Gilliland is a Clinical Tutor at Wellington School of Medicine. She is also a member of Clinical Advisory Group Ora Toa PHO.

Bryan Betty is a Board member of Porirua Health Plus.

Taima Fagaloa is a councillor at Porirua City Council.

Ken Whelan is a director and Geoff Robinson is a trustee of Wellington Hospital and Health Foundation.

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

Remuneration

The key management personnel remuneration is as follows:

	2009 Actual	2008 Actual
Short-term employee benefits	*2,558*	*2,781*
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	*142*
	2,558	**2,923**
Board members	*391*	*345*
Executive team	*2,167*	*2,578*
	2,558	**2,923**

Key management personnel include all Board members, the Chief Executive, and the remaining 8 members of the management team.

The Board of the DHB as at 30 June 2009, 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.

Board members

			2009	2008
Sir John Anderson	Appointed	Board Chair	*50*	*28*
Judith Aitken	Elected	Chair DSAC	*30*	*41*
Brendon Bowkett	Elected		*-*	*11*
Ruth Bradwell	Elected		*-*	*9*
Ian Brown	Appointed		*31*	*17*
Peter Dady	Elected		*-*	*12*
Ken Douglas	Appointed	Deputy – Chair, Chair – Risk, Safety & Quality Assurance	*36*	*33*
Margaret Faulkner	Elected	Chair – DSAC and Audit Sub Committee	*33*	*31*
Ruth Gotlieb	Elected		*29*	*26*
Virginia Hope	Elected	Chair - HAC	*32*	*16*
Selwyn Katene	Appointed	Chair- CPHAC	*31*	*14*
Kiri Parata	Appointed		*-*	*13*
Fuimaono Karl Pulotu-Endemann	Appointed		*-*	*13*
Helen Ritchie	Elected		*29*	*27*
Peter Douglas	Appointed (April 07)		*30*	*25*
Peter Roberts	Elected		*31*	*14*
Donald Urquhart-Hay	Elected		*29*	*15*
			391	**345**

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)	2009	2008
Finance, Risk and Audit Committee		
Margaret Gillon	*1*	*1*
Neil Styles	*-*	*-*
Community and Public Health Advisory Committee		
Herani Demuth	*5*	*5*
Tavita Filemoni	*2*	*-*
Linda Hobman		*3*
Frances Hughes	*1*	*-*
Ken Patel	*2*	*-*
Stephen Palmer	*1*	*-*
Api Rongo-Raea	*1*	*-*
Puspa Wood	*-*	*1*
Disability Support Advisory Committee		
Nathan Bond	*1*	*-*
Valerie Bos	*-*	*3*
Tavita Filemoni	*1*	*-*
Margaret Guthrie	*1*	*3*
Liz Mellish	*1*	*2*
Judy Small	*1*	*-*
Hillary Stace	*2*	*-*
Hospital Advisory Committee		
Hilda Broadhurst	*7*	*6*
Marion Bruce	*-*	*3*
John Cook	*-*	*3*
Malakai Jiko	*4*	*-*
Lynn McBain	*3*	*3*
	34	**33**

Sales to related parties	2009 Actual	2008 Actual
HIQ (associate)	*308*	*2,243*
CRTAS (joint venture)	*23*	*12*
Wakefield Hospital	*32*	*42*
Capital PHO	*89*	*96*
Tumai mo te Iwi	*27*	*38*
Kapiti PHO	*22*	-
Ora Toa PHO	*7*	-
MATPRO LTD	*0*	-
Te Roopu Awhina	*90*	-
Wellington School of Medicine	*1,822*	-
Royal Australasian College of Physicians	*1*	-
Wellington Free Ambulance	*64*	-
Compass Health Wellington Trust	*62*	-
Porirua Health Plus Ltd	*3*	-
Mid Central Health	*831*	-
Wellington Hospital and Health Foundation	*12*	-
Hawkes Bay DHB	*880*	*793*
	4,273	**3,224**

Purchases to related parties	2009 Actual	2008 Actual
HIQ (associate)	*20,771*	*19,146*
CRTAS (joint venture)	*41*	*763*
New Zealand Post	*421*	*363*
Healthcare of New Zealand Ltd	*7,328*	*5,750*
Te Roopu Awhina	*137*	*111*
Wakefield Hospital	*5,230*	*3,864*
Maddison Projects	*454*	*432*
PowerHouse People Ltd	*289*	*550*
Wellington Independent Practices Association	-	*277*
Compass Health Wellington Trust	*4,927*	-
The Greater Wellington Health Trust	*1,751*	*4,905*
MATPRO Ltd	*118*	*83*

Capital PHO	*22,991*	*20,446*
Tumai mo te Iwi	*8,287*	*7,805*
Wellington City Council	*885*	*560*
Wellington Free Ambulance	*17*	*-*
Royal Australasian College of Physicians	*21*	*-*
Wellington Hospital & Health Foundation	*84*	*-*
Porirua City Council	*570*	*-*
Kapiti PHO	*7,126*	*-*
Ora Toa PHO	*3,030*	*-*
Porirua Health Plus	*1,684*	*-*
Hawkes Bay DHB	*167*	*129*
	86,329	**65,184**

Outstanding balances to related parties	2009 Actual	2008 Actual
CRTAS (joint venture)	*-*	*10*
New Zealand Post	*1*	*-*
Healthcare of New Zealand Ltd	*944*	
Te Roopu Awhina	*1*	*21*
Wakefield Hospital	*-*	*96*
Compass Health Wellington Trust	*879*	*-*
The Greater Wellington Health Trust	*-*	*746*
MATPRO Ltd	*13*	*11*
Capital PHO	*194*	*44*
Tumai mo te Iwi	*347*	*53*
Wellington City Council	*35*	*-*
Hawkes Bay DHB	*3*	*821*
Kapiti PHO	*325*	*-*
Porirua City Council	*13*	*-*
Royal Australasian College of Physicians	*3*	*-*
Wellington Free Ambulance	*1*	*-*
Ora Toa PHO	*190*	*-*
Porirua Health Plus	*391*	*-*
	3,340	**1,802**

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 $0.9m of interest and Bank fees where charged to the DHB and the DHB earned $0.5m of interest. The ASB Bank Ltd provides a working capital facility of $40m to the DHB. The facility Utilisation as at 30 June 2009 was $32.7m.

Outstanding balances from related parties	2009 Actual	2008 Actual
HIQ (associate)	*8,948*	*7,577*
CRTAS (joint venture)	*2*	*14*
Wakefield Hospital	*5*	*6*
Compass Health Wellington Trust	*11*	-
Hawkes Bay DHB	*3*	-
Wellington Free Ambulance	*3*	-
Wellington School of Medicine	*140*	-
	9,112	**7,597**

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 (2008: $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 84.98% shareholding in HIQ Ltd (2008: 70.82%). 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	
	2009	2008	2009	2009	2009	2008
Class A shares	*1*	*1*	*1*	*1*	*2*	*2*
Class B shares	*27,915,360*	*20,351,140*	*4,935,560*	*7,567,550*	*32,850,920*	*27,918,690*

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.

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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.

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 2009	Number of employees 2008
100 – 110	55	71
110 – 120	53	48
120 – 130	55	37
130 – 140	40	22
140 – 150	23	26
150 – 160	28	19
160 – 170	16	16
170 – 180	20	15
180 – 190	17	19
190 – 200	19	19
200 – 210	16	14
210 – 220	14	14
220 - 230	15	6
230 – 240	13	7
240 – 250	8	5
250 – 260	7	7
260 – 270	7	5
270 – 280	9	1
280 – 290	7	4
290 – 300	4	2
300 – 310	5	3
310 – 320	5	2
320 – 330	5	1
330 – 340	1	1
340 - 350	3	1
350 – 360	3	-
360 – 370	2	-
370 - 380	1	-
380 - 390	1	1

400 – 410	*1*	-
420 – 430	*1*	-
430 - 440	*1*	*1*
530 - 540	*1*	-
550 – 560	*1*	-
	457	**367**

Of the 457 employees shown above, 342 are or were medical or dental employees and 115 are or were neither medical nor dental employees. This represents an increase of 90 staff in total over the previous year. Of these, 56 are or were medical and dental employees and 34 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 677, compared with the actual total number of 457.

Number of employees	Amount paid
1	*526*
1	*2,621*
1	*6,340*
1	*6,510*
1	*6,990*
1	*7,327*
1	*7,500*
1	*7,815*
1	*7,840*
1	*7,873*
1	*10,335*
1	*10,337*
1	*11,250*
1	*11,877*
1	*12,010*
1	*12,424*
1	*12,875*
1	*12,949*
1	*14,000*
1	*14,566*
1	*15,336*

Number of employees	Amount paid
1	*16,364*
1	*16,738*
1	*16,959*
1	*17,240*
1	*18,250*
1	*18,441*
1	*18,912*
1	*19,273*
1	*20,432*
1	*21,430*
1	*22,395*
1	*22,572*
1	*22,996*
1	*23,333*
1	*24,213*
1	*24,462*
1	*27,670*
1	*28,169*
1	*28,347*
1	*28,750*
2	*30,000*
1	*32,603*
1	*32,617*
1	*34,490*
1	*36,425*
1	*37,986*
1	*38,631*
1	*40,985*
1	*46,871*
1	*49,231*
1	*62,500*
1	*118,687*
54	**1,227,273**

24. Subsequent event

On 1 July 2009 the DHB exchanged its interest in HIQ Limited for assets owned by HIQ Limited, which were required for the DHB 's Informative Technology needs.

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.

Finance and operating leases

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

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

26. Borrowing costs

The total amount of borrowing costs capitalised during the period ended 30 June 2009 was $8.0m (2008: $11.2m)

The capitalisation rate used to determine the amount of borrowing costs eligible for capitalisation during the year was 6.5% (2008: 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 2009.

Statement of financial performance

The DHB recorded a deficit of $66.0m compared with the budgeted deficit of $52.7m. The variance, $13.3m adverse, was the net of revenue $23.8m over budget and costs $20.8 over budget. (including $6.7m of one off costs relating to the move to the New Regional Hospital) A significant part of the variance was due to a land sale at Porirua which was budgeted but not finalised. 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
- borrowings (term and current at $336m differ from budget owing to a revised borrowing programme for financing the New Regional Hospital
- the unfavourable bank overdraft reflects the adverse result, combined with trade payables being under budget.

Changes in equity

The variance of $24.9m mainly reflects the adverse result, together with the non receipt of equity for asset purchases.

Statement of changes in cash flow

The net cash flow was $15.2m better than budget. The major reasons were

- Operating cash flow, at $26.2m better than budget reflects both reduced funding receipts, reduced payments to suppliers and increased GST payments. Interest paid is favourable owing to drawing down timing changes of loan finance, plus higher than planned interest costs being capitalised on the New Regional Hospital project.
- Investing cash flow, variance $44.0m adverse to budget reflects timing differences with the New Regional Hospital costs, plus advances to the DHB's associate, partially offset by low proceeds from the sale of surplus assets
- Financing cash flows, in total, are close to budget with equity receipts offsetting non receipt of budgeted loan finance.

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.

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	*704,906*	*6,997*	*458,504*	*(418,207)*	*752,200*
Other	*691*	-	*18,031*	-	*18,722*
Total Revenue Expenditure	**705,597**	**6,997**	**476,535**	**(418,207)**	**770,922**
Personnel	-	*3,032*	*318,720*	-	*321,752*
Depreciation	-	*5*	*21,521*	-	*21,526*
Capital Charge	-	-	*5,915*	-	*5,915*
Other	*707,172*	*20,453*	*178,360*	*(418,207)*	*487,778*
Total Expenditure	**707,172**	**23,490**	**524,516**	**(418,207)**	**836,971**
Net Surplus/ (Deficit)	**(1,575)**	**(16,493)**	**(47,981)**	**-**	**(66,049)**

	Funding	Governance and funding administration	DHB hospital provider	Elimination	Total DHB
Opening Retained Earnings	*8,731*	*(5,847)*	*(150,276)*	-	*(147,392)*
Surplus/ (deficit) for the year	*(1,575)*	*(16,493)*	*(47,981)*	-	*(66,049)*
Closing Retained Earnings	**7,156**	**(22,340)**	**(198,257)**	**-**	**(213,441)**

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 2008/09 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 18 September 2009 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