ANNUAL REPORT 2009/2010

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

CONTENTS

ABOUT OUR ANNUAL REPORT

This report presents Capital and Coast District Health Board's (C&C DHB) performance for the year 1 July 2009 to 30 June 2010. 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) 2009/10, 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 women have babies
- 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).
- 2740 patients are seen by a GP or practice nurse
- 5400 prescriptions are filled by community pharmacies
- Around 3800 tests are performed by the community laboratory
- 1350 people are cared for in subsidised aged residential care beds.

MESSAGE FROM THE CHAIR

Sir John Anderson

The 2009/10 year has been very financially challenging for C&C DHB, as it has for other health organisations and most Government departments.

The recession has meant belt tightening across both public and private sector and health was no exception.

Despite these challenges, the DHB has continued to work hard to make savings wherever possible, while maintaining frontline services and targeting what funding is available to those who need it most.

To this end, a comprehensive and ambitious recovery plan was established which encapsulated health and hospital services, as well as primary and community care. Part of the recovery plan includes making sustainable savings of just over $27m over the next financial year (and ongoing), across the board. Under this plan, costs around unnecessary administration and duplication of services and funding will be targeted, as opposed to cuts to services.

This plan is on track and we hope to see its impact in the next financial year.

The health system is experiencing a new direction in its overall governance at a national level, particularly in terms of the National Health Board and the Shared Services Board. There have also been initiatives to establish regional clinical services co-operation, together with consolidation of a number of PHOs, which have been positive.

Perhaps, more importantly the increased involvement in Senior Medical Officers and clinicians in C&C DHB's services to the community has been very successful.

Three years ago the DHB was in a state of flux, with a new CEO required, a new hospital to complete, and IT systems lacking reliability and service. The operating deficit had risen to around $40 million.

In the coming year the DHB will have no operating deficit, however the costs of the new Regional Hospital of $40 million a year (via finance costs, capital charge and depreciation) which are balance sheet structural costs, still have to be addressed.

The move to the new Regional Hospital was extremely well managed and patient safety and services were maintained. The technology issues have been addressed and increased services at Kenepuru have been developed and now complement those services provided in primary care.

During the year Ken Douglas retired from the Board and Keith Hindle was appointed as his replacement. The Crown Monitor, Dr Ian Brown, also retired and Debbie Chin was appointed Crown Monitor as his replacement. Ruth Gotlieb has advised she will not be standing for the Board in this year's election. Ruth has been on the Board since 2001 and her contribution has been very valuable.

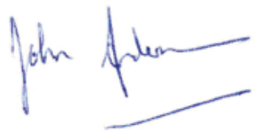
On my own, and the Board's behalf I would like to thank Ken, Ian and Ruth for their contribution during their terms at the C&C DHB.

I would like to pay tribute to Chief Executive Ken Whelan and Chief Operating Officer Shaun Drummond who, along with senior managers, senior medical officers and clinicians have really led the organisation to where we are today through hard work and determination.

Clinician-led decision making has been the key to ensuring that resources are channelled appropriately. This approach has been fostered throughout the organisation, with excellent results for patients as well as the community gaining confidence in their health provider.

My own role finishes in December. I would like to thank the Board of C&C DHB for their support and contribution, and for their efforts in ensuring the decisions they have made as a Board have enhanced the care of patients, both in the hospitals and in the community over the past three years.

C&C DHB is now an organisation that all staff, management and clinicians can be proud of. My warm thanks go to them all along with my best wishes for the future, both in the hospitals and in the community.



Sir John Anderson
Chair

MESSAGE FROM THE CEO

Ken Whelan

The past couple of years at C&C DHB has seen a number of leading initiatives finally come to fruition after months, and for some, years of planning and development.

Not least of these, is the successful completion and move into the outstanding new hospital building, of which we are very proud. This allowed us an unprecedented opportunity to redesign the way we do our core business, to make it more efficient and effective, and provide greater access to services.

It changed not only the physical environment in which we do a large chunk of our work, but also changed the dynamic of the workplace. Since arriving here, I have seen recruitment and staff morale take a great leap forward, leading to a positivity around our organisation and where we are heading.

While we continue to battle with a large deficit and the ongoing costs associated with the concrete of the new building, great strides have been made towards reaching break even with our operating costs.

I have to pay tribute to the dedicated staff who have made some difficult decisions around reducing wastage and looking at how we can better target our spending, without cutting into frontline services. I also commend our health partners in the community, who have understood the pressures we face and have helped us find solutions that work best for all.

When comparing us to like-sized organisations, we stack up very well and in fact, looking at tertiary services, we are equal to or better than others in a number of specialties – something that I don't think many realise and which deserves more public acknowledgement.

There are many other successes across the organisation, but I would like to point out just a couple of key projects that are already bearing fruit.

The development of the Health Education Research Collaborative is a leading light for a joint approach between educational institutions, research and medical facilities in this country. Post-graduate nursing students from Victoria University have now moved into the HERC Centre

and having them onsite at Wellington Hospital, a tertiary health facility, will provide a chance to learn at the coal face of health. Meanwhile, the Medical Research Institute of New Zealand has also moved onsite, providing our staff and others a great opportunity to take part in cutting edge research – from basic biomedical science through to clinical trial activity.

Another project which has made a difference right across the district, is increasing the utilisation of Kenepuru Hospital in Porirua. This excellent resource was significantly under-used until we instituted a plan to increase elective surgery and move much more outpatient activity to both Kenepuru and Kapiti Health Centre. Not only has this provided more convenient treatment for people in the northern area of our district, it has also allowed us to reduce waiting times and pressure on Wellington Hospital's resources. Initiatives like this have meant we have been able to free up theatre time in Wellington for specialist tertiary treatment such as cardiac surgery. Our cardiac waiting list is now one of the lowest in the country and is something to be very proud of.

We also over-delivered on our contracted elective targets for this year, which meant more people got access to surgery than ever before.

Of course, one of the key reasons we have been able to achieve some of these things has been the support and initiative of our clinical teams. When I first arrived, one of the key challenges was to remove the division between clinicians and management and instead ensure decisions were made based on clinical involvement. I believe we now have a strong structure, which includes over 50 percent of the senior management team being practising clinicians. This has led to greater leadership, focus and understanding of our direction on an organisation-wide basis.

I have been greatly encouraged by the continual passionate messages from staff who make suggestions for how to improve services for their patients. It's not about themselves, or complaining about others, it's about doing what's best for the patient. This kind of attitude and approach to the job is not something you get everywhere.

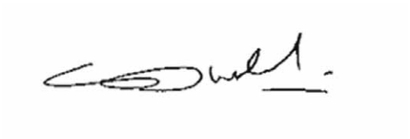
There are a whole lot of people out there who care a lot about what they do. I've worked in a number of places and not seen it to the extent that I've witnessed it here – and that is something of which staff should be very proud.

I hope that in the future the incredible work our staff do gets greater recognition in the community, because we know that if you are sick in our region, the care you will get here is some of the best you'll get anywhere. People rely on us to be able to feel safe in our hospitals and when receiving care at home, so we also have an obligation to tell people about our successes and celebrate these so our community has continued confidence in us.

I would like to thank the Board for their continued support, particularly Sir John Anderson, whose leadership has been truly an inspiration – I will treasure all that I have learned from him. I also wish to pay tribute to my management team and clinical leaders, who have had to make some difficult decisions in the past year, but who have shown true dedication – often in trying circumstances.

As I leave the organisation, I would just like to say that I believe it takes a very special person to work in Wellington – the pressures here are unique. But I think we are on the verge of creating something great and I truly hope, and indeed anticipate, that with the continued outstanding support of staff in this organisation, you will do just that.

I wish you well and I will be watching from my next port of call with great interest.



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, NGOs, 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 percent in Porirua and 14 percent 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 general hospitals; Wellington and Kenepuru, supported by the Kapiti Health Centre and other community based services. It also operates a range of mental health inpatient and community facilities, for the region and nationally. It is a major employer in the Wellington region with about 3,500 full-time equivalent staff with an additional number working on part-time or casual basis.

A brand new, state of the art Wellington Regional Hospital was opened on 6 March 2009. Staff, patients and their families now deliver and receive care 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.

In the past year, we have brought our Planning and Funding Directorate and Board facilities to Wellington Hospital. This brings together all of our Directorates on the one site.

Photograph courtesy of Louise Goossens, Wellington School of Medicine & Health Sciences

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 under 15 years
- Kapiti Coast has a large population aged over 65 years.
- We have fewer than average Māori (10 percent) and a higher than average Pacific population (7 percent). 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 percent 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 percent 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 – 2012 District Annual Plan*.

Photograph courtesy of Life Flight Trust

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

There has been a strong case from the Minister of Health for clinical leadership over the past year, and I believe C&C DHB has taken this up with alacrity and success.

Clinicians as Clinical Directors, the Director of Allied Health, Scientific & Technical and the Director of Nursing & Midwifery and myself, are the majority of the hospital's management committee. This has been fostered by the Chief Executive and Chief Operating Officer.

Over 70 senior doctors are in clinical leadership roles as Directors or Clinical Leaders (Heads of Departments), or on sub-committees of the Clinical Governance frameworks, which includes the important Primary/Secondary Governance Committee.

The latter is the formal interface with Primary and Community Services and develops interface issues including referral processes, discharge planning, IT systems, medication management and clinical pathways.

It is notable that with services embedded now in the new hospital, the DHB has fewer major adverse clinical events and adverse media exposure from the Health and Disability Commissioner or Coronial findings.

Reportable event reviews are completed in a timely manner and the tracking systems are much improved. The appointment of a Patient Safety Officer has been extremely helpful here.

C&C DHB continues its successful tradition of providing a strong commitment to undergraduate and postgraduate medical education, in partnership with the University of Otago Wellington School of Medicine, the New Zealand Medical Council and Medical Colleges.

We are endeavouring to better support General Practice Training also and develop relations with Health Workforce New Zealand, which is considering some new funding arrangements – particularly to assist in retention of the New Zealand health workforce.

I would like to acknowledge the Wellington Regional Hospital's new educational facilities – including a new lecture theatre and seminar rooms. The Health Education Research Collaborative is developing well in the arenas of research, skills training and collaborative education and clinical trials unit.

A great deal of time and effort from senior clinicians has been directed to regional DHB integration, both in the local North Island and sub-regionally with Hutt Valley and Wairarapa DHBs.

> Hopefully their endeavours will continue to attract quality senior and junior medical staff, although pleasingly C&C DHB medical staffing has been near full over the past year.

Plans have been developed for joint clinical governance, joint appointments, regional leadership and service planning but this has been fraught with difficulties associated with the current DHB planning and funding model, contracting and DHB reporting requirements.

Paediatrics has indicated a willingness for a regional service and C&C DHB will need to consider in this context the possibility of a new paediatric hospital facility, as well as improving the health of children in certain areas of need – particularly Porirua.

It is ironic that in this setting of a favourable C&C DHB report, there exists a demoralising industrial environment with various persistent strike actions diverting attention from optimal service provision and timely patient outcomes.

DIRECTOR OF NURSING & MIDWIFERY

Kerrie Hayes

DIRECTOR OF NURSING PRIMARY HEALTH & INTEGRATED CARE

Vicky Noble

This year the Directors of Nursing for the Hospital and Health Service (HHS) and Primary Health and Integrated Care committed to work more closely together in the interest of best possible outcomes for patients.

Work was focused on smoothing the interface of primary and secondary care, as people access our services across primary, community and hospital settings and integrating systems for good nursing and midwifery practice.

Our teams have worked closely with Nurses and Midwives across the DHB to establish a clear shared commitment to provide

"Person/family centred care using current evidence to assist people to achieve their optimum health."

Priority actions to achieve this have focussed on delivering:

- Safe care
- Enabling better teamwork
- Growing and supporting our nursing and midwifery workforce.

In addition we have begun to work collegially with our neighbours in the Hutt and Wairarapa DHBs, seeing the need to maximise our resources to better support nursing and midwifery practice development and better health and wellbeing outcomes for all our communities.

This has been a year of consolidation and building strong foundations for nursing and midwifery practice, as we finished the first year of delivering care in our new hospital.

Nurses and midwives have strived to improve the delivery of safe and effective health care as we tested, tweaked and explored the full capacity of our new environment.

Together with our other professional colleagues we have implemented a range of initiatives aimed at making care safer for our patients. Some of these initiatives include:

- Releasing Time to Care (RTTC) – implemented in eight inpatient units and continuing to roll out next year across inpatient ambulatory and community care teams
- Our nursing and midwifery care – is it good enough? Using our patients and their family's experience of our care to challenge and improve the standard of "person centred" care we provide and deliver
- Capture and reporting of nursing and midwifery sensitive indicators to demonstrate trends, inform improvements and support clinical governance
- Nurse/midwife led improvements that deliver on better, sooner, more convenient care for our community including smoking cessation, wound clinics in primary and community health care services, nurse led protocols in the Emergency Department and Medical Assessment and Planning Unit (MAPU) to fast track patients treatment and care, outstanding breastfeeding rates and baby friendly hospital accreditation – to name but a few.

The past year has been a sentinel one for nursing and midwifery professions and as a workforce, with some exciting developments for our DHB including:

- Victoria University School of Nursing, Midwifery and Health moved permanently into a fantastic education and learning precinct on the Wellington campus
- Whitireia Polytechnic, in partnership with our DHB, delivered our first post graduate paper to 96 nurses on the NETP first year of practice programme

- Otago Polytechnic commenced undergraduate midwifery education for the region with clinical placements and lectures within DHB services and campuses
- Appointment of joint roles to further develop the nursing and midwifery workforce, career pathway frameworks and support practise development from the first year of practise to expert and advanced practise roles across hospital, community and primary health care
- The development and support of nurse practitioner candidacy roles in primary mental health, specialist diabetes, care of the older person, child health, palliative care and the establishment of a sub-regional forum for nurse practitioners networking and development
- Post graduate Health Workforce New Zealand funding specifically for midwives to support professional development from the first year of practise to doctoral level. The continuation of voluntary bonding and commitment to first year of practise has ensured that our workforce is continuing to grow to serve our community.

DIRECTOR ALLIED HEALTH, TECHNICAL & SCIENTIFIC

Sally Taylor

"One voice – many different professions"

It is important to remember the many people who work alongside our doctors and nurses in a vast range of healthcare professions, to ensure our patients get the best care.

Allied Health makes up approximately 16 percent of the workforce, with 700FTE – this compares with medical staff who also make up 16 percent, and nursing staff who are 44 percent of our total staffing numbers.

This means clinical staff make up 76 percent of the total workforce within the DHB – the rest being management, administration, and support.

Within our DHB, the Allied Health Scientific and Technical workforces continue to develop its representation within governance structures and developmental projects within the organisation.

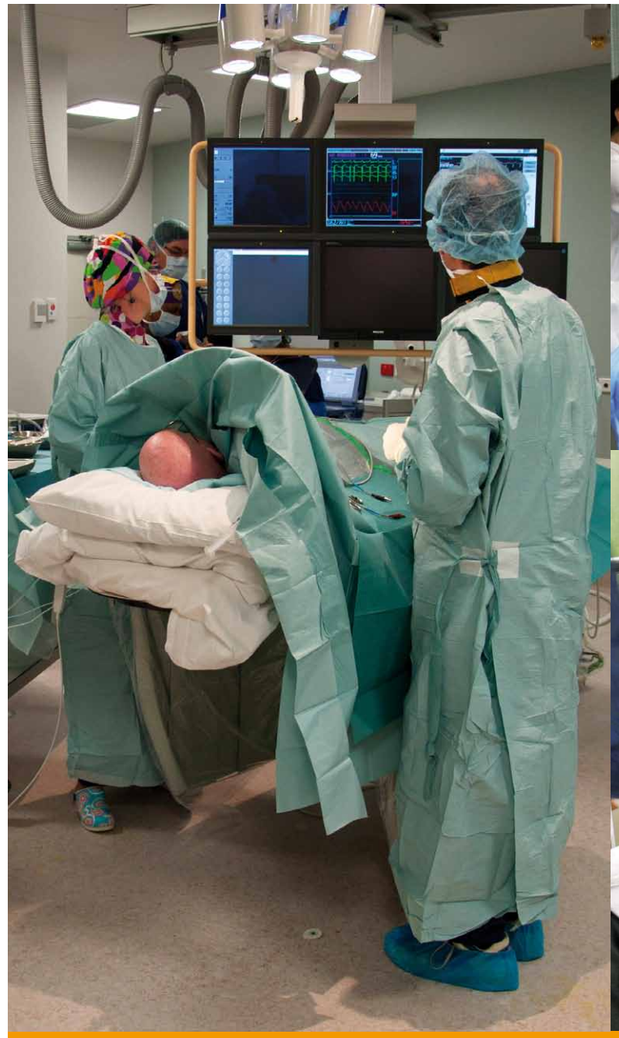
Examples of this are Dr Serena Rooker, a laboratory scientist, who is the voice for our professions within the research steering group, and Jo Stewart who is one of our representatives within the clinical governance sub-committee, the Health Information, Documents and Records Committee.

The past year has seen a number of changes and innovation such as:

- Radiation Therapy students are now able to attend different cancer centres as part of their training after a change to the way student placements are organised
- In collaboration with the Māori Development Group, two Māori allied health internships are being piloted (physiotherapy and dietetics) and are a great opportunity for developing our Māori workforce

YEAR IN REVIEW

- We have also trained our first Allied Health Assistant in the level 3 community support worker NZQA qualification. This was a multidisciplinary approach where this training was provided by the Nurse Educator who trains hospital health care assistants.
- Scientists within the Genetics Laboratory have gained accreditation to be a sole provider (within New Zealand) of micro array based comparative Genomic Hydridisation testing (DNA testing).
- Within General and Mental Health the development and enhancement of supervision training has been completed. This supports professional development for our staff.



Additional photography courtesy of Louise Goossens

WHERE THE MONEY WENT

2009/2010 SPENDING ($M)

(Figures shown are for funder arm only)

133.74
Hospital - Surgical, Theatre, Anaesthesia & ICU *

171.53
Hospital - Medicine, Cancer & Community *

69.30
Hospital - Mental Health Services *

75.32
Hospital - Women's & Children *

1.03
Hospital - Clinical and Corporate Support *

13.95
Other Hospital Services

23.48
Mental Health Services
(Including inter-district)

45.57
Primary Health Organisations & GP Services

14.57
Community Laboratories
(Paid to Hutt DHB)

18.53
Care Coordination & Home-Based Services for the Elderly

16.58
Other Elderly & Disability Support Services

47.21
Aged Residential Care

62.87
Community Pharmaceuticals

43.99
Inter-District Outflows

26.78
Other Services

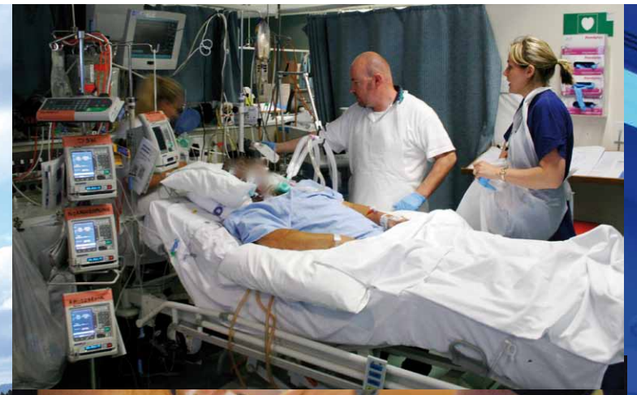
** including pro-rata allocation of $13M negative adjuster.*

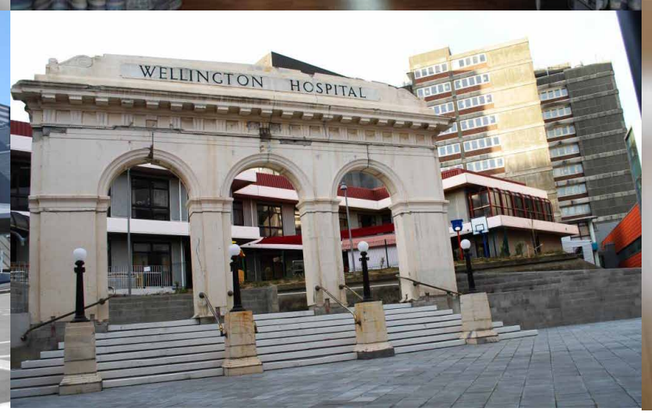
2009/2010 REVENUE ($M)

602.79
Ministry of Health

157.63
Other DHBs

1.16
Other Revenue




WELLINGTON HOSPITAL


EXIT

SURGERY & OUTPATIENTS

The 2009/10 year was the first full year of operation in the Wellington Regional Hospital following the move in April 2009, there was much anticipation of what the new facility could offer.

With this in mind staff set about testing the capability and capacity of the new building and found it was definitely up to the challenge.

SURGERY

A number of services had been limited by the environment in the old hospital and these limitations were reduced and in many cases removed with the move to the new building.

Many of the larger secondary services experienced a 25 percent increase in demand from the local population for acute surgical interventions.

The total number of acute procedures carried out rose 22 percent between 2007/08 and 2008/09, and a further 14 percent between 2008/09 and 2009/10. In the last financial year, this meant 5,834 people received acute surgery.

Similarly, there was a 13 percent increase in elective surgery between 07/08 and 08/09 and a 10 percent increase between 08/09 and 09/10 – resulting in 11,049 elective procedures carried out in the past year.

The Surgical Service moved into refurbished administration space in the Clinical Services Block. The space is light, bright and airy and brings together for the first time in one space the surgical staff, along with their key administrative and support staff.

Cardiothoracic

This service has seen a much improved result over the past year, with greater access to surgery for patients.

A total of 585 patients from Wellington and the wider region received cardiac surgery in 2009/10 – with 576 of these having their surgery at Wellington Hospital. This was a further increase on the 427 of the previous year, and one of the best yet for the service.

The reduction in both the size of the waiting list and the continuing improvements in waiting time are a tribute to the focused team effort in this service.

At the end of the financial year, there were fewer than 30 patients waiting for surgery and the wait time being a matter of weeks for most elective patients.

This is a great achievement, of which the service is justifably proud.

Orthopaedics

Introducing bi-lateral joint replacements (two joints at a time) at Kenepuru Hospital has also provided more timely access to this procedure for these patients.

> The past year was very successful for the Orthopaedic Service, with a record 556 joint replacements completed at Wellington and Kenepuru Hospitals. This was a result of improved access to theatres and in-patient beds across both campuses.

The improved access has meant that there have been times when the current workforce has struggled to utilise the available resources, so in order to meet the demand, the service has plans to increase the Senior Medical Officer workforce over the coming two to three years.

Ophthalmology

After a long anticipated wait, the Ophthalmology Outpatient Department moved into their new location in the Grace Neill Block.

The space has been reconfigured and fitted out to support the delivery of Ophthalmic Services. The new space is a pleasant and functional environment for both patients and staff.

ADVANCES IN NEUROSURGERY

Minimally invasive surgery for removing pituitary and skull base tumours

Since 2007, the neurosurgeons at Wellington Hospital and an Ear, Nose and Throat surgeon from Wakefield Hospital have performed over 70 endoscopic trans-nasal transphenoidal operations for removal of pituitary and skull based tumours.

This minimally invasive technique makes use of sophisticated radiology images, 3-D navigational equipment, telescopes via the nose and a High Definition camera.

The improved technique now makes it possible for most of these tumours to be completely removed with a single intervention reducing the need for patients to undergo radiotherapy or a second operation. Other benefits include increased patient comfort, reduced hospital stay and resolution of symptoms related to coincidental sinus disease.

In some cases the tumours now being removed by this method would have previously been deemed inoperable due to their inaccessible location and the unacceptably high surgical risk.

While currently the surgery is completed in the private sector, as one of the few units in Australasia doing these operations, we look forward to doing this surgery on the Wellington Hospital campus from July 2011, when the additional equipment required to do so will be available.

Awake brain surgery

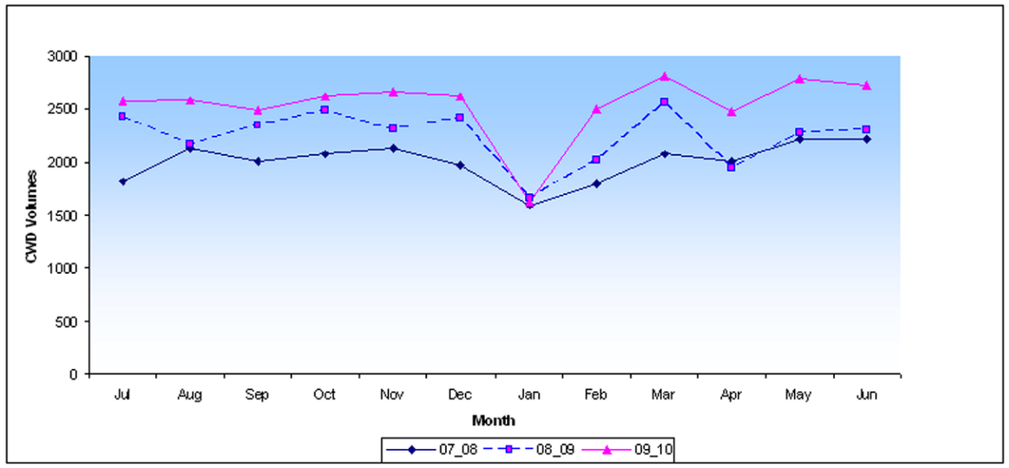
Over the past 18 months, at least 11 patients have undergone neurosurgery for brain tumours via a traditional craniotomy with one major difference – instead of being anaesthetised they have been awake during the procedure.

Brain surgery carries with it a risk of brain injury. The brain is a complex and complicated system and often relatively small insults can result in significant functional damage.

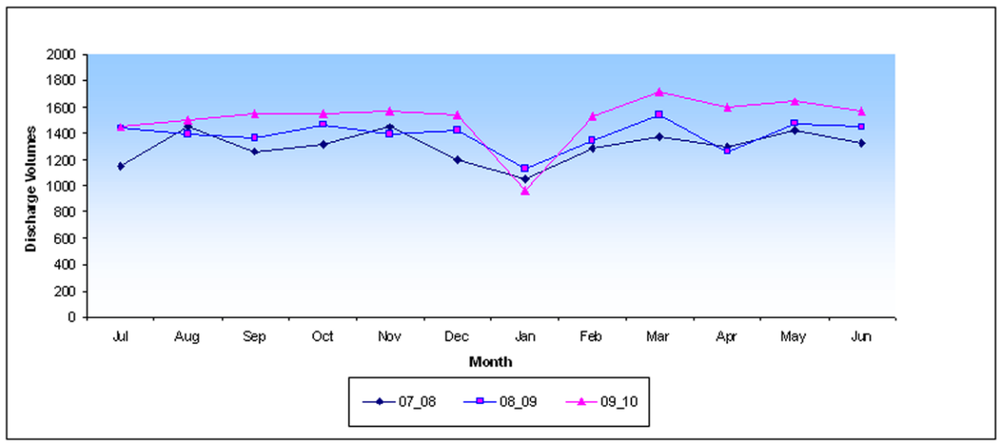
By having some patients awake during the operation to remove brain tumours, ongoing testing of vital functions can be done, so that potential damage can be minimised or prevented entirely. This allows the surgeon to adjust his approach in order to preserve vital function.

We are once again, one of the few neurosurgical units in Australasia using this approach.

Surgery, ICU & Anaesthesia Directorate Case Weighted Volumes for 07-08, 08-09 & 09-10



Surgery, ICU & Anaesthesia Directorate Discharge Volumes For 07-08, 08-09 & 09-10



Number of surgical cases completed

	2007-2008	2008-2009	2009-2010
Not coded	140	115	10
Acute	4,195	5,119	5,834
Elective	8,870	10,043	11,049
Total	**13,205**	**15,277**	**16,893**

OUTPATIENTS

Outpatient appointment numbers continue to grow – up to 148,770, from the previous year's 140,056.

Outpatient attendance
(Including outreach)

	2007-2008	2008-2009	2009-2010
First	32,509	36,371	38,401
Follow-up	96,600	103,685	110,369
Total	**129,109**	**140,056**	**148,770**

INPATIENTS

The number of inpatient discharges – made up of both medical and surgical patients – rose in the past year, continuing the trend of increasing demand for services.

There were a total of 43,658 discharges in 2009/10, up from 40,237 the previous year. The 2009/10 figures were made up of 11,804 day patients and 31,854 hospital inpatients.

ANAESTHESIA, THEATRES, INTENSIVE CARE UNIT (ICU) & PATIENT SERVICES COORDINATION UNIT (PSCU)

The Anaesthetic and Theatre Services settled into their new facility this year, allowing for improved processes, while integrating new technologies into practise. The utilisation of resourced theatres exceeded 80 percent for the year.

The Intensive Care Unit has been very busy in the past year, but was able to meet its increase in demand with their expansion to 16 beds and exceeded 100,000 patient hours for the first time. This service continues to provide outstanding care to patients from all over the central region of New Zealand.

The 24 Hour Operations Service resulted from the improvements to how patient flow is managed across the hospital. The Transit team continues to provide safe patient movement, supporting inter- and intra-hospital patient transfers.

The DHB staff continue to work closely with our key local partners, Wellington Free Ambulance, Westpac Rescue Helicopter and Life Flight Trust, as well as transfer services based across the wider region.

MEDICINE, CANCER & COMMUNITY SERVICES

MEDICAL SERVICES

One of the key additions for the medical service has been the opening of a new Medical Assessment and Planning Unit (MAPU) at Wellington Hospital in November 2009, which has lead to an improved patient experience.

The MAPU, one of the last sections of the new Wellington Regional Hospital to open, is a key step towards improving the flow of patients through the hospital, while ensuring people are seen sooner by those best able to treat their problem.

The 24-bed unit includes six High-Dependency Bay beds, with the remaining beds used for medical assessments and the accommodation of patients who are expected to remain in hospital for less than 36 hours.

About half of the patients are usually discharged home after an assessment and treatment plan, or short inpatient stay in the MAPU, while the rest are admitted to wards for a longer stay in hospital.

The unit means people who are referred by their GP after having been diagnosed can bypass a repeat assessment in ED and can instead be seen directly by a specialist.

The diabetes service is continuing to develop community based secondary care clinics, integrating with primary care teams. These are being held in multiple locations focusing particularly on high needs practices in Newtown, Strathmore and Porirua. The clinic model aims to deliver care in the community and to up skill the primary care team, such that outcomes improve across the whole practice.

The diabetes team have won a Health Research Council contract to research this model and formally assess its impact at the Porirua Union clinic. Additional clinics are also held at Victoria University and Newtown Medical. The Endocrine and Diabetes research unit continues to be very active and growing further with a mix of self-generated studies and pharmaceutical industry sponsored studies. This year sees the first research fellow as part of the group.

The Gastroenterology and GI Endoscopy Services moved to the new purpose built unit in the Ward Support Block.

The new unit has increased recovery bed space allowing for an increase in throughput for endoscopy services.

Outpatient facilities have been retained within the unit allowing flexibility and convenience for staff and patients alike in consultations. This is important as nurse pre-assessment for colonoscopy is now a regular clinic requiring additional room space. Nurse pre-assessment has enabled patients to be better prepared for their procedures with fewer cancelled or abandoned procedures as a result.

Diversification of the workforce has been implemented with technicians now involved in cleaning and re-processing endoscopic equipment, leaving nurses with more time for more patient focussed work.

Gastroenterology has been on target for contract volumes for procedures.

A future challenge for the Service is the introduction of Colorectal Cancer Screening.

Photo: Dominion Post

CANCER SERVICES

In May 2010 the Minister of Health, Hon Tony Ryall, opened the new dedicated brachytherapy suite in the Wellington Blood and Cancer Centre.

With the opening of the suite, the co-location of the brachytherapy service and the Linear Accelerator (Linac) has been resolved, resulting in the centre now having more Linac capacity to treat external beam patients.

This has helped C&C DHB achieve the new national wait time target of four weeks and ensuring that we can deliver a more efficient brachytherapy service.

The C&C DHB Cancer Plan 2010-2015 was also put into action earlier this year. In April 2010 the Board agreed to the plan and a number of the short term initiatives outlined in the plan are now being progressed.

An excellent new resource for cancer patients was developed and introduced in late 2009 to help them keep track of their own progression through cancer.

The objective of the Patient Held Record, developed by the Wellington Blood & Cancer Centre, is to provide patients with information and documentation during their Cancer Treatment.

The development and the introduction of the record was supported by the Cancer Society and the Hospitals and Health Foundation.

RENAL SERVICES

The renal service has had significant success this year, with a record number of 35 renal transplants being performed – 16 from deceased donors and 19 from live donors.

One particular week last year, the teams pulled out all the stops and managed to complete five transplants.

We have established and appointed to the Clinical Nurse Specialist Renal role to support renal inpatient care and specialty nursing practice.

Patients will see the benefit of more staff in the in-centre dialysis unit, with the development of a Health Care Assistant role in this area.

There has also been an extension of opening hours at Porirua Community Dialysis Centre to increase capacity for in-centre haemodialysis.

EMERGENCY DEPARTMENT

Emergency Department presentations continued to rise last year, with 51,383 people being seen. This was up from 48,389 in the 2008/09 year and follows the consistent trend of year-on-year increases in presentations.

The Minister of Health set a range of targets for District Health Boards to reach, one of which was to ensure patients were assessed in the Emergency Department within six hours.

The increased focus on this rule for our Emergency Department has seen an improvement towards this goal.

A number of staff across the organisation have been working to drive this target and improvements towards this goal have been made, with the DHB reaching 80 percent compliance. A number of initiatives have been put in place to improve on this over the next year.

A physiotherapy team has undertaken a pilot in the Emergency Department as part of a number of initiatives for the six hour rule, which was positively received and saved patients waiting long periods for treatment.

ED presentations

	2007-2008	2008-2009	2009-2010
Total	47,095	48,389	51,383

COMMUNITY SERVICES

The Kenepuru Accident & Medical service implemented new after-hours initiatives which saw decreased waiting times and an increased focus on primary care.

The service also participated in the cellulitis project, seeing half of the patients who received treatment.

Also on the Porirua campus, the Kenepuru Surgical Unit has been developed to support increased theatre utilisation at this facility, with increased staff skill and focus around the surgical patient.

Meanwhile, Ward 5 at Kenepuru has been dedicated to care for older adults, with improved multi-disciplinary team processes and planning. The initial implementation of Older Adult and Rehabilitation Services has been followed up with collaboration at the sub-regional level and work with the Central Region's Technical Advisory Service.

Capital Support, the under 65 needs-assessment and service co-ordination centre (NASC), has assisted in the training of other NASCs to implement approved processes and procedures mandated by the Ministry of Health.

The development of Community Health Services has included increasing flexibility and consistency of service delivery. They have increased assistance to inpatients with IVs and specialised wound dressings, to support patient flow through the hospitals.

A Wound Care Clinic has been introduced in the primary care setting as a pilot to investigate effectiveness of networking with primary care and

access for patients. This has already shown signs of success, with positive feedback from patients and primary care.

There has been a new focus on Community Clinical Nurse Specialist positions to provide additional support to areas where there are high patient numbers and need through portfolios of clinical responsibility e.g. wound care, palliative care and acute care. These positions will be responsible for developing appropriate practise standards, education of teams and consistency of delivery.

Capital Coast Rehab have continued to have short waiting times, to the benefit of patients, while the community teams have also explored specific stroke pathways to meet the needs of this specific group in a timely and evidence-based manner.

The Speech Language Therapy service has been involved in the cutting edge surgery being undertaken at Wellington Hospital, which involves patients undergoing craniotomies while awake. The team has also been part of the implementation of a Tracheostomy outreach service from ICU.

In other services, the Dietetics staff have supported the implementation of Buckeye, the new food ordering programme, while the Social Work team has provided support to the implementation of the family violence programme though training and expertise.

WOMEN'S & CHILD HEALTH

WOMEN'S HEALTH SERVICES

Women's Health has spent its first full year in the new hospital and the benefits of co-location of women's inpatient beds, delivery suite and the Neonatal Intensive Care Unit have become evident.

In 2009/10 year, the focus has been on improving work processes and communication within the new environment.

We continue to receive many compliments in relation to the standard of clinical care from women and they also make positive comments about the new hospital facilities.

Maternity Services

It was another busy year in the maternity suite, with 3918 women giving birth to a total of 4018 babies.

The number of maternity inpatients at Wellington means we have increased staffing levels after receiving additional funding for increasing postnatal length of stay. The unit's average daily occupancy target of 32 was achieved – up from the previous year's figure of 28.

Baby Friendly Hospital Initiative

Paraparaumu Maternity Unit on the Kapiti Coast underwent an audit for reaccreditation of the Baby Friendly Hospital Initiative and achieved a remarkable result of a 99 percent exclusive breast feeding rate.

Of the 72 maternity services across the country that have been BFHI accredited, there are only five that achieved 99-100 percent.

The audit, which took place in April, was the third time the unit had been assessed – an event which is undertaken every three years.

Kenepuru Maternity Unit in Porirua is due for assessment in August 2010 and Wellington in November 2010.

Breastfeeding Education and Support

During the year we successfully recruited to the position of Māori & Pacific Lactation Consultant.

With increased resources, we are now able to provide antenatal breastfeeding education classes at Kenepuru Hospital in addition to the Wellington classes and both have high attendance rates.

To increase the access to specialist lactation consultancy expertise in the community, the Breastfeeding Support Centre in Cannon's Creek, Porirua, opened in February. The centre is open for two, four-hour sessions each week.

Pregnancy and Parenting Education

This year we have introduced funded Pregnancy and Parenting Education classes.

While the more traditional evening classes over a 4- to 6-week period continue to be available, we have also introduced group session classes. This innovative model provides complete antenatal care (assessment, education and support) in a group setting. This model is aimed at the primary care women who are most vulnerable and hard to reach.

Newborn Hearing Screening

In 2009/10, we offered hearing screening to 3918 babies and just 65 (1.6 percent) declined the screening.

The most common reasons for declining screening included non-residents who are required to pay, where there is a language barrier, and women who have chosen early discharge and who do not wish to return for outpatient screening.

The remaining 93 babies are those who were transferred from another DHB to NICU and the screening has not been done prior to transfer back to DHB of origin or discharge home.

Now that Newborn Hearing Screening is available at all DHBs, these missed babies will be picked up by the local service.

We have now been offering Newborn Hearing Screening for just over a year and 14 babies have been diagnosed with a hearing loss and received early intervention.

Gynaecology Services

Improved staffing and utilisation of theatre lists for gynaecology resulted in a year end result of 232 case weights, or 26 percent, more cases carried out than the target.

Improved access to gynaecology First Specialist Appointments also achieved a reduction in waiting time.

Colposcopy services also reduced waiting time over the year and women now wait a maximum of 3 months for a non-urgent appointment.

We exceeded our target by 273 for colposcopy examinations and 30 for colposcopy treatments.

The service also purchased an image capture system so a digital record of the examination can be held on the patient's clinical file. This was a recommendation from the last colposcopy audit and also assists in the teaching of medical students and trainee registrars.

CHILDREN'S HEALTH SERVICE

This year saw the position of Professor of Paediatrics being taken up in March by Professor Marie Johannesson.

Prof Johannesson has an extensive research background and her specialties include: working with children with Cystic Fibrosis, children with respiratory disorders and children with obesity.

A new paediatrician also joined the service in March, adding to the experience of the team. Dr Arno Ebner originates from Germany and was working in Timaru before coming to Wellington, and has a special interest in paediatric oncology.

The new children's outpatients service on Level 5 of the Grace Neill Block opened in the beginning of February 2010 and is a great improvement on the previous area.

The new facility has meant we have been able to increase from 6 to 14 consulting rooms and as a result, the Paediatric Surgeons have been able to hold their clinics in a child friendly environment.

The reconfiguration of the Children's Ward will provide an enhanced acute assessment area, better drug storage and working space. Planning for this work in the Children's Wards is underway.

Paediatric Surgery

This unit was very busy this year and once more there was an increase in the number of children receiving elective surgery.

We planned to carry out about 358 case weights in the past year, but we actually delivered 475.

In recognition of this, this service has applied for and been given some additional resources for surgical volumes for the coming financial year.

Neonatal Intensive Care Unit

Staff in the NICU organised and successfully hosted the Perinatal Society of Australia and New Zealand Conference in March, with a number of international speakers taking part.

The service is still enjoying their new facilities, and a lower volume of babies over the past year has given them time to properly settle in.

The average occupancy over the year was 32 patients. There was,

however, a peak in the last two months where the numbers were over 40 and at one stage as many as 50 babies. Overall 824 babies were admitted to NICU in the 09/10 year.

The service is adding more resource with two more Neonatal Nurse Specialists who started training earlier this year. It is expected that they will take up positions in December.

It is pleasing to see the excellent level of training amongst the junior staff, with eight junior doctors in the department recently completing their Part One exams. This year the unit finished on a good note with a waiting list of Registrars and Senior House Officers who want to come and work in this service.

Genetics

The Genetics Service is in discussions with the National Health Board around setting up the National Clinical Service on our Wellington campus. The genetics laboratory continues to expand its repertoire of tests available, including a new blood test for detecting DNA discrepancies in unborn babies.

The Child Development Team

The number of children referred for Autism Spectrum Disorder Assessment has increased and accordingly, we have increased the number of clinics for this assessment to reduce waiting times.

The majority of the year there has been a full complement of staff which has also helped reduce waiting lists and increased staff morale.

PRINCE WILLIAM'S VISIT

January 2010

MENTAL HEALTH SERVICES

HEALTH PASIFIKA

A brand new facility was opened to house the Health Pasifika team, vastly improving the environment for staff and clients.

The Health Pasifika Mental Health Teams were based in dated facilities on the old Porirua Hospital grounds for a number of years.

These refurbished facilities are especially designed to reflect the Pacific cultures right on the Kenepuru Hospital campus.

It allows for the continued ability for Health Pasifika clinicians to work within a purpose-built environment that enhances the cultural input into the clinical work undertaken by staff.

Access to the service has also increased through having a bus-stop close by, as well as the Kenepuru Hospital shuttle service operating between the three sites – Wellington, Porirua and Kapiti.

TE HAIKA

Te Haika (the anchor) has been set up to coordinate and action all referrals to the local mental health sub directorate.

The objective of Te Haika is "to deliver an integrated Mental Health Service that is easily accessed".

Te Haika's central role involves the following:

- A toll free number (0800 745477 listed in the 09/10 White Pages)
- Currently during day time hours but planned to go 24/7
- All crisis and new referrals to General Adult MHS with a progressive plan to include all adult services in the first half of 2011 across the Local Mental Health Directorate
- GP/ Police/ Emergency Department first point of contact and priority treatment through a priority call line
- A call back facility to callers phoning into Te Haika as of the beginning of 2011.

The benefits of Te Haika include:

- Enhanced, clear and immediate access to clinical resource
- Prompt and consistent triage and assessment
- More efficient utilisation of resources
- Real time management of issues to minimise escalation to crisis
- Improved access data for analysis and planning
- Shared Global diary for MH Teams.

The indications are that Te Haika is having a positive effect on access within General Adult Mental Health Services. There have already been some excellent results, including:

- An increase in referrals
- An increase in people being seen
- A decrease in waiting times
- A decrease in multiple handling of referrals.

There has also been direct feedback about the improvements from service stakeholders such as GPs.

Te Haika is based at Kenepuru Hospital.

OTHER SERVICES

There have been a number of new facilities and initiatives put in place over the past year.

These have included the opening of Ruaumoko, the new Māori cultural centre for the Ratonga Rua o Porirua campus.

Also opened was Pukeko House, a purpose-built four bedroom Lockwood facility on the Ratonga Rua Hospital campus, which increases service flexibility and the number of beds available for the central region in the Rehabilitation and Extended Care Service.

The Ratonga Rua Hospital Duress Project was put in place, replacing old equipment in the inpatient areas. It involved the installation of new equipment for access cards and closed circuit cameras.

A staff exchange programme was put in place at Te Korowai-Whariki, the regional forensic facility. The programmes are designed as a workforce development initiative, with like organisations both within New Zealand and abroad.

This year, staff from the Intellectual Disability Service Group and from Central Regional Services Group have both visited and exchanged with staff from similar services in Melbourne.

KENEPURU HOSPITAL & KAPITI HEALTH CENTRE

KENEPURU HOSPITAL

Kenepuru Accident & Medical Clinic continues to be a very busy unit, functioning similarly to an after hours GP-run medical centre.

In the past year, patient numbers remained high – at about 34,000 visits.

Outpatients

In order to provide the opportunity for as many patients as possible to have access to specialist appointments close to home, we have boosted the number of outpatient clinics being held.

> This has increased by 12.8 percent in the past year, compared with the previous year. The total number of outpatient appointments reached 35,377 in the 2009/10 year, up from 30,866 in the previous year.

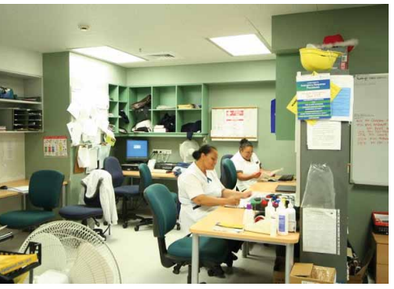
The two key reasons for this increase have been:

- The introduction of new clinics over the past 15 months – including Anaesthetic Pre-assessment, General Surgery/Breast, Newborn Hearing, Neurology and Pain Management.
- And some clinics having significant increases in numbers this year. Those to experience the highest percentage increase were Endocrinology, Gynaecology, Endoscopy, Ophthalmology and Respiratory.

Surgery

In 2008/09 we had an increase in surgical activity at Kenepuru while the theatres at the new Wellington Regional Hospitals were under construction and the key for this year was to ensure that a significant amount of this remained at Kenepuru.

This would provide us with a solid elective surgery base heading into 2010/11.



Overall for 2009/10 there were 2656 elective procedures done at the Kenepuru theatres.

This is 305 fewer than the previous year however, overall this was a good result given the migration to the new hospital theatres and the work done by Orthopaedics to widen the scope of surgical procedures.

In 2009/10 the following percentages of the total elective cases were carried out at Kenepuru Community Hospital:

- Dental Surgery 63.2 percent
- Ophthalmology 50.0 percent
- Orthopaedic 49.8 percent
- Paediatric 21.5 percent
- Gynaecology 17.1 percent

Changes implemented to support surgery at Kenepuru

Audits were carried out that included the surgical list and patient cancellations, changes to theatre sessions, endoscopy list turnaround times and patient selection processes.

Other initiatives have included:

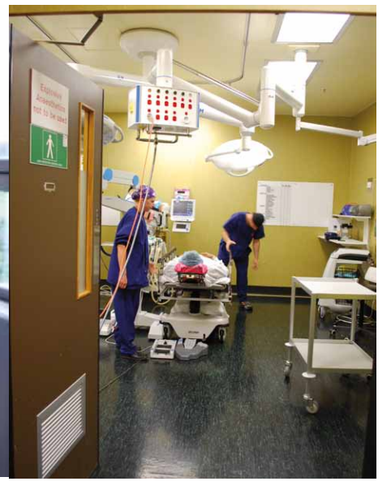
- Updated pain management training for nursing staff completed, while RMO training is underway and will continue over upcoming months as required
- The Kenepuru surgical patient selection process has been reviewed and changes to the process have been agreed by senior clinical staff. Anaesthetic staff make the final decision on whether a patient is fit for surgery at Kenepuru or not
- Radiology support is in place until 5pm – previously this was 2pm, which impacted on some surgery lists
- There have been changes to administration support to better facilitate gastroenterology activity and streamline the documentation process
- Two additional half-day scoping lists per week have been added
- Two additional clinics per month have been added by gastroenterology
- A high observation area is now in the Kenepuru Surgical Unit with two monitors now in place
- There is now a new anaesthetic pre-assessment clinic at Kenepuru, including five half day nurse and two half day Senior Medical Officer clinics. Patients for these clinics will initially be orthopaedic patients but once the process is evaluated other specialties will be included. Patients for these clinics will be selected from Tawa north.
- The development of transfer protocols for deteriorating patients at Kenepuru has progressed through the quality process and will be presented to Clinical Governance for approval
- Data collection is underway for comparison between July 08 and July 09 in terms of Kenepuru Outpatient activity
- Data collection of activity for DHB-funded services in Kapiti is underway in preparation for public campaign. This will include a breakdown of Kapiti residents accessing services at Kenepuru.

Work is continuing on initiatives to increase the utilisation of the Kenepuru surgical facilities.

Older Adult and Rehabilitation Services

The development of Older Adult and Rehabilitations Services continues with a work plan in place for completion by the end of the calendar year.

Work with our Planning and Funding directorate is ensuring the strategic direction for delivery of services to older adults is able to inform the focus within our services on improvements within the Hospital and Health Service.



Work has also begun with Hutt Valley and Wairarapa DHBs to explore opportunities for sub-regional collaboration in older persons and rehabilitation services, with the current focus on sharing ideas and plans to look at future clinical audit opportunities.

Our current work plan is focused around ensuring that appropriate access criteria, particularly for inpatient service delivery, is clear and ensures timely transfer to Kenepuru in support of the six-hour Emergency Department rule.

We have also completed some patient journey work with Regional Technical Advisory Service, which will be collated with central region information to provide baseline data to inform improvement priorities.

Consumers

The Consumer Committee for Kenepuru community hospital is progressing with expressions of interest currently being sought.

Staff forums were held so that staff can also assist by identifying appropriate consumers who access their services.

A selection panel will assess applications in October and training for this Consumer Committee is scheduled for November 2010.

KAPITI

Kapiti Health Hub

The Kapiti Health Hub, which includes representatives from Kapiti Coast District Council, Capital and Coast DHB, Kapiti PHO, Kapiti Community Health Group Trust, Te Ati Awa Ki Whakarongotai, Winnie Laban's office and chaired by local MP Nathan Guy, has met recently to discuss further opportunities to increase access to health services closer to home for Kapiti people.

The Kapiti Health Hub has identified the importance of continuing to grow outpatient services in Kapiti.

Over the upcoming months, work will be done to identify which outpatient clinics are most viable for Kapiti.

Clinical staff will be consulted to see what opportunities for growth exist, including the possibility to work more closely with primary health providers and community services which may have an interest in developing some local special interest services.

We will also be investigating what resources these services may need to support an increase in service delivery in Kapiti.

Outpatient Clinics

The number of people seen in outpatient clinics at Kapiti Health Centre this financial year compared with the previous year has increased by 262 (5.1 percent). The most significant increase in the past few months has been in Accident, Treatment and Rehabilitation and diabetes clinics.

In the 2008/09 year, we provided 4869 appointments, but this increased to 5131 in the current year.

A list of clinics now includes:

- Cardiology
- ATR
- Diabetes
- Endocrinology
- Gastroenterology
- General Medicine
- Gynaecology
- Haematology
- Newborn Hearing
- Obstetrics
- Orthopaedics
- Paediatric Medicine
- Paediatric Diabetes
- Paediatric Endocrinology
- Renal

CLINICAL & CORPORATE SUPPORT SERVICES

Clinical and Corporate Support Services have again achieved significant financial efficiencies with a favourable year end result of $7m compared to budget. A number of initiatives were achieved by the directorate over the last financial year, including:

IMPROVING PATIENT CARE AND THE OVERALL HOSPITAL EXPERIENCE

Food, Food and More Food!

For the first time in 10 years, the Patient Menu underwent a full review and revamp with the intention to give patients modernised meal options which not only mean more culinary choices for the patient but also ensured that the menu met the dietary needs of unwell patients.

The new menu is designed to capture 35 different diet codes as well as nutritional standards and dietician recommendations.

The new menu was developed by Spotless Services Limited in conjunction with our own dieticians, and complies with food safety and nutritional standards. It is now more versatile and takes into account differing age groups and cultural needs, especially those who prefer vegetarian options, and it also has a specific vegan menu.

To date, the feedback from patients has been very favourable with comments such as:

"Your staff are a real asset…food is pretty good with good variety."

"Dear Chef, thank you for such a tasty dinner. No need to wash my plate."

"The choice of food is better than some hotels around."

Buckeye – Integrated Food Management System

This year we rolled out an Integrated Food Management System known as Buckeye, which eliminates the manual processing of a patient's meal from the bedside to the kitchen.

The system allows the dietician to update the dietary requirements of the patient in real time and thus changing the meal choice associated to that diet code to ensure that the right meal gets to right patient at the right time.

Additional benefits of the system include:

- The patient's ability to order meals for same day consumption rather than the day prior to service delivery
- Improved diet management through real time changes and data transfer to the kitchen
- Improved control over food quality and consistency
- Improved accuracy in the delivery of meals.

Reducing the (Did Not Attend) DNA Rate

Patient Administration Services implemented a number of strategies to encourage patients to attend their appointments.

The team vigorously worked on a reminder system and the result has seen an improved attendance rate of 1 percent, which translates to 400 additional First Specialist Appointments and over 1200 follow up appointments being attended first time.

Improved Interface with Primary Care

Patient Administration Services have been proactively working with the GP Clinical Advisor to improve communication and processes between the DHB and the Primary Care Services.

The focus has seen an improvement in communication between the parties with respect to patient waiting lists and specialist assessment appointments. A dedicated priority line was set up in the call centre to allow faster accessibility for the GP to obtain information from patients' medical records and status.

Wayfinding

With all of the changes to Wellington and Kenepuru Hospital facilities over the past couple of years, a number of wayfinding exercises were held at both sites to provide an independent view on the ease of identifying and accessing health services when on campus.

A good level of feedback allowed us to improve our signage on both campuses to minimise the level of disruption experienced by visitors trying to find their way to our many services.

Cutting Edge Testing

Capital &Coast DHB was the first laboratory in the country to validate and implement a vastly more sensitive test for diagnosing Myocardial Infarctions (Heart Attacks).

This test is called high-sensitivity Troponin-T and has the potential to diagnose the condition earlier than the more conventional Troponin-T test.

Swine Flu

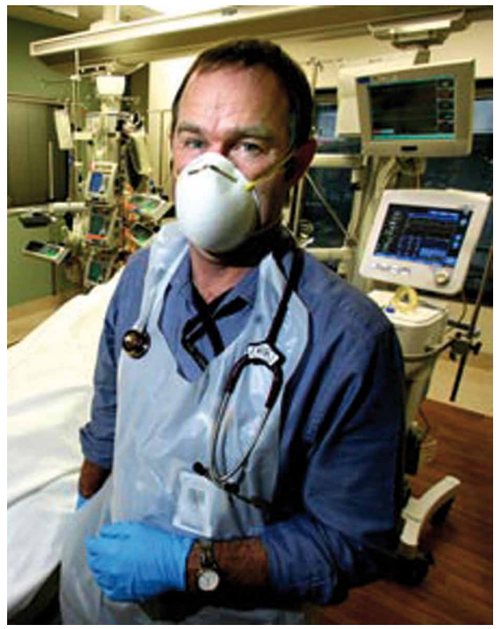


Photo courtesy of The Dominion Post

Swine Flu placed a heavy toll on the community and health services last year and the Wellington Hospital laboratory played a pivotal role in our region by providing the results of very large number of tests in record time.

This allowed patients, and their families to have a speedy diagnosis and appropriate care.

Wellington was the first region in New Zealand with a major outbreak and our experience led the country. We helped to shape how other regions prepared and managed this epidemic.

Radiology

Radiology introduced two new investigations – CT Colonography and Cardiac MRI scans – to improve our patient care and patient experience.

These new tests give much better information and are less invasive than the tests they replace.

Radiology and neurosurgery combined to perform a world first stent procedure for a brain aneurysm. The special tapered artery stent was the first of its type to be used to bypass the balloon like aneurysm that had caused a life threatening bleed.

Technology

A number of new technologies were introduced with the opening of the new regional hospital.

Wireless VOIP telephones have revolutionised the way some of our critical services work, such as our intensive care staff now being able to make and receive phone calls, on the hospital phone system, from anywhere in the building.

IMPROVING STAFF FACILITIES/ACCESSIBILITY AND COLLABORATION

In June 2010, the $346 million project, which encapsulated the New Regional Hospital Build and associated project works was signed off. The sign off by the Crown Health Financing Agency confirmed that all works as outlined in the business case for the new Regional Hospital Project at Kapiti, Kenepuru and Newtown sites had been completed and done so within budget.

But after all the new buildings were occupied, the project team were not yet able to have a rest.

A significant amount of refurbishment was achieved in the 2009/10 financial year, with a focus on centralising all Corporate Services on the Wellington Campus, including bringing back the Planning and Funding Directorate from Cambridge Terrace and ICT services from the Ewart Building.

The Grace Neill Block, and several floors of the Clinical Services Block and Ward Support Block were refurbished into office space.

Work completed during the year resulted in approximately 1500 staff being relocated in new or refurbished premises.

Additional parking was provided as part of the redevelopment work with the demolition of the Community Health Building and old Finance Prefab building.

The team worked hard on refurbishing floors for Victoria University and MRINZ for the collaboration work in the spirit of the Health Education Research Collaboration (HERC) and also built a lecture theatre and seminar room to enable greater availability for staff to access training facilities on site.

The opening of the staff-only cafe in June 2010 was the realisation of the vision to create an environment where staff felt comfortable and could relax, as well as provide informal lounge areas for staff to meet, socialise and discuss clinical issues confidentially.

The cafe has been a resounding success with an increase in patronage being experienced, highlighting the need for such a facility.

IMPROVING OUR FINANCIAL POSITION

Central Equipment Pool

The roll out of the final stage of the Central Equipment Pool was completed in April. The pool was created in 2009 with the intention of streamlining the process used to rent or hire speciality equipment to enable specific patient care.

A significant amount of clinical time was being spent on acquiring such equipment – both at an inpatient and outpatient level and cost was not transparent or adequately monitored.

The centralisation of equipment and process has seen a reduction of operating expenditure of over $1.5 million per annum for the organisation.

Further analysis after obtaining an initial 12 months of data will no doubt further benefit the financial position of the organisation by considering purchase versus rental costs.

The Central Equipment Pool service also offers clinical staff the following benefits:

- Designated equipment rooms to store equipment and provide an area for items requiring removal and replacement
- An agreed level of equipment available for immediate use
- A scheduled pick up and delivery service in clinical areas
- A reduction of paperwork associated with a request or return of equipment
- Improved equipment tracking to manage service, maintenance and replacement requirements

The central pickup point on wards also supports staff with their ongoing clinical projects, such as the nursing programme, Releasing Time to Care.

Feedback from clinicians has been very positive, an example of which is:

"There's now a system for clinical and operational monitoring so that we can evolve the service to make sure we meet the needs of our patients. As a clinician, when I send notification that a piece of equipment is required, it is a relief to know that I don't have to worry about how the piece of equipment gets there, it just gets delivered and collected when I'm finished with it."

Decoupling of the Kenepuru Site

All surplus land on the Kenepuru site was decoupled and subdivided this year and then sold in two lots – one lot to the Crown Health Financing Agency and the main portion of the land to the Crown.

The decoupling project was a very intense number of months ensuring the essential services of the site were maintained and future-proofing the area to ensure continued supply of services is protected for the future use of the hospital sites.

The reduction in the land footprint ultimately reduces the unnecessary operating costs associated with the area, and enables a more focused emphasis being placed on the core health services provided on the retained land.

Reducing our Laundry Imprest Levels

The laundry team took out first place in the 2009 Quality Quest awards with their Business Process Re-Engineering Project, which focussed on the linen imprest levels held within the wards and the method of transporting the linen to and from the laundry.

The outcome of the review resulted in a significant reduction of imprest linen per ward, improved infection control procedures and greater delivery efficiencies.

RESEARCH

HEALTH EDUCATION AND RESEARCH COLLABORATIVE

The Health Education Research Collaboration (HERC) centre has moved from vision to reality with the refurbishment of 8000 square metres of education and research space on the Wellington Hospital site.

It is now occupied by Victoria University's School of Nursing, the Medical Research Institute of New Zealand, and with plans for a Massey University and Whitireia Polytechnic presence next year.

The newly refurbished space also provides for a new 175-seat lecture theatre and a 50-seat seminar room with state-of-the-art audiovisual technology. These rooms have been named after leading former and current staff members who have each contributed a huge amount to the education of others, as well as the excellent care they have provided to many, many patients over the years.

The smaller room has been named the Easthope Seminar Room, in honour of long-serving Cardiologist and Wellington Hospital's own historian, Ron Easthope.

Meanwhile, the larger room has been named the Horne Lecture Theatre, after leading Orthopaedic Surgeon, Professor Geoffrey Horne (ONZM).

We are delighted that both these outstanding clinicians agreed to have these facilities named, most deservedly, in their honour.

The HERC represents a collaboration and partnership of academic, research and teaching organisations which aim to foster research, clinical trials, health education and training with the ultimate aim of improving health outcomes in New Zealand.

Partners in HERC include:

- Victoria University of Wellington School of Nursing, Midwifery and Health and Biological Sciences
- University of Otago School of Medicine and Health Sciences
- Medical Research Institute of New Zealand (MRINZ),
- Whitireia Community Polytechnic College Faculty of Health Education and Social Sciences
- Massey University School of Health Sciences
- Wellington Free Ambulance.

Other key milestones include the appointment of 11 of our senior medical staff as Adjunct Professors with the Biological Sciences faculty at Victoria University; the development of the Post Graduate Diploma in Clinical Research at Victoria, run by our own Dr Jeremy Krebs, Clinical Leader, Diabetes and Endocrine Service; and the recent advertisement for a joint appointment for a Professor of Clinical Research also at Victoria University.

This year has seen a significant increase in Health Research Council funding for research associated with C&C DHB staff and services. We, in partnership with Malaghan Institute of Research, have been awarded $4.5 million.

The Research Office has now been established and will provide a one stop shop for research at C&C DHB. The aim of the office is to provide a well organised and efficient service to support and assist our researchers.

Planning is well underway for a 12 to14 bed Clinical Trial Unit (CTU) and it is scheduled to open in early 2011.

The facility will enable Phase 2, 3 and 4 clinical trials to be performed 24/7 on the Wellington Regional Hospital campus. The facility will also provide a space for multi disciplinary and service based researchers to congregate and collaborate.

Many of our staff have carried out significant research over the past year, much of which has been published in leading national and international journals and other publications.

A number of staff also hold positions on boards and committees in national and international medical organisations. Staff regularly contribute and present at conferences around the world, where they share their knowledge and expertise on their speciality with other leading medical professionals.

If you would like to see a list of published work, conferences presented to and positions held, please visit www.ccdhb.org.nz/publications

PRIMARY, INTEGRATED & COMMUNITY CARE

INTEGRATION BETWEEN PRIMARY AND SECONDARY SERVICES

During 2009/10 a key focus was to enhance integration between primary and secondary services.

One initiative has been the establishment of the Clinical Pathways Collaborative, which is a new way of working across the interface between primary, secondary and tertiary services.

This process involves general practitioners, specialists, nurses, allied health and management personnel working together to develop pathways to improve patient care and to set up models for working together across the continuum.

These pathways in turn aim to reduce needless referrals and hospital visits by ensuring ready access to diagnostic and specialist support in primary care and community settings.

To administer and oversee this clinical integration programme, we have established the Primary/Secondary Clinical Governance Group, chaired by the Chief Executive.

The group's purpose is to ensure patient outcomes are maximised by improving quality and reducing risk across the patient journey through Primary/Secondary/Tertiary systems.

Workstreams established during 2009/10 included:

- an anticoagulant project developing a safe and effective means of initiating, monitoring and dosing complex anticoagulant therapy
- gastroenterology clinical pathways
- improved cancer collaboration across Primary and Secondary Care
- more integrated palliative care services across the district
- an improved journey for clients moving from paediatric to adult care.

Under each workstream, each had key issues to focus on.

Palliative Care

- Making provision for Palliative Care patients to access required medication at any time of the day or night in a timely way, close to their residence.
- All patients with life limiting illness having their care assessed and planned for, their needs met, to be involved in conversation regarding their future care and end of life, be able to access information and tools to improve their quality of life remaining.
- Shared care across the hospice, HHS palliative care service, district nurses and primary care.

Paediatric to Adult Transition

- Referral pathway for patients aged over 16 years with ADHD needing review of medications and/or further assessment.
- DHB participation in a network regarding the issue of no clinical pathway for over 16-year-olds with an intellectual disability.

Cancer

- Improving the referral by GPs and feedback to GPs by improving communication and sharing accurate information.
- Improving shared care of patients by educating clinicians to promote Care Plus and identify opportunities where GPs can help with follow-up.
- Providing education to improve GPs understanding and knowledge in the treatment in the care of patients, e.g. side

effects of medication, modern interventions.

Gastroenterology

- Guidelines for Primary Care on the diagnosis, investigation and dietary management of Functional Gut Disorder or Irritable Bowel Syndrome
- Data system capture and triggers for high risk patients requiring recall or surveillance in the future
- Consistent referral criteria for GPs for CT Colonography in the community.

Anticoagulation Therapy

- A new primary and secondary integrated model for anticoagulation management was developed and approved by the Primary-Secondary Clinical Governance Group.
- This model is unique, due to its collaborative approach across the primary and secondary interface and includes a number of components including standardised provider education, patient information, patient care across the interface, anticoagulation protocols as well as quality and safety systems.
- The model will be implemented in 2010/11.

Cellulitis management in the community

- The community cellulitis treatment pilot was completed and the model is under review through a Clinical Pathway Collaborative process involving primary and secondary care clinicians.
- More than double the targeted number of adults were given IV therapy for cellulitis in a community setting in the past year and primary health care are keen to continue to work with secondary care, to make improvements in cellulitis care across the DHB.

CLINICAL ADVISOR PRIMARY AND INTEGRATED CARE

The Clinical Advisor Primary and Integrated Care has been heavily involved in the above workstreams.

Particularly, the Clinical Pathways Collaborative to improve Primary Secondary Integration, which will develop pathways to improve patient care and to set up models for working together across the continuum.

This will focus on defining clinical pathways by collaboration of primary and secondary clinicians.

This includes ongoing work on the projects outlined above – the anticoagulant project, which aims to develop a safe and effective means of initiating, monitoring and dosing complex anticoagulant therapy; gastroenterology clinical pathways; improved cancer collaboration across Primary and Secondary Care; more integrated palliative care services across the district; and an improved journey for clients moving from paediatric to adult care.

Management and oversight of this clinical integration programme will be undertaken by the Primary/Secondary Clinical Governance Group.

Further input has also been made in the following areas:

- Cooperation with specialist clinicians into referral and discharge processes involving the new Medical Assessment and Planning Unit
- The development of a new Acute Medical Clinic
- The development of a new regional TIA (Transient Ischaemic Attack) and non-disabling stroke service based at Wellington Hospital for those with possible stroke symptoms
- Rollout of a new electronic discharge summary
- Improved telephone access for GPs to specialists for telephone advice and a priority telephone line for Primary Care into the hospital.

PRIMARY HEALTH CARE NURSING & INTEGRATED CARE

Workforce development and integration continues to be a key focus of the primary health care and integrated nursing care team's work.

We have had appreciable success with the expansion of our Nurse Entry to Practice (NETP) programme, with a total of 10 new graduates employed into both primary care/general practices and community based aged and residential care services joining our programme.

Our nursing professional development and career pathway has also been further strengthened across the health care continuum, with a growing number of primary health care services signing a professional development agreement with C&C DHB.

This agreement provides access to registered nurses across the district to the same career pathway framework support, further contributing to both integration and career portability .

Additional professional support was provided through Clinical Training Agency funding for 40 registered nurses from primary care/general practices and community based aged and residential care services enrolling with tertiary providers to undertake a wide range of post graduate education.

An appointment has been made to the nurse practitioner candidacy position in the Older Person Services. This position aims to support aged and residential care by building capacity and capability within the sector as well as minimising hospital admissions.

The DHB's rates of immunisation have increased over the last year and we are heading towards 95 percent of two year olds fully immunised at a steady rate. We continue to achieve well above our immunisation targets and are a leading DHB in increasing immunisation rates. We are on track to achieve the target of 95 percent two year olds fully immunised by 2012.

A feature of our work over the past year, and certainly an achievement to be proud of, is the minimal disparity that now exists with immunisation rates for Māori (86 percent) and Pacific people (89 percent) two year old population. We owe this to two high functioning Outreach Immunisation Providers that are making a direct, measurable impact on reducing inequalities for Māori and Pacific children.

It has also been very pleasing to see the higher numbers of registered nurses in primary settings taking up the opportunity of postgraduate education.

OTHER HIGHLIGHTS FOR THE PAST YEAR

Ambulatory Sensitive Hospitalisations (ASH) targets have been exceeded and we are one of the leading DHBs in the country.

Similarly, immunisation targets were achieved and our rates are well above the national average.

Our diabetes detection and cardiovascular risk targets were achieved for all ethnicities.

Meanwhile, all of the PHOs' CarePlus uptake continues to be above the national target of 70 percent enrolment.

Consolidation of PHOs

Consolidation of PHOs within the C&C DHB district has been a focus in 2009/10 with Capital, Tumai mo te Iwi and Kapiti PHOs combining to form a new entity Compass Primary Care Network; and Porirua Health Plus and South East and City PHOs combined into a new entity Well Health.

Both these new entities took effect from 1 July 2010.

Contribution to DHB Financial Recovery Plan

The DHB has worked closely with the primary care sector in the last year to identify savings that could be made in 2010/11 with minimal impact on health service delivery.

This exercise has led to $3 million savings from 1 July 2010.

IMPROVING THE HEALTH OF OUR CHILDREN AND YOUTH

Child health has received a significant increase in focus within the DHB with the Board signing off a new strategic area of focus targeted at improving the health of children across our district.

As a result, a five-year action plan is currently in development with an initial focus on:

- Eliminating the incidences of rheumatic fever within the district
- Improving the detection and treatment of serious skin infections amongst children – particularly in Porirua
- Improving the detection and treatment of respiratory conditions amongst children in the district.

A new permanent Child Health Improvement position has been established in the Planning and Funding Directorate to support this work over the coming months.

The DHB's Child Health Action Group, led by Community Paediatrician, Dr Nikki Blair, has been exploring how primary and secondary services for children can be better integrated, and where there are opportunities to improve child health outcomes from both social determinant and service delivery perspectives.

This work is ongoing and it is anticipated will produce good solutions over the coming months.

IMPROVING THE HEALTH OF OLDER PEOPLE

The demand for the provision of home support and care services to those aging in home continues to outpace funding increases for these services.

The DHB continues to support the restorative approach to community support services but as funding pressures increase, enhanced targeting of services to those most in need is required to ensure that our aging population is equitably and appropriately served.

Significant work is currently underway to improve the efficiency of community support services over the coming months, with significant work already completed in respect to the improved assessment of client need and allocation of required services.

Improved resourcing of respite and day programme services has been an important move this year, as has the significant improvements made in regularly reviewing the needs of clients at home.

The year ahead will produce further funding pressures and the DHB has recently brought its eligibility criteria around lower level cleaning and home management services in line with other DHBs.

The restorative approach is also being redeveloped within the service model to ensure it is better targeted and more focused on restoring function and social participation than before.

These changes will assist the DHB to continue to provide the high quality services at home that our older people need.

A very strong level of demand for aged residential care services, particularly in the areas of psycho-geriatric and dementia care are also starting to impact on capacity availability in the district.

This growth is forecast to continue for some years and Capital & Coast, together with Hutt Valley and Wairarapa DHBs are working together to develop a capacity management plan for the years ahead.

Our local facilities continue to provide high level of care with strong monitoring and clinical and safety improvement activity being driven out of the planning and funding directorate.

IMPROVING ORAL HEALTH

The implementation of the Oral Health Service Provision for Child and Adolescents Project is on track.

The School Dental Service has significantly increased screening rates for children. Consequently necessary treatments are delivered earlier, which should result in fewer children having decay problems requiring a hospital admission.

The school dental service finished the calendar year with an arrears rate of 6.8 percent, which is equal to about 3,500 children. This is an improvement of 6 percent (3,000 children) on the 2008 calendar year figures.

None of the 3,500 children are waiting longer than 15 months since their last annual examination. We hope to have a zero arrears rate by the end of this calendar year.

Oral health achievements are reported for the calendar year. The table below provides the 2007 to 2009 activity trends for the Hutt Valley DHB and Capital and Coast DHB.

(C&C DHB and HVDHB)	2007	2008	2009
Enrolees	50,915	51,028	51,507
Annual Examinations	33,423	44,886	47,445
Total Contacts	57,135	67,534	73,687
Completed Patients	32,620	44,010	47,522

The Oral Health Business Case build of the new dental facilities is progressing for the first four sites: Koraunui, Naenae, Brandon and Titahi Bay.

Tenders for the build close in August 2010 with construction contracts awarded in September, with a build completion date of February 2011.

Consultation with the communities has taken place before finalising each site. Regular newsletters update key stakeholders and communities of progress.

LONG TERM CONDITIONS

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.

All our PHOs have maintained their percentage of people enrolled in Care Plus above the national goal.

The MOH targets for cardiovascular screening have also been achieved for all population groups.

A diabetes multidisciplinary case conferencing model through the collaborative work between the primary and secondary care teams is working well in Porirua.

An Annual Diabetes Report has been completed, highlighting the activities and outcomes achieved in the DHB for diabetes patients.

We have continued to support people with diabetes and cardiovascular disease with the ongoing development of diabetes and cardiovascular support in the DHB.

This has been through the extension of the diabetes hospital team's support in the community, the practice support by the diabetes nurses placed with PHOs, the dietary support through the community dieticians, as well as the cardiovascular risk screening and management support.

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

The pulmonary rehabilitation programme has been strengthened following the completion of a successful pilot.

COMMUNITY ACTION

The Kapiti Health Hub was convened during 2009/10 comprising members of the DHB, Kapiti Community Health Group Trust and the Kapiti City District Council, to explore opportunities for the development of services at the Kapiti Health Centre.

An assessment was undertaken of the existing services and health needs.

Having the Kapiti community working in partnership with the DHB provides a great opportunity to further enhance existing services.

The Mayor and other members of the Kapiti Health Hub have identified this as a priority and are prepared to do what they can to make delivering these services in Kapiti as attractive and efficient as possible for the clinical staff.

Over the upcoming months work will be done to identify which outpatient clinics are most viable for Kapiti.

Clinical staff will be consulted to see what opportunities for growth exist, including the possibility to work more closely with primary health providers and community services which may have an interest in developing some local special interest services.

C&C DHB supported the annual Creekfest event in Cannon's Creek, Porirua. Once again this event attracted a large crowd of about 40,000 and provided an opportunity for key health messages to be promoted by local community organisations in their local community.

CANCER CONTROL

A Cancer Control Plan was developed in collaboration with many community groups during the last year and implementation will begin during 2010/11.

PROGRESSING THE NZ DISABILITY STRATEGY

Promoting Participation, the C&C DHB framework for progressing the NZ Disability Strategy, has been reviewed and refocused into a new document entitled Kotahi Tatou, Valued Lives – Full Participation with four Focus Areas; Health, Inclusion and Support, Access, and Leadership.

Disability responsiveness education

A programme of disability responsiveness, blindness awareness, and deaf culture workshops is conducted at Kenepuru and Wellington Hospitals and are open to community health providers as well as DHB staff.

An innovative education development process has been started in 2009-10 and will continue to be developed and applied through hospital and community health and disability support services.

Physical accessibility

The new Wellington Regional Hospital complies with access requirements of building regulations and much of the detail came from advice provided to the project team from the disability community.

A wayfinding exercise with members of that community has also helped us identify issues that have helped us refine the some environmental and organisational issues needing to be addressed to improve things further.

The accessibility of GP practices has been monitored since 2005, which has helped us identify relatively accessible GP practices in all the areas and communities in the district.

Some 24 community health facilities have had full accessibility assessments carried out. Many of these practices belong to the Cornerstone quality improvement programme which includes accessibility standards.

Communication and access to information

Information about a range of disability issues and associated links has been posted on our website.

A project to flag people's needs in hospital and health settings has developed into the Health Passport project being lead by the Health and Disability Commission.

NZ sign language taster classes and deaf culture workshops are provided.

We are increasing our responsiveness to the communication needs of blind and vision impaired people.

Employment opportunities

Data recording the numbers and FTEs of C&C DHB staff who identify as having a disability has been collected since 2006. These charts show the data collected up to June 2010. There is no significant change since June 2009.

The number of disabled people working in leadership roles on disability issues has increased.

Community engagement

The CEO and other members of senior management have participated in meetings with disability community leaders throughout the year.

These discussions and forums feed into planning processes related to improving health service environments or service delivery such as, new hospital orientations, or, families of children involved with the Child Development Unit.

The "Inflow Outflow" electronic newsletter provides a comprehensive Disability Issues Network with health related information relevant to disabled people.

REGIONAL AND SUB-REGIONAL COLLABORATION

Regional and sub-regional collaboration has been an increasing focus in 2009/10 with representation on a number of Regional Collaboration Groups. These have included the Regional Leadership Group, Regional Clinical Leadership Group and Sub-Regional Clinical Integration Committee.

Projects that have progressed include the development of a sub-regional GP Training Pilot with input from C&C DHB, Hutt Valley DHB and Wairarapa DHB as well as the Royal College of General Practitioners that has now gone to Health Workforce NZ for approval.

There has also been a focus on vulnerable services with regional working groups established to look at solutions for radiology and women's health services issues which include workforce, information technology and equity of access.

MĀORI HEALTH

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

SERVICE DEVELOPMENT

Contract Review

The Māori Health Development Group undertook a review of all contracts within the Māori Health portfolio to provide a view of:

- The current context about how and what Māori health services are being provided across C&C DHB; and
- Clarifying provider services and the value that they add to improving outcomes.

The review presented the opportunity to openly discuss what is working well, where improvements can be made and what changes may be required. As a result, all contract agreements now have:

- Integrated contracts, where applicable, into a single agreement;
- Redesigned service specifications; and
- Extension of contracting periods, where appropriate.

Leadership & Management

Local Māori Health workers were supported to enrol in the New Zealand Institute of Management Diploma in Management (Advanced). The aim of the initiative was to progress their leadership and management skill and knowledge. In December 2009, six participants celebrated graduating with a diploma.

CAPABILITY DEVELOPMENT

Increasing the capacity and capability of our Māori health workforce remains a priority for C&C DHB.

Māori Nurses Forum

Some 50 people attended the annual Māori Nurses Forum at Maraeroa Marae in Porirua in April 2010.

The forum included a combination of nurse leadership presentations and discussion on how complementary therapy and alternative medicines can support the delivery of health services to whanau.

The Honourable Tariana Turia, Associate Minister of Health, presented her vision for Whanau Ora and the role that Māori nurses within C&C DHB could play.

Workshops gave participants the opportunity to learn more about mirimiri, naturopathy and rongōa and most importantly self-care.

Hauora Māori Clinical Training Agency Funding

This funding has provided the opportunity for six Māori health provider community health workers and seven Māori Health Care Assistants to participate in the C&C DHB Community Health Worker Care Training - Level 3.

Delivered out of Nursing's Professional Development Unit, the New Zealand Qualifications Authority certificate level training signals C&C DHB's commitment to increasing the qualifications of non-regulated workers within the district.

Kia Ora Hauora – Māori health as a career programme

On behalf of the Central Region DHBs, C&C DHB is leading the implementation of a Māori workforce initiative – "Kia Ora Hauora".

This national programme aims to influence, motivate and support more Māori onto health-related career pathways and ultimately into the health sector. There are four regional coordination centres, each responsible for enrolling 250 Māori into the programme.

To date, the Central Region Coordination Centre has exceeded this target and continues to promote and encourage participation on the Kia Ora Hauora programme using a range of regional interventions.

Allied Health Internships

In conjunction with Allied Health, two new Māori graduate internships are being piloted in the areas of Physiotherapy and Dietetics.

This initiative has been established to enable Māori new graduates to better consolidate and strengthen their clinical skills whilst working alongside experienced allied health professionals.

New Graduate Nurse Internship

In a collaborative venture between the Māori Health Development Group, Nursing Directorate and two local Māori health providers, two Māori New Graduate Nurse internships have been established.

This initiative seeks to support the new graduates to develop necessary clinical skills within a supportive environment. It also assists in addressing some of the barriers that prevent graduates from entering the primary care sector.

Employed within the Māori Health providers, the New Graduate Nurses will participate on the C&C DHB Nurse Entry to Practice (NEtP) programme.

Māori Provider Training

A programme in contract and financial management within the health sector was developed and implemented by the New Zealand Institute of Chartered Accountants for Māori health providers.

The aim of this programme was to develop and strengthen the business and financial skills within local providers through presentations and discussion on contract design and reporting, improving cash flow and business sustainability.

RESPONSIVENESS TO MĀORI HEALTH

Tikanga Guidelines

In August 2009, C&C DHB launched the "Tikanga Māori - Guidelines to support Health Workers" flipchart.

The pocket-sized flipchart was part of a time-bound quality initiative established to support and guide the implementation of Tikanga education across the Hospital and Health Services and its subsequent integration into everyday health practice.

During the implementation, approximately 72 percent of staff had participated in education sessions with a further 25 percent accessing the online e-Learning assessment tool to self-monitor progress.

Key learnings from this initiative illustrate that shared responsibility can be a mechanism for improving Māori health outcome, especially if:

- individuals are provided the opportunity to improve their engagement with Māori
- high level champions such as the CEO and CMO are utilised to improve the likelihood of successful implementation
- a combination of learning mediums are used to consolidate participation and the retention of information
- user-friendly and easily accessible training supports participation
- credible presenters provide practical and service-relevant examples.

The status of this initiative has evolved from a time-bound initiative to an ongoing and regular occurrence at our DHB.

Māori Health Indicators Report

Six monthly reports have been developed for the Māori Partnership Board to regularly track the status of Māori health within our district.

In line with the Minister of Health's expectations, these reports use the national health targets as the agreed performance indicators and where possible have been categorised by ethnicity.

Included in the report is background information, supporting graphs and updates of related C&C DHB District Annual Plan activity.

Reports also include monitoring against:

- Primary Health Organisation coverage
- Te Plan II target of investments in Māori Health and Disability services
- Tikanga Māori Guidelines education and implementation.

PACIFIC HEALTH

The Pacific population in the Capital and Coast district is predicted to increase by 15 percent over a 20 year period.

The population will experience significant ageing, with more than twice the number of older people by 2026, while the number of children and young people may decline slightly.

Other factors affecting health need include:

- Pacific people being significantly more likely to live in a crowded household compared with all other ethnic groups
- Unemployment rates are significantly higher for Pacific compared to European and Asian
- Pacific are significantly more likely to have a low income than European or Māori
- Pacific are significantly less likely to have access to a telephone or vehicle than European or Asian.

The Pacific Health Directorate has extended its work programme to incorporate a range of activities linking to other initiatives being delivered within the HHS by Clinical Directorates, within the Primary Healthcare Sector and Mental Health Sector. Programmes include:

Clinical Training Agency funded programmes for Pacific People

We have developed linkages with the Clinical Training Agency's objectives in promoting workforce development for Pacific people with a specific focus on Pacific nurses.

Within this year, two fono that identified and promoted professional development for nurses within the Hospital and Health Service and primary care sector have encouraged more Pacific nurses to consider developmental opportunities including the NetP programme.

This initiative links in with the Ministry of Health Serau Workforce Development Strategy.

Pacific Reconfiguration Programme

Our Pacific Directorate is reconfiguring its investment in primary and community services, with the goal of improving the health for all Pacific in our district.

Strengthening the services that are delivered to Pacific people accessing mainstream services, as well as targeting Pacific people that may not be accessing the services they need, are the two objectives for the Pacific Directorate.

Developing and maintaining the links that mainstream primary care has with Pacific communities, in particular Pacific churches and Aoga Amata, is a key part of this reconfiguration.

Pacific Communications Programme

Improving communications between our DHB and Pacific communities has been a priority for the Pacific Directorate.

In April 2010 the new Pacific Communications Programme commenced with all Pacific radio programmes delivering one hour each of health information and key messages predominantly to Pacific speaking people. This has been a collaborative approach between our DHB, Catalyst Pacific and Samoa Capital Radio.

Pacific HEHA programmes with Pacific churches

The Pacific Directorate introduced the Fetai'aimauso Project which is a HEHA initiative that will reinforce principles in relation to Healthy Eating Healthy Action.

This initiative has worked closely with Pacific churches and community organisation.

An example of the benefit of this programme is the influenza vaccination programme delivered in Pacific churches, which resulted in a significant number of Pacific people receiving their flu shots in their own church hall.

Pacific immunisation programmes

Pacific communities are encouraged by the increase in Pacific people engaging in immunisation programmes throughout the district.

Our DHB features throughout the latest MOH stats as being in the top performing DHBs for Primary Care and School Based programmes.

Pacific girls within our DHB have achieved 52 percent coverage for primary care cohort for dose one (national average 45 percent) – C&C DHB are one of only nine DHBs to reach over 50 percent for this group.

Immunisation coverage for Pacific two-year-olds reflects minimal ethnic disparity issues within immunisation for our DHB.

The end of year target for Pacific two-year-olds is 83 percent, but we achieved 89 percent immunisation coverage.

Cancer support services – translation for cancer treatment resources

The Cancer Support Service, our own DHB and Hutt Valley DHB Pacific Directorates have collectively produced translations for Pacific people in four Pacific languages.

The translated resources are in Samoa, Cook Island, Tongan and Tokelauan.

The resources will provide Pacific patients with advice when receiving radiation treatment to the mouth, neck and throat, patients receiving radiation treatment and general skin care and Medical Alert Neutropenic Fever.

HUMAN RESOURCES

Work continued through the year on building Human Resource capability, establishing central administrative processes and running various training and education programmes to support managers across the organisation.

Continued development of good strong collaborative relationships with unions has been a feature and focus of the year, both at a local level, and through participation in national collaborative forums.

The work of the RMO Unit has continued to build on our DHB's reputation as a good employer for resident medical officers. Entry interviews indicate a high level of satisfaction among RMOs starting work with our DHB.

In the past year, vacancy rates for this group have continued to be low by comparison with other DHBs and there has continued to be a reduction in the use of agency staff (as opposed to DHB employees).

Centralised recruitment processes continued to be developed throughout the year, with previous work in this area being consolidated and built upon to continue to enhance the recruitment services received by the organisation and by applicants.

In early 2010, the HR Directorate was disestablished and HR support was devolved to directorates. The centralised functions – including HR Services, recruitment, the RMO and SMO Unit, Organisational Development and Employment Relations – moved into the Organisational Development and Patient Safety Directorate.

In the year ahead, the focus will be on consolidating the new arrangements for the centralised functions, and ensuring processes are in place to develop and deliver organisation-wide HR strategies and policies that meet the needs of the directorates.

Breakdown of employees

Employee Type	Number of Staff
Permanent/Full-Time	2,714
Permanent/Part-Time	1,729
Casual	543
Fixed-Term/Full-Time	107
Fixed-Term/Part-Time	56
On Leave	39
Total	5,188

ORGANISATIONAL DEVELOPMENT & PATIENT SAFETY

This directorate is now into its second year, and recently expanded to include the centralised Human Resource function.

The directorate is responsible for leading and informing the organisation about workforce development, capability and capacity and is responsible for the development and at times implementation of best practice methodology, systems frameworks and tools.

The Patient Safety Officer role has also been in place for 18 months and has made a real difference in the management of adverse events through the establishment of robust monitoring and reporting systems, development of skills of staff to manage these events, and implementing an Open Communication policy.

A survey of our staff was undertaken to understand their views on patient safety and with 73 percent of staff completing the survey, this provided an excellent baseline of information.

The results have been used by services to highlight both strengths and weaknesses and ultimately enhance the quality and safety of care provided.

Risk management continues to be integrated into organisational planning and management systems, and is now a standing agenda item of clinical and corporate management meetings.

The Risk Maker, Risk Taker training continues to be successful and now forms part of the organisation's generic staff training programme.

We have evaluated our model of accreditation, and decided to move to an internal evaluation framework in the coming year.

This approach will give ownership of identifying and implementing service improvements back to services, and provide strategic direction to the executive team, ensuring improvement initiatives reflect service identified priorities.

The management of patient complaints has been improved by an increase in early and direct interaction with patients and other complainants, which enables us to better understand what they have to say.

The result of these improved practises is demonstrated through the reduction in the number of formal complaints. In addition to this, the DHB receives significantly higher levels of compliments to complaints.

A legislative compliance programme has been implemented which enables us to better manage legal risk in the organisation; and through enhancement of the in-house legal team we have significantly reduced expenditure on external legal costs.

The Postgraduate Medical Education and Training Unit (METU) is responsible for coordination of postgraduate medical education programmes, maintenance of training quality, definition of new training initiatives, and administration of the Workforce NZ medical training contract.

The increased recruitment and retention of junior medical staff highlights in part the success of some of the initiatives implemented by the METU and the RMO unit.

This has included the Postgraduate Year 2 training programme and trial of a new Professional Development Programme, aligned to Physician and Surgeon training requirements – both a first in New Zealand; and also the delivery of 'Safe Prescribing Practise' for the Postgraduate Year 1 structured training programme, and consistently high pass rates in specialty examinations.

The Simulation and Skills Education Centre has continued to run simulated skills training for internal and external staff, and have commenced the planning process to move into a purpose built facility in 2011 as part of the HERC development.

The new facility is recognition of the commitment our DHB has to life-long education and training for staff.

Strategic collaboration with tertiary education providers will ensure that this is cutting edge and aligns with the vision of Workforce New Zealand.

We retained tertiary level employment status with ACC through the leadership of the Occupational Health and Safety team (OH&S).

OH&S also supported staff during a very busy winter period in 2009 managing the H1N1 (Swine Flu) pandemic and in the build up to the 2010 winter period achieved a 49 percent flu vaccination rate – up from 43 percent in 2009, and in the top five DHBs in the country to achieve this rate.

CLINICAL GOVERNANCE

The Clinical Governance Executive (CGE) meets twice a month with the purpose of coordinating and supporting activities of the HHS Executive team, therefore enabling the HHS Executive team to effectively deliver on its objectives. The HHS Executive reviews Clinical Governance activity every month.

The clinical professional heads and Executive Directors of Organisational Development and Patient Safety attend monthly directorate performance meetings so that clinical and operational governance is integrated.

The implementation of clinical governance continues to evolve – the new structure is complete and continues to strengthen. A quality framework has been agreed by the HHS Executive and has adopted the four clinical governance pillars of consumer value, workforce, clinical effectiveness and risk. The quality framework integrates both clinical and corporate activity.

All committees have inter-professional representation and a clinical governance committee member sponsors all committees. All committees now provide regular information and where appropriate recommendations to the clinical governance committee. The Restraint Approval Group is the only sub committee which is not led by a member of the CGE. The committee structure demonstrates clinical leadership and engagement in action.

A number of committees have been set up under the structure, including the Clinical Practice Committee, Death Review Committee, Resuscitation Committee, Blood Transfusion Committee, Restraint Approval Group, Medication Committee, Infection Control Committee, Clinical Ethics Committee, Information, Documents & and Records Committee and Consumer Committee.

LENDING A HAND TO THOSE LESS FORTUNATE

Over the past year, as in previous years, a number of our staff have given up their own time to help out in communities, both here and overseas, where many are facing great hardship.

The health needs in these communities are often immense and access to good services poor.

Some examples of how our staff have lent a hand to those less fortunate, include:

THE SAMOAN TSUNAMI

Theatre nurse and Service Leader for Theatres, Judy Tully and Orthopaedic Surgeon Robert Rowan, were part of a team who responded to the urgent medical care needs of people in Samoa in the wake of the Tsunami. Over the following weeks, a number of our other staff also volunteered to help and travelled to Samoa to offer their expertise.

Judy and Rob's story:

Judy and Rob found broken bones, deep tissue wounds and a truly hardy people when they first in tsunami-ravaged Samoa to help victims.

They were part of a medical contingent that went on a week-long stint in Samoa. Others included specialist wound nurses, an anaesthetist and a plastic surgeon from other DHBs.

The team worked tirelessly until late most nights to complete the surgery needed for all the victims of the tragedy.

Other teams who had gone before had done much already, so it was up to this group to finish up the rest of the necessary surgery. Dr Rowan also performed an additional non tsunami-related hip surgery that local medical staff would not have been able to do.

It was Rob's first time in a disaster zone.

"There were a lot of open wounds all over backs, legs, arms – and some wounds that had got infected," Rob says.

Judy and Rob both paid tribute to the rest of the visiting medical team, but also to the great local staff who did a fantastic job with the limited resources available.

There was limited medical equipment and the hospital was full of injured, making conditions even more difficult.

Each patient had a sad story to tell.

"One of the girls that we operated on – she'd lost her baby and she'd lost two other children as well. The wound-care nurses would spend a lot of time talking to families," Rob says.

The pair managed to take a few hours to travel through the devastated area and said the thing that struck them was the spirit of the people themselves. "The Samoan people are so resilient and tough," Rob says.

"It was pretty devastating, everything it touched, it destroyed."

They said that they were in a privileged position as trained doctors and nurses, in that they were able to help and they said they would do it again.

HAITI

Paediatric physiotherapist Fiona Millard recently went to Haiti where she spent a month in the quake-stricken community.

Fiona's story

Fiona volunteered to help out in the aftermath of the catastrophic magnitude 7.0 earthquake that hit the capital Port Au Prince on January 12, killing an estimated 300,000 people and leaving millions homeless.

Fiona went with Hearts and Hands for Haiti NZ as one of three Kiwi physiotherapists based in the University Hospital of Justinien in Cap-Haitien, at the opposite end of Haiti to the earthquake-devastated capital Port Au Prince.

No stranger to adapting to unusual situations, Fiona had previously spent three years working as a physiotherapist in Cairo as well as time in Jordan.

"I definitely knew what it was like to work in developing places and working with other cultures but the breadth of the devastation, months after the event, is shocking, especially with millions of people still living in tent cities," Fiona says.

"I went there knowing very little about Haiti aside from guessing that

we would be dealing with a lot of trauma. The first thing that hits you is the degree of devastation, poverty, and lack of infrastructure.

"You also have to deal with the heat, which was around 40 degrees with 80 percent humidity, and within the hospital there is dirt and overcrowding, as well as the lack of privacy in the wards."

As there had previously been no local physiotherapy service, Fiona's primary focus was training three local nurses to become physio nurses as well as establishing an outpatient physiotherapy clinic and an inpatient service within the hospital.

"I come from a predominately paediatric background but in Haiti I was working with adults as well as children.

"The conditions we saw included orthopaedic trauma – crush injuries and amputations from the earthquake, as well as trauma from car accidents and spinal injuries from people falling from trees while looking for fruit. We also saw neurological conditions, some even presented with strokes that happened up to three years previously but had not been able to receive any rehabilitation."

Now that Fiona is back at Capital & Coast she's enjoying the more structured environment but doesn't rule out a return trip.

"I'm passionate about helping developing counties becoming self-sufficient and while it can be incredibly draining it is very rewarding also. It's nice to know you are part of something so positive and can make a difference."

TOKELAU

Wellington Hospital nurse consultant Bronwen Markham shares her experiences of unremitting boat journeys and high seas as she helped respond to a suspected influenza outbreak on Tokelau:

Bronwen was one of a team of people who responded when there was a call for help from New Zealand's tiny and last remaining dependent territory, Tokelau.

The Ministry of Health coordinated a response when a suspected influenza outbreak threatened to overwhelm health services on the isolated atolls.

A swift response was required with nearly 150 people reported sick out of a population of 1500 people live on the three atolls, more than 500km north of Samoa, separated by 60km of open ocean, which make up Tokelau.

With about 10 percent of the population reported ill, Tokelau's acting Director-General of Health, Lee Pearce, sought urgent assistance from the New Zealand Health Ministry on 29 March.

Bronwen took her partner Carl Reller, an environmental manager at the NZ Transport Authority who is also a medical technologist, along for support and to help educate local nurses on using the rapid test kits.

After a flight to the Samoan capital of Apia, where they met Lee and World Health Organisation (WHO) doctor Jacob Kool, they caught the fortnightly sailing to Tokelau.

"Everyone spreads their mattresses on deck like in a marae and looks after each other as best they can," Bronwen says.

After 45 hours in horrific sea swells they finally arrived at Fakaofo late on 1 April.

After reaching Atafu they met with the Taupulega who granted permission at a formal meeting to proceed with the work of vaccinating and screening. The team then headed to the hospital to set up a base.

Nurses were trained in vaccination technique then, accompanied by members of the team proceeded to vaccinate the community going from house-to-house. Approximately 200 of the 350 doses were administered on the first day, which was a majority of the population on Atafu.

Local health services had acted swiftly to limit the spread of the disease. The school had been closed, public gatherings banned, sick people advised to stay home and the message of hand washing reinforced.

"We were feted like heroes – people were so touched that New Zealand was at last acknowledging them. They are incredibly generous people; we were overfed like there was no tomorrow," Bronwen says.

The team spent nine days in Tokelau, testing and treating the sick, vaccinating the population and training nurses.

The nature of the illness remains a mystery. Tests showed negative results for influenza Type A and B and instead results show it to be an 'influenza-like illness' with similar symptoms to the flu but of shorter duration and not as dangerous.

TOGO, WEST AFRICA

Gastroenterology Department Registered Nurse Ruth Mangnall shares her story of nursing on a Mercy Ship off the Coast of Togo, West Africa.

Ruth's story

Having heard about Mercy Ships some eight years ago when a friend volunteered in Africa, Ruth decided the time was right for her to act on her "passion to help the poor and hurting".

After arranging with an organisation called Mercy Ships to Lome, Togo, Ruth arrived at the largest non-profit medical ship, the Mercy Africa for an eight-week stint beginning in June this year.

"I was one of the admissions nurses, admitting people onto the ship prior to their surgery. I worked in a tent out on the dock beside the ship and through translators, did the necessary paperwork and blood work to prepare the patients for surgery," Ruth says.

Living onboard the ship with five others from UK, America, Germany and of course New Zealand, had its challenges but she soon got used to it. She soon saw many things that she wouldn't see in New Zealand.

"I saw people with huge goitres, neurofibromas, lipomas, cataracts, facial tumours and met women who had been incontinent of urine for many years through having prolonged labour," Ruth says.

Many types of surgery were performed on the Africa Mercy, as well as other programmes. She also visited the dental clinic that Mercy Ships ran in a local building in Lome.

Ruth says the health challenges that Togo faces are many, but they key issues were the provision of basic care, dental care and health care – particularly for the women of Togo.

"I was so humbled by people that I met that told me that if it wasn't for Mercy ships providing free health care, they would not be able to get the help they so desperately needed, and in many cases would most likely die," Ruth says.

"The need for basic health care in West Africa is huge, and the care and help the Africa Mercy provides is really only a drop in the bucket, but what care that is given is something, and so very humbling to be a part of."

Ruth says she has come to New Zealand with a much greater appreciation for the health care that can be accessed here, and a desire to someday return to West Africa.

"I would love to go back, and once again use the skills and abilities I have as a nurse to bring hope and healing to some of the world's forgotten poor."

DEMOCRATIC REPUBLIC OF TIMOR-LESTE

A New Zealand Team led by Wellington Paediatric Surgeon Brendon Bowket regularly visits this small nation.

Shortly, a volunteer medical team from Wellington Hospital will travel to Dili, Timor-Leste, for the ninth time to operate on children suffering conditions such as Anal Anomaly and Hirschsprung's Disease, giving to them the possibility of a healthy life and giving their communities the prospect of a productive citizen.

Most Timorese have known only fear and hardship in their lifetime. During the 25 years of Indonesian occupation that began in 1975, more than 300,000 Timorese lost their lives to violence and hunger.

Following the referendum on 30 August 1999, when 78 percent of the people voted for independence, Timorese militia, organised and supported by the Indonesian military commenced a large-scale scorched-earth campaign of retribution.

Approximately 1300 Timorese were killed and as many as 300,000 were forcibly relocated into West Timor as refugees. Most of the country's infrastructure, including homes, irrigation systems, water supply systems and schools, and nearly 100 percent of the country's electrical grid systems were destroyed.

On 20 September 1999, Australian and New Zealand peacekeeping troops arrived in Dili bringing the violence to an end. Timor-Leste became a fully independent republic on 20 May 2002.

Australia and New Zealand quickly responded to the need for reconstruction and development in the world's newest nation. The Royal Australasian College of Surgeons began a Programme of Assistance funded by the Australian Agency for International Development (AusAID) that aimed to improve population health by the delivery of tertiary health services.

Medical teams began visiting on rotation to perform otherwise unavailable surgical procedures. The New Zealand Team led by Paediatric Surgeon Brendon Bowkett with Anaesthetist Mark Featherston and Theatre Nurse Lyn Brown began annual visits in 2002.

In 2004 Lyn left her position as Quality Facilitator for Child Health to become the RACS perioperative nurse advisor to the national hospital in Dili and continues to provide Specialty Practice Education for theatre nurses there and from outlying hospitals.

This year Anaesthetist Sandy Garden and Theatre Nurse Gill Rose joined the team and are already discovering the challenges and charms of working in an environment of true resource paucity.

The team acknowledges that it is the support of family, friends, colleagues and C&C DHB which enables the ongoing goodwill exchange in this beautiful island where the history of traumatisation still casts a shadow.

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, Cancer and Community Services; Surgery and Outpatients; Anaesthesia, Intensive Care Unit and Patient Services Coordination Unit (PSCU); Women's and Children's Health; Mental Health; Clinical and Corporate Support Services; Primary, Integrated & Community Care; Māori Health; Pacific Health; and Organisational Development and Patient Safety.
- Governing the District Health Board.

BOARD MEMBERS

Sir John Anderson Board Chair, Appointed Member

Ken Douglas Deputy Chair, Appointed Member (until 22 October 2009)

Margaret Faulkner, Elected Member

Virginia Hope, Elected Member (Deputy Chair as of 30 November 2009)

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 (resigned 23 November 2009)

Keith Hindle, Appointed Member (as of 23 November 2009)

Debbie Chin, Crown Monitor (as of 23 November 2009)

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 (being held again in October 2010) and four are appointed by the Minister of Health. A Crown Monitor was appointed in the 2007/08 year and replaced by a new Crown Monitor in November 2009.

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.

Disability Support Advisory Committee (DSAC)

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

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

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

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

Other 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).

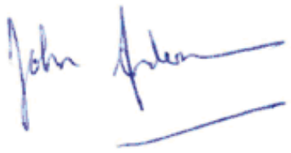
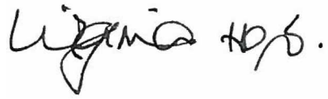
STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2010:

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 2010, fairly reflect the financial position and operations of Capital & Coast District Health Board.

 Sir John Anderson Chair 29 October 2010	 Virginia Hope Deputy Chair 29 October 2010
 Shaun Drummond Acting Chief Executive Officer 29 October 2010	 Theo Koenders Chief Financial Officer 29 October 2010

STATEMENT OF SERVICE PERFORMANCE

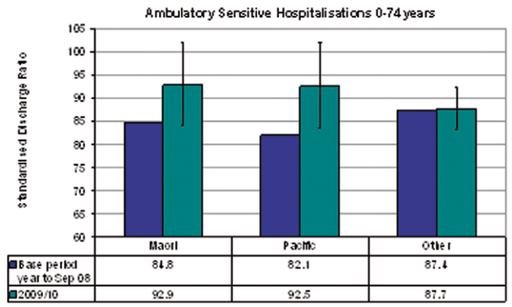
The Statement of Service Performance sets out Capital & Coast DHB's key performance measures as described in the Statement of Intent for the period 1 July 2009 to 30 June 2010. Whilst our performance targets are often expressed in specific terms, actual performance is likely to vary, positively or negatively, in each case.

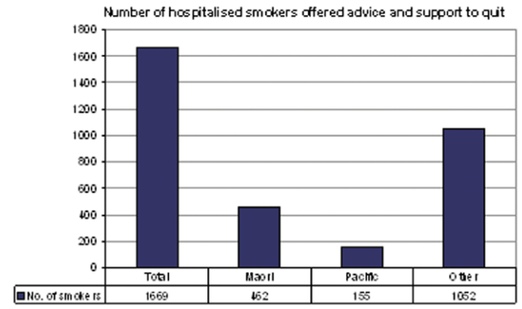
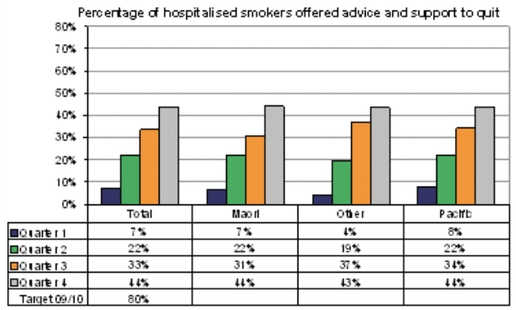
The criteria for rating our performance are shown below:

Rating	Criteria
Achieved	Where the target has been reached.
Progress made toward target	Where 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 no targets within the performance measure have been achieved.

OUTCOME ONE: IMPROVED HEALTH OF OUR LOCAL PEOPLE, FAMILIES AND COMMUNITIES - AND REDUCED INEQUALITIES WITHIN OUR POPULATION.

Output Class: Public Health Services		
Medium term outcome	**Reducing avoidable admissions** Poor quality housing contributes to a range of poor health outcomes, from respiratory conditions and CVD to poor mental health and infectious disease. In particular, insulating houses is a cost effective way to improve respiratory symptoms and decrease the use of health services and reduce avoidable hospital admissions. C&C DHB funds this activity as a joint venture with Wellington City Council and the Wellington School of Medicine.	
Performance measure	2009/10 performance	Achievement

Number of houses insulated in the housing programme Target: >546	400 houses were insulated in the 2009/10 Healthy Homes programme. Although this is less than the original target of 546, it is significantly more than the provider's target of 300 houses for the 2009/10 year. The baseline included houses of non-Community Services Card holders, whereas in 2009/10 non-CSC holders were ineligible	Progress made toward target
Ambulatory sensitive hospitalisations – standardised discharge ratio Target: remain below 95% of the national average	 Actions to reduce ambulatory sensitive hospitalisations have included: • Continuing to improve access to primary care services – particularly primary care capacity and PHO enrolment in Porirua. PHO level initiatives such as services to improve access, CarePlus and health promotion services continue. • Emphasis by joint primary / community / secondary clinical network on improving the processes around discharge to reduce readmissions. • Ongoing support for the implementation of a combined primary-secondary diabetes management model through the close linkages and partnership between the secondary diabetes team and primary care. • Intersectoral initiatives such as healthy housing in Wellington, Porirua and Kapiti TLAs, and the Work & Income Nurse initiative in Porirua. • A smoking cessation facilitator role has been established within a PHO to work with primary care across the district to support smoking cessation activity. • The combined effects of our long term conditions action plan, existing and planned ambulatory programmes and primary care activity in these areas.	Achieved

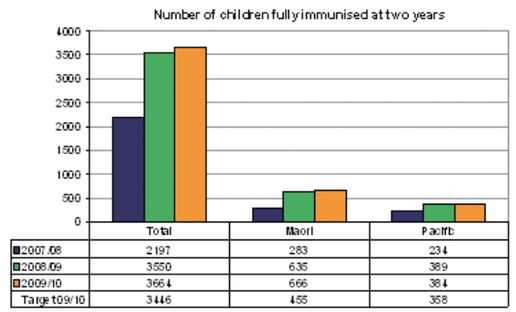
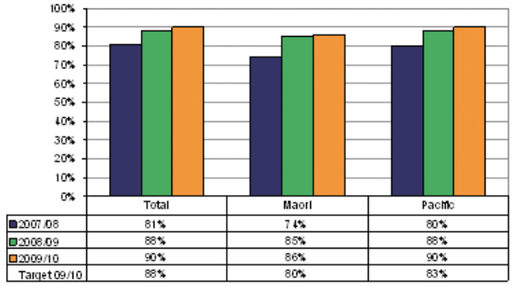
Medium term outcome	**Improving tobacco control** Smoking is a major contributor to inequalities in health. It is the main cause of lung cancer and chronic obstructive pulmonary disease and is a major cause of heart disease, strokes and a variety of other cancers. Health promotion is a cost effective way to target long-term conditions that arise through lifestyle choices. By targeting the smoking population we hope to decrease the incidence of many of these diseases.	
Performance measure	**2009/10 performance**	**Achievement**
Number of hospitalised smokers offered advice and support to quit Target: establish baseline	 The baseline has been established and this will form the basis of future target setting.	Achieved
Percentage of hospitalised smokers offered advice and support to quit Target: 80%	 Although the target of 80% has not been reached, steady progress has been made on this indicator which was implemented in July 2009. By the last month of the year, 49% of hospitalised smokers were offered advice and help to quit. • Actions towards achieving this indicator have included: • Introduced a Smoking Dependence & Cessation Referral record and a sticker documenting the health target to be place on the patient information form. • A resource 'help card' is given to documented smokers.	Progress made toward target

	• In-service training provided in wards and departments as well as regular communications around e-learning and promotion of cessation services. • Study days are provided for nurses and midwives as part of the professional development programme. • Hospital Coordinator accepts referrals from clinicians and runs an outpatient clinic at both Wellington & Kenepuru. • NRT standing orders are in place.	

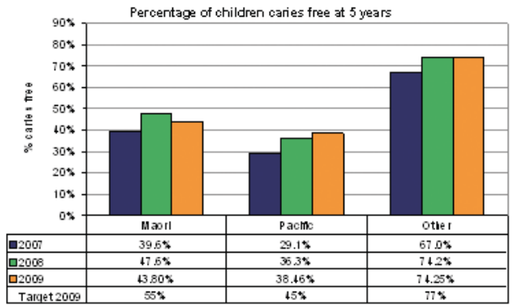
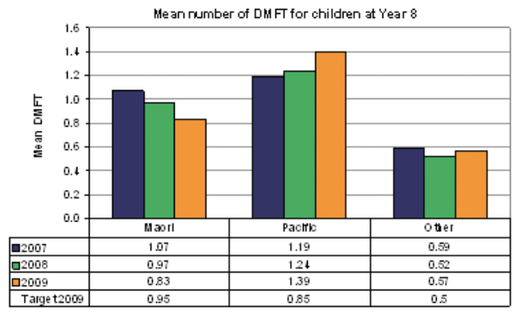
Output Class: Primary and Community Health Services

Medium term outcome	**Reducing hospital admissions - cellulitis** Ambulatory sensitive hospital admissions are used to provide an indication of access to, the effectiveness of and quality of primary care. It has been accepted that if there is good access to effective primary care for all population groups, then it is reasonable to expect that there will be lower levels of ambulatory sensitive admissions. Cellulitis is a condition that is in the top five causes of ASH admission in most DHBs. C&C DHB is one of the few DHBs that have cellulitis as the highest rate of ASH admission across the 0-75 year's age group. There is an opportunity to reduce the level of admissions for cellulitis in our district through targeted management of patients requiring IV therapy for cellulitis in the community. This should help decrease our ASH rates while also providing services closer to people's homes, and improving efficiency through fewer people being admitted to hospital.

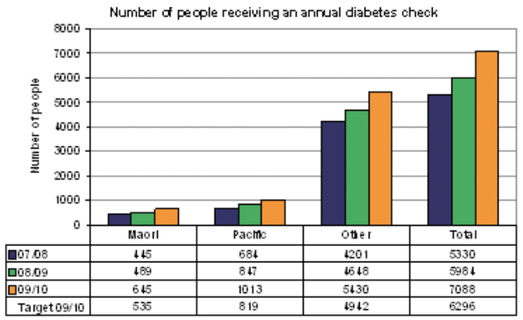
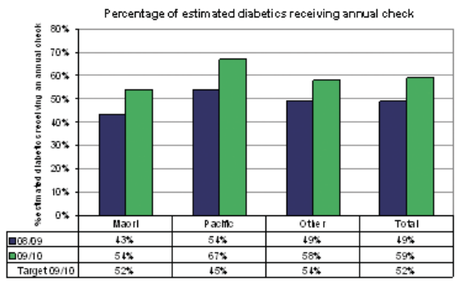
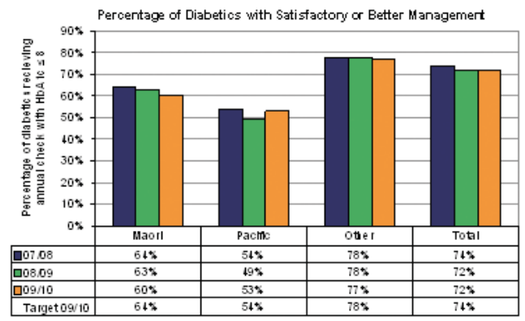
Performance measure	2009/10 performance			Achievement
Number of adults given IV therapy for cellulitis management in the community Target: 131	**Baseline (2008)**	**2009/10 performance**		Achieved
		Target	Actual	
	104	131	304	
	More than double the targeted number of adults were given IV therapy for cellulitis in a community setting in the past year. Primary health care are keen to continue to work with secondary care, to make improvements in cellulitis care across the DHB. The community cellulitis treatment pilot is currently under review through a Clinical Pathway Collaborative process involving primary and secondary care clinicians.			
Ambulatory sensitive hospitalisations – standardised discharge ratio Target: remain below 95% of the national average	Standardised discharge ratios have remained below 95% of the national average for all ethnic groups in C&C DHB. Note actual results are provided in the public health output class above.			Achieved

Medium term outcome	**Reducing hospital admissions – infectious disease** Immunisation is one of the most cost-effective and successful preventive health interventions known. It is an important component in keeping both children and adults free from preventable diseases. C&C DHB rates of immunisation are increasing and we are heading towards 95% of two year olds fully immunised at a steady rate. To ensure that we continue this we aim to increase the number of vaccinations that we carry out yearly for Māori and Pacific children and so increase the number of children that are fully immunised at 2 years of age.	
Performance measure	**2009/10 performance**	**Achievement**
Number of children fully immunised at two years Target: 3446	 Total / Maori / Pacific 2007.08: 2197 / 283 / 234 2008.09: 3550 / 635 / 389 2009/10: 3664 / 666 / 384 Target 09/10: 3446 / 455 / 358	Achieved
Percentage of two-year-olds immunised Target: 88%	 Total / Maori / Pacific 2007.08: 81% / 74% / 80% 2008.09: 88% / 85% / 88% 2009/10: 90% / 86% / 90% Target 09/10: 88% / 80% / 83% We continue to exceed our immunisation targets and are within the top six performing DHBs for immunisation coverage. C&C DHB have two high functioning Outreach Immunisation Providers that are making a direct, measurable impact on reducing inequalities for Māori and Pacific children. It is anticipated that C&C DHB will have ethnic equality by 2011. We are on track to achieve the target of 95% by 2012.	Achieved

Medium term outcome	**Reducing hospital admissions and the impact of long term conditions** Poor oral health in children has been linked to poor child development and poor general health; both in childhood and in later adulthood. Improving oral health can have benefits over an entire lifetime. Early tooth loss caused by dental decay can result in impaired speech development, failure to thrive, absences from preschool, inability to concentrate, reduced self esteem and other psychosocial problems. One of the measures to see how we are improving the oral health of our children is the number of completed dental visits carried out each year. This measures the number of children that were seen by the dental service and either completed some necessary dental care or their check up found their oral health to be at an acceptable level. By increasing this number we can improve oral health outcomes for our community.	
Performance measure	2009/10 performance	Achievement
Number of completed dental visits Target: 26,352	**Baseline (2008)** | **2009/10 performance** (Target | Actual) 23,902 | 26,352 | 26,402 The number of children who have completed dental visits continues to rise with the 2009 target number exceeded. The implementation of the oral health business case will change the way children access dental services, with new community clinics opening and mobile assessment units beginning to operate. This will increase the number of completed dental visits and will continue the trend of children being seen more regularly, which will have a positive impact on DMFT at Year 8 in particular. Increased capacity will enable increased activity in preschoolers, which should have an impact on the rate of children who are caries free at 5 years.	Achieved

Percentage of children caries free at five years Target: Māori 55% Pacific 45% Other 77%	 Māori | Pacific | Other 2007: 39.6% | 29.1% | 67.0% 2008: 47.6% | 36.3% | 74.2% 2009: 43.80% | 38.46% | 74.25% Target 2009: 55% | 45% | 77% Dental caries is also known as tooth decay. We did not reach our caries free targets for 2009/10, however the trend for Pacific and Other is positive. The business case for school dental services was approved in 2009 and this was an important step in moving forward with our approach to improving performance against target.	Progress made toward target
Mean DMFT at Year 8 Target: Māori 0.95 Pacific 0.85 Other 0.5	 Māori | Pacific | Other 2007: 1.07 | 1.19 | 0.59 2008: 0.97 | 1.24 | 0.62 2009: 0.83 | 1.39 | 0.57 Target 2009: 0.95 | 0.85 | 0.5 A decreasing DMFT (decayed, missing or filled teeth) score is a positive result. We have achieved our target for Māori children, however further work is required to improve outcomes for Pacific children. Mean DMFT for children of other ethnicities was slightly higher than target.	Progress made toward target
Medium term outcome	**Reducing the impact of long term conditions** To achieve the desired goal of improved health and independence of our people as well as reduce inequalities we need to have a coherent and systematic pathway leading to them. Cardiovascular disease (CVD) and diabetes are leading causes of death in New Zealand and disproportionately affect Māori and Pacific peoples and people of low socio economic status. The prevalence of diabetes in Māori and Pacific populations is around three times higher than among other New Zealanders so we want to increase checks carried out on those ethnicities at a higher rate to reduce current health disparities.	

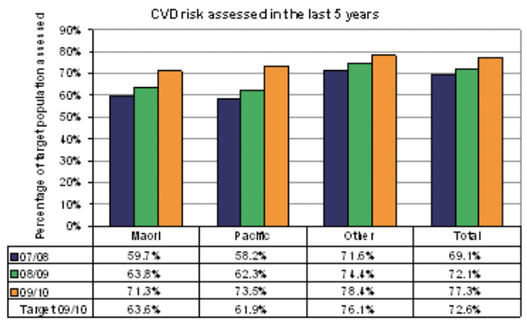
	The diabetes health target aims to increase access to checks and management of people with diabetes within the New Zealand population. By carrying out more checks we aim to control the burden of diabetes on members of our community. The CVD measure records the number of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years.

Performance measure	2009/10 performance	Achievement
Number of diabetes annual checks Target: Māori 535 Pacific 819 Other 4942	 Maori / Pacific / Other / Total 07.08: 445 / 684 / 4201 / 5330 08.09: 489 / 847 / 4648 / 5984 09/10: 645 / 1013 / 5430 / 7088 Target 09/10: 535 / 819 / 4942 / 6296 The number of people who have received an annual diabetes check has exceeded the target numbers for each population group. Pacific peoples and Māori have achieved a greater increase in the number of annual diabetes checks compared to their targets. The Pacific target was exceeded by 24%, the Maori target was exceeded by 21% and the total population target was exceeded by 13%.	Achieved
Percentage of diabetics receiving an annual check Target: Māori 52% Pacific 45% Other 54%	 Maori / Pacific / Other / Total 08.09: 43% / 54% / 49% / 49% 09/10: 54% / 67% / 58% / 59% Target 09/10: 52% / 45% / 54% / 52% C&C DHB has achieved target percentages of annual diabetes checks for all ethnicities. Māori and Pacific have exceeded their targets by the largest percentages. The Pacific percentage detection has exceeded the total population performance and Māori percentage detection is moving closer to performance observed in the total population.	Achieved
Percentage of those checked with satisfactory or better management Target: Māori 64% Pacific 54% Other 78%	 Maori / Pacific / Other / Total 07.08: 64% / 54% / 78% / 74% 08.09: 63% / 49% / 78% / 72% 09/10: 60% / 53% / 77% / 72% Target 09/10: 64% / 54% / 78% / 74% Although the targets were not met, significant progress has been made with the number of diabetes patients who achieve HbA1c ≤ 8% (satisfactory or better blood sugar level).	Not achieved

	2008-09 Q4 Actual Numbers with HbA1c ≤ 8%	2009-10 Q4 Actual Numbers with HbA1c ≤ 8%	Increase in patients HbA1c ≤ 8% from 08-09 to 09-10	% Increase in patients from 08-09 to 09-10 Q3
Māori	309	388	79	26%
Pacific	416	534	118	28%
Other	3,607	4,193	586	16%
Total	4,332	5,115	783	18%

Actions to improve diabetes management include:

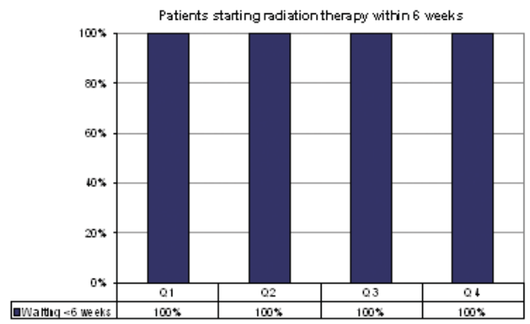
- Primary care is being resourced with diabetes nurse specialists and PHO diabetes nurses are working with practices to identify system improvements (eg efficient recalls, links with CVD screening) that will support effective diabetes management
- PHO community dieticians are working to support patients with diabetes with a particular focus on Māori and Pacific
- Secondary care diabetes specialists and clinical nurse specialists are working in collaboration with primary care to support individual patient management and case reviews in targeted areas of Porirua, Newtown and Kapiti.
- Both the secondary care service and PHO diabetes nurses are working with primary care to establish processes and training for the initiation of insulin earlier in patients, in line with best practice.

Percentage of eligible population with CVD risk assessed Target: Māori 63.6% Pacific 61.9% Other 76.1% Total 72.6%	 Maori / Pacific / Other / Total 07/08: 59.7% / 58.2% / 71.6% / 69.1% 08/09: 63.8% / 62.3% / 74.4% / 72.1% 09/10: 71.3% / 73.5% / 78.4% / 77.3% Target 09/10: 63.6% / 61.9% / 76.1% / 72.6% Currently the number of fasting lipid and glucose tests is being used as a proxy for CVD risk assessments. We continue to improve our results against this indicator and have achieved targets for all ethnicities in 2009/10.	Achieved

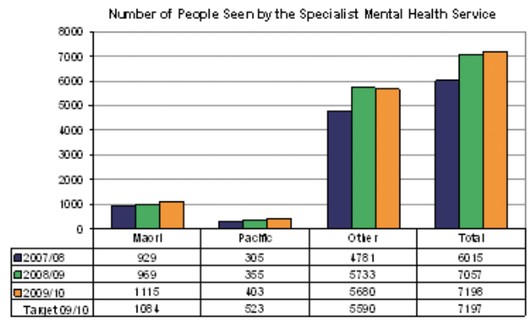
Output Class: Hospital services

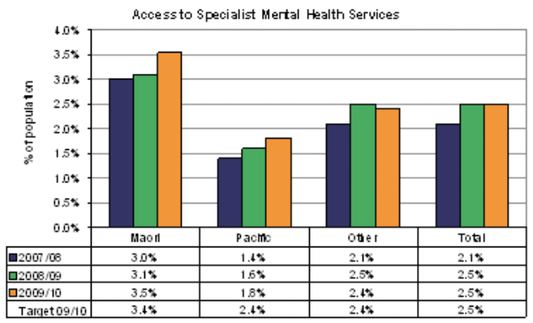
Medium term outcome	**Reducing cancer treatment waiting times** A key priority performance measure is to reduce waiting times for cancer patients who are referred for radiotherapy treatment. Radiotherapy reduces the impact of a range of cancers and delays to treatment are likely to lead to poorer outcomes. The cancer waiting time is defined as the time between the first specialist assessment and the start of radiation treatment. Waiting times for radiation treatment indicate how well the cancer treatment system is working by measuring one part of the cancer patient's journey. This measure looks at the number of attendances at the radiation therapy department. While building up to capacity for the 3rd Linear accelerator we would expect increases in the number of attendances, once that is established we will expect consistency of that volume.

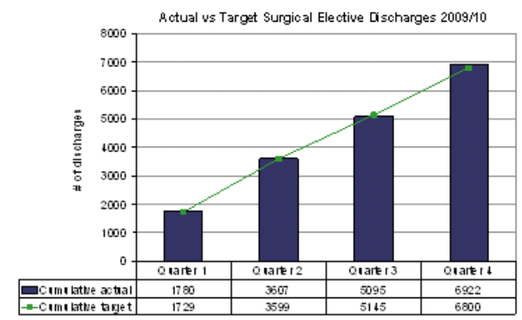
Performance measure	2009/10 performance				Achievement
			2009/10		
Number of attendances for radiation therapy Target: 24,855	**2007/08**	**2008/09**	**Target**	**Actual**	Progress made toward target
	17,521	19,225	24,855	20,891	
	Our 2009/10 SOI sets a target of 24,855 attendances for radiation therapy. This is much higher than the planned volumes for the 2009/10 year. The 2007 business case for a third linear accelerator (linac) at Wellington Blood and Cancer Centre suggested a volume of 19,901 for 2009/10. Actual planned volumes for the year were 20,616, which we exceeded. In the first half of the year the third linac was housed in a bunker shared with HDR (high dose rate) brachytherapy. This meant the linac could not be run at full capacity.				

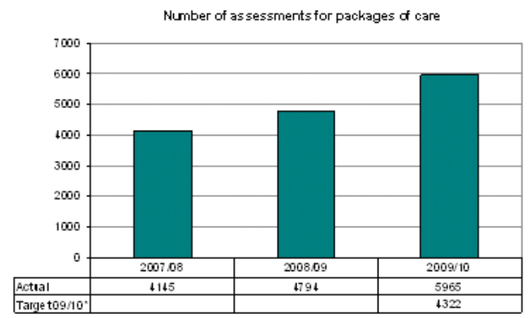
Percentage of patients starting radiation therapy within six weeks Target: 100% by the end of June 2010	 Q1 / Q2 / Q3 / Q4 Waiting <6 weeks: 100% / 100% / 100% / 100% All C&C DHB patients requiring radiotherapy in 2009/10 received this within 6 weeks of the first specialist assessment. Note that this measurement is for C&C DHB domiciled patients only, and any patients waiting longer than six weeks for reasons outside the department's control are excluded (eg patient request, awaiting other procedures).	Achieved

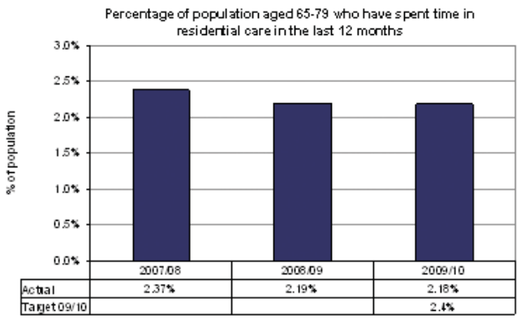
Medium term outcome	**Improving mental health service utilisation rates** The number of people who are seen by our mental health services is an indicator of the extent to which we are meeting mental health needs. We are aiming to improve the health status of people with severe mental illness so that they have the same opportunities and can fully participate in the everyday life of their communities and whānau. We aim to provide recovery-focused mental health services that provide choice, promote independence and are effective, efficient, responsive and timely.

Performance measure	2009/10 performance	Achievement
Number of people seen by secondary mental health services Target: Māori 1,084 Pacific 523 Other 5,590	 Maori / Pacific / Other / Total 2007/08: 929 / 305 / 4781 / 6015 2008/09: 969 / 355 / 5733 / 7057 2009/10: 1115 / 403 / 5680 / 7198 Target 09/10: 1084 / 523 / 5590 / 7197 C&C DHB has met the target for Māori and Other ethnic groups. Whilst the number of Pacific accessing secondary mental health services has increased steadily each year, we did not meet our target for 2009/10. See below for comments.	Progress made toward target

Percentage of population seen by secondary mental health services Target: Māori 3.4% Pacific 2.4% Other 2.4%	 While the number of people seen for ethnic groupings Māori and Other met or exceeded target, access rates for Pacific were below target. Despite the C&C DHB providing a range of mental health services configured for Pacific clients, a common observation from both hospital and health service and NGO Pacific service providers is that Pacific clients are less likely to seek help for mental health related disorders than other ethnic groups. A cohesive Pasifika Mental Health awareness/acceptance campaign has been identified as one critical success factor to effective service delivery for Pacific peoples. Identifying the scope, nature and implementation of this will comprise one part of the mental health work programme.	Progress made toward target

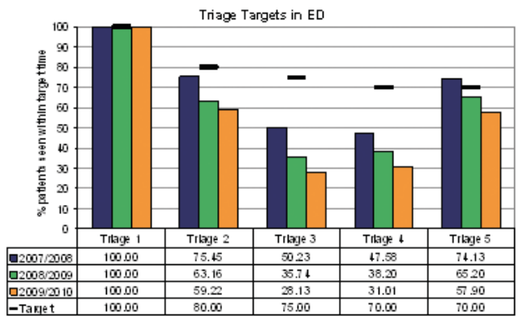
Medium term outcome	**Improving access to health services** Increasing elective surgery discharges improves the access to services for our local population and access to increased funds from the additional electives funding pool.	
Performance measure	**2009/10 performance**	**Achievement**
Number of elective discharges Target: 7,896 total 6,800 surgical	 We have exceeded both our surgical elective and total elective discharge targets for 2009/10. C&C DHB achieved 6922 surgical elective discharges, compared with a target of 6800 and 7,948 total elective discharges compared with a target of 7,896.	Achieved

Output Class: Support Services		
Medium term outcome	**Increase primary providers with disability plans** Primary care providers who have a disability plan are demonstrating that they have considered access and attitudinal issues that clients may experience when accessing the services that they provide and improving the quality of their services.	
Performance measure	**2009/10 performance**	**Achievement**
Number of primary care providers with disability plans	Each of the PHOs has policies and guidelines in place around improving access. We are currently working with them to develop these into full plans. Physical access to GP practices continues to be monitored and a number have had full accessibility audits carried out. This, combined with cornerstone quality improvement process which includes activity around improving disability access will contribute to the full development of these plans in 2010/11.	Progress made toward target
Number of people working in primary care who have undertaken disability responsiveness training	Implementation of this initiative has been deferred so we cannot currently report against this indicator.	
Medium term outcome	**Integrating services for older people and those with long term conditions** An integrated continuum of care and support for older people and their families will provide then with the right care and support services in the right place at the right time. These services, for example assistance with personal care, meals, housework, in the community will improve the function and health of older people in order to maximise their wellbeing, and make their quality of life greatly improved. By providing more flexible and restorative focus through these packages of care (POC) services the growth of entry into residential care expected by the increasing population in the 65 years plus will be managed.	
Performance measure	**2009/10 performance**	**Achievement**
Number of assessments for packages of care completed in the last 12 months Target: 4322*		Achieved

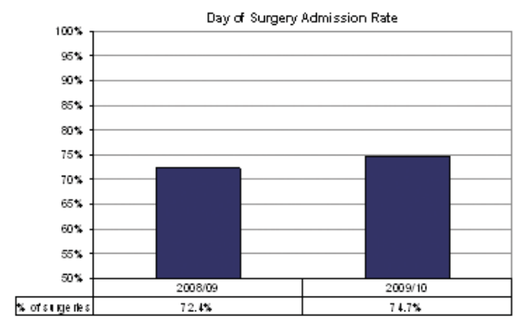
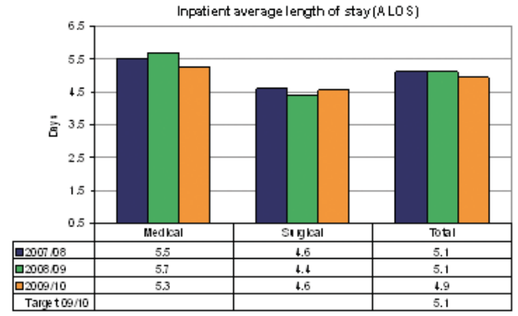
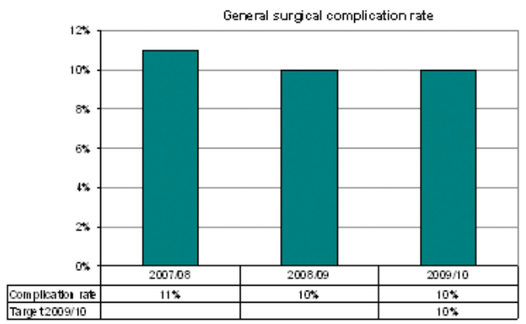
	* Target was incorrectly printed in the 09/10 SOI and has been corrected above. The past year has been one of refinement of the assessment process, whilst also ensuring assessments are completed in a timely manner. The CCC has responded well to ongoing development of the allocation guidelines and this has improved the quality of the assessment undertaken and in the targeting of services applied. This is a key mechanism for the DHB in getting its costs under control whilst still delivering the services required to people at home.	
Number of clients receiving a package of care in the last 12 months Target: 3111*	There were 3805 people who received a package of care in the community during the 2009/10 year. This exceeds our target of 3111* people. * Target was incorrectly printed in the 09/10 SOI and has been corrected above.	Achieved
Percentage of the population aged 65-79 years who have spent time in residential care in the last 12 months Target: Maintain current proportion	 The percentage of 65-79 year olds who spent time in residential care in the last 12 months continues to remain below the threshold of 2.4% set in 2007/08. A lower percentage is a positive result. This is actively managed through our package of care programme to ensure we are able to manage people in home for as long as possible before the need for residential services arises.	Achieved

OUTCOME THREE: FINANCIAL AND CLINICAL VIABILITY OF SERVICES, FACILITIES AND SUPPORT

Output Class: Hospital services		
Medium term outcome	**Improving efficiency and productivity** Hospitals in New Zealand are almost always successful in ensuring that patients with very serious conditions requiring urgent attention (triage category 1) are seen immediately. Nevertheless, many hospitals in New Zealand have historically struggled to match the benchmarks for patients with less urgent conditions, in triage categories 4 and 5. This means there is still a lot of potential to improve the speed at which patients are treated in hospital emergency departments. Improving the flow of patients through hospitals is now the subject of ongoing work. The intent is to eliminate waits and delays for patients in all parts of the hospital, including the emergency department. Such improvements will not only improve the patients' experience of care, but should also lower costs, improve staff morale and provide better clinical outcomes. Greater efficiency will lead to more capacity in the health and disability sector so more can be achieved with the available funding.	
Performance measure	**2009/10 performance**	**Achievement**
Percentage of patients admitted, discharged or transferred from ED within six hours Target: 90%	 The national aim is for 95% of patients to be admitted, transferred, and discharged from ED within 6 hours. C&C DHB is working towards achieving this with a local target for 2009/10 of 90%. Actions to increase compliance have included: • A Medical Assessment and Planning Unit was opened in November 2009 • Three work streams have been formed and are working in three areas: managing people in the community so they don't need to come to ED, improving patient flow within the hospital (from arrival at ED to discharge), and making sure people aren't returned to ED after discharge.	Progress made toward target

Proportion of patients seen within triage waiting time guidelines Target: Triage 1= 100% seen immediately Triage 2= 80% seen within 10mins Triage 3= 75% seen within 30mins Triage 4= 70% seen within 60mins (semi urgent) Triage 5= 70% seen within 120mins (non-urgent)	 Triage 1 / Triage 2 / Triage 3 / Triage 4 / Triage 5 2007/2008: 100.00 / 75.45 / 50.23 / 47.58 / 74.13 2008/2009: 100.00 / 63.16 / 35.74 / 38.20 / 65.20 2009/2010: 100.00 / 59.22 / 28.13 / 31.01 / 57.90 Target: 100.00 / 80.00 / 75.00 / 70.00 / 70.00 We have not achieved our targets for triage levels 2-5. Overall volumes through the Emergency Department increased in the 2009/10 year.	Not achieved
Medium term outcome	**Improving efficiency and productivity** Surgical complication rates have a direct influence on the DHB's average length of stay. By keeping our complication rates at an acceptable level we can ensure patients are having the shortest length of stay that is considered safe and so increasing our productivity and ability to meet our elective surgery targets. This measure also contributes to our elective target that day of admission is the day of surgery. The surgical theatres at Kenepuru hospital are underutilised. By increasing the number of elective operations performed there, C&C DHB can increase productivity and help achieve the target increased elective volumes. This will also have a direct positive effect on our theatre utilisation rate. Theatre utilisation only offers one view of how we are using our theatres, as well as meeting daily targets for efficiency we want to ensure that surgical procedures are completed within the allocated time, without requiring overtime charges. This theatre timing measure illustrates how often that is achieved.	

Performance measure	2009/10 performance	Achievement
Number of people who have elective surgery on the day of admission Target: Increase from baseline	In 2008/09 there were 2976 elective events where surgery occurred on the day of admission. This number increased in 2009/10 to 3273.	Achieved

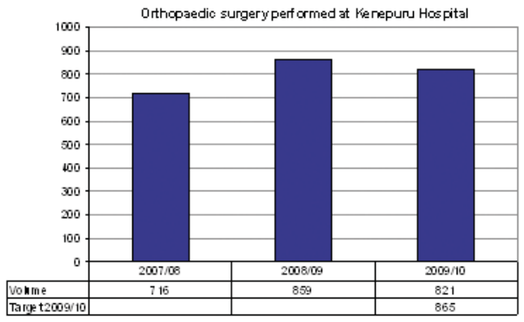
Proportion of elective surgeries performed on day of admission (DoSA rate) Target: Increase from baseline	 2008/09 / 2009/10 % of surgeries: 72.4% / 74.7% Our target for day of surgery admissions was to increase from baseline. The baseline set in 2007/08 of 82.3% included obstetrics and neonates, whereas more recent methodology does not. This means rates are now lower. Day of surgery admission has increased from 2008/09.	Progress made toward target
Total hospital inpatient average length of stay Target: <5.1 days	 Medical / Surgical / Total 2007/08: 5.5 / 4.6 / 5.1 2008/09: 5.7 / 4.4 / 5.1 2009/10: 5.3 / 4.6 / 4.9 Target 09/10: / / 5.1 We have achieved our target of reducing inpatient length of stay. The total reduction is due to the decreasing length of stay in medical specialties.	Achieved
Percentage of general surgery events with complications Target: 10%	 2007/08 / 2008/09 / 2009/10 Complication rate: 11% / 10% / 10% Target 2009/10: / / 10% We have achieved our target of a 10% or lower complication rate in general surgery.	Achieved

<table>
<tr><td>Elective theatre utilisation rate

Target: >80%</td><td><table><tr><td></td><td>2009/2010</td><td></td></tr><tr><td>Baseline (2007/08)</td><td>Target</td><td>Actual</td></tr><tr><td>80%</td><td>>80%</td><td>81%</td></tr></table>We have achieved our target of an increase in theatre utilisation over the 2007/08 baseline.

Note that there has been a change in methodology for the 2009/10 year and going forward. This involves no longer counting as “available” minutes for sessions that have been pre-indicated as closed or cancelled, and changes in the way overruns are calculated.

C&C DHB have implemented an upgraded theatre information system with more rigorous controls around data entry and accuracy checks. These changes have allowed more accurate theatre utilisation reporting.</td><td>Achieved</td></tr>
<tr><td>Number of elective surgery volumes at Kenepuru Hospital

Target: >865</td><td> 

The number of orthopaedic surgery volumes at Kenepuru Hospital decreased slightly from 2008/09, so we did not meet our target of 865.</td><td>Not achieved</td></tr>
<tr><td>No of theatre session late starts and over-runs

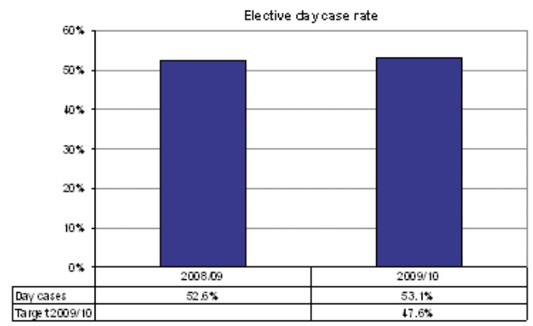
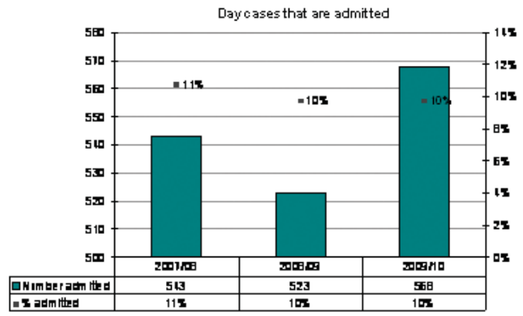
Target:

Late starts 2,804

Over-runs 1,880</td><td><table><tr><td></td><td>2009/2010</td><td></td></tr><tr><td></td><td>Target</td><td>Actual</td></tr><tr><td>Late starts</td><td>2,804</td><td>3,653</td></tr><tr><td>Over-runs</td><td>1,880</td><td>3,543</td></tr></table>Actual results for the 2009/10 year are not directly comparable with the baselines and targets. There has been a change in the definitions and methodology used to calculate late starts and over-runs and an upgraded theatre system implemented.

The increased volume of overall elective surgery impacts on the absolute number of late starts and over-runs.</td><td>Not achieved</td></tr>
<tr><td>Medium term outcome</td><td>Improving hospital systems and processes

This indicator measures improvement in hospital systems and processes. It measures the number of elective daycases as a percentage of all elective procedures.</td><td></td></tr>
</table>

Performance measure	2009/10 performance	Achievement
Proportion of elective discharges done as a day-case Target: >47.6%	 We have exceeded our target for electives performed as day cases. Note that methodology for calculating this measure has been updated, so the figure reported for 2008/09 may not be comparable with that reported elsewhere.	Achieved
Number of people initially identified as elective day-case that are admitted Target: 490	 In 2007/08 there were 543 intended day cases that were admitted (11% of all day cases). Based on this a target of 490 was set for 2009/10; a reduction to 10% of all day cases. Since 2007/08 there has been an increase in intended day cases and as such we have not achieved the target number of 490, however we have reduced the proportion admitted to 10%.	Progress made toward target

AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of the Capital and Coast District Health Board's financial statements and statement of service performance for the year ended 30 June 2010

The Auditor General is the auditor of the Capital and Coast District Health Board (the Health Board). The Auditor General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf. The audit covers the financial statements and statement of service performance included in the annual report of the Health Board for the year ended 30 June 2010.

Unqualified opinion

In our opinion:

- The financial statements of the Health Board on pages 130 to 196:
  - › comply with generally accepted accounting practice in New Zealand; and
  - › fairly reflect:
    - › the Health Board's financial position as at 30 June 2010; and
    - › the results of its operations and cash flows for the year ended on that date.
- The statement of service performance of the Health Board on pages 109 to 127:
  - › complies with generally accepted accounting practice in New Zealand; and
  - › fairly reflects for each class of outputs:
    - › its standards of delivery performance achieved, as compared with the forecast standards included in the statement of forecast service performance at the start of the financial year; and
    - › its actual revenue earned and output expenses incurred, as compared with the expected revenues and proposed output expenses included in the statement of forecast service performance at the start of the financial year.

The audit was completed on 29 October 2010, and is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

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

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;

- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement and statement of service performance disclosures are adequate.

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

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

Responsibilities of the Board and the Auditor

The Board is responsible for preparing the financial statements and statement of service performance in accordance with generally accepted accounting practice in New Zealand. The financial statements must fairly reflect the financial position of the Health Board as at 30 June 2010 and the results of its operations and cash flows for the year ended on that date. The statement of service performance must fairly reflect, for each class of outputs, the Health Board's standards of delivery performance achieved and revenue earned and expenses incurred, as compared with the forecast standards, revenue and expenses at the start of the financial year. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

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

Independence

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

In addition to the audit, we carried out an assignment to provide independent assurance over the management of a value for money project, which is compatible with the independence requirements above. Other than the audit and this assignment, we have no relationship with or interests in the Health Board.

S B Lucy

Audit New Zealand

On behalf of the Auditor General

Wellington, New Zealand

FINANCIAL STATEMENTS

Statement of comprehensive income

For the year ended 30 June 2010
in thousands of New Zealand dollars

	Note	2010 Actual	2010 Budget	2009 Actual
Revenue	1	841,446	844,575	770,922
Total income		841,446	844,575	770,922
Employee benefit costs	3	350,565	352,578	321,752
Depreciation and amortisation expense	6,7	37,983	38,425	21,526
Outsourced services		20,255	16,350	30,620
Clinical supplies		97,998	92,467	91,772
Infrastructure and non-clinical expenses		41,621	43,291	58,421
Payments to non-health board providers		304,184	313,174	288,965
Other operating expenses	2	8,620	1,919	5,312
Finance costs	4	20,940	22,507	12,733
Capital charge	5	6,763	11,525	5,915
Total expenses		888,929	892,236	837,016
Surplus/(deficit) for the year		(47,483)	(47,661)	(66,094)
Other comprehensive income				
Share of profit / (loss) of associates	9a	-	-	45
Movement in revaluation property, plant, and equipment		(164)	(2,191)	(1,160)
Other comprehensive income for the year		(164)	(2,191)	(1,115)
Total comprehensive income for the year		(47,647)	(49,852)	(67,209)

Explanations of significant variances against budget are detailed in note 23.

Statement of recognised income and expense

For the year ended 30 June 2010
in thousands of New Zealand dollars

	Other reserves				
	Crown equity	Revaluation Reserve (Land)	Revaluation Reserve (Plant & Equipment)	Retained earnings	Total equity
Balance at 1 July 2008	231,250	24,269	8,741	(147,392)	116,868
Contribution from the Crown	70,862	-	-	-	70,862
Repayment of equity	(3,484)	-	-	-	(3,484)
Total comprehensive income of the year	-	-	(1,160)	(66,049)	(67,209)
Balance at 30 June 2009	298,628	24,269	7,581	(213,441)	117,037
Balance at 1 July 2009	298,628	24,269	7,581	(213,441)	117,037
Contribution from the Crown	87,148	-	-		87,148
Repayment of equity	(3,484)	-	-		(3,484)
Total comprehensive income for the year	-	-	(164)	(47,483)	(47,647)
Balance at 30 June 2010	382,292	24,269	7,417	(260,924)	153,054

The accompanying notes form part of these financial statements.

Statement of financial position

As at 30 June 2010
in thousands of New Zealand dollars

	Note	2010 Actual	2010 Budget	2009 Actual
Assets				
Current assets				
Cash and cash equivalents	11	2,868	13	13
Trade and other receivables	10	37,837	70,370	58,503
Inventories	8	6,406	6,000	6,807
Trust/special funds	12	7,383	5,900	6,851
Total current assets		**54,494**	**82,283**	**72,174**
Non-current assets				
Property, plant and equipment	6	550,061	517,860	507,543
Intangible assets	7	15,921	47,343	938
Investments in associates	9a	-	-	27,641
Investments in joint ventures	9b	-	-	-
Total non-current assets		**565,982**	**565,203**	**536,122**
Total assets		**620,476**	**647,486**	**608,296**
Equity				
Crown equity		382,292	411,167	298,628
Other reserves		31,686	30,819	31,850
Retained earnings/(losses)		(260,924)	(258,027)	(213,441)
Total equity		**153,054**	**183,959**	**117,037**
Liabilities				
Current liabilities				
Bank overdraft	11	-	15,464	32,727
Borrowings	13	28,279	-	24,240
Employee entitlements	14	49,316	-	50,942
Provisions	15	1,125	5,762	379

The accompanying notes form part of these financial statements.

Statement of financial position - cont'd

Trade and other payables	16	70,797	92,086	65,068
Patient and restricted funds	17	156	-	154
Total current liabilities		**149,673**	**113,312**	**173,510**
Non-current liabilities				
Borrowings	13	311,816	339,000	311,984
Employee entitlements	14	5,773	5,250	5,675
Provisions	15	160	-	90
Patient and restricted funds	17	-	5,965	-
Total non-current liabilities		**317,749**	**350,215**	**317,749**
Total liabilities		**467,422**	**463,527**	**491,259**
Total equity and liabilities		**620,476**	**647,486**	**608,296**

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2010
in thousands of New Zealand dollars

	Note	2010 Actual	2010 Budget	2009 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		815,013	785,129	726,172
Other receipts		29,363	22,388	41,518
Cash paid to suppliers		(465,854)	(450,536)	(439,404)
Cash paid to employees		(352,093)	(326,855)	(319,655)
Cash generated from operations		26,429	30,126	8,631
Goods and Services Tax (a)		3,622	(18,000)	(26,839)
Capital charge paid		(6,388)	(9,209)	(5,956)
Net cash flows from operating activities	**11**	**23,663**	**2,917**	**(24,164)**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		13,429	23,000	12
Interest received		425	201	1,022
Acquisition of property, plant and equipment		(49,089)	(37,699)	(79,942)
Advances to associates		-	-	(9,150)
Acquisition of intangible assets	7	(19,042)	(13,841)	(373)
Net appropriation from trust funds	12	(530)	862	(1,272)
Net cash flows from investing activities		**(54,807)**	**(27,477)**	**(89,703)**
Cash flows from financing activities				
Proceeds from equity injection		87,150	69,764	92,345
Borrowings raised		4,000	-	24,000
Repayment of equity		(3,484)	-	(3,483)
Interest paid		(20,940)	(19,238)	(12,864)

The accompanying notes form part of these financial statements.

Statement of cash flows - cont'd

For the year ended 30 June 2010
in thousands of New Zealand dollars

Net cash flows from financing activities		**66,726**	**50,526**	**99,998**
Net increase in cash and cash equivalents		35,582	25,966	(13,869)
Cash and cash equivalents at beginning of year		(32,714)	(41,418)	(18,845)
Cash and cash equivalents at end of year	**11**	**2,868**	**(15,452)**	**(32,714)**

(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.

Statement of contingent liabilities

As at 30 June 2009
in thousands of New Zealand dollars

	Note	2010 Actual	2009 Actual
Legal proceedings against the DHB		82	325
Other contractual matters		9	-
		91	**325**

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 2010 (2009: 3).

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 (2009: $nil).

The accompanying notes form part of these financial statements.

Statement of commitments

As at 30 June 2010
in thousands of New Zealand dollars

	Note	2010 Actual	2009 Actual
Capital commitments		**9,969**	**24,786**
Non-cancellable commitments – provider commitments			
Not more than one year		128,376	117,397
One to two years		23,459	31,690
Two to five years		39,463	54,972
Over five years		2,145	-
		193,443	**204,059**
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,210	1,562
One to two years		1,768	868
Two to five years		2,056	829
Over five years		37	36
		6,071	**3,295**

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 by NZIAS 1.

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

The accompanying notes form part of these financial statements.

Notes to the financial statements

Statement of accounting policies For the year ended 30 June 2010

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.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

The DHB has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). 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 owners. The DHB has decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated accordingly. Items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used, and requires the maturity analysis of derivative liabilities to be presented separately from non-derivative financial liability contractual maturity analysis.

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

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB are as listed below. The DHB has not yet assessed the effect of the new standards and expects they will not be early adopted.

- NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004) and is effective for reporting periods commencing on or after 1 January 2011. The revised standard:
  - i) Removes the previous disclosure concessions applied by the DHB for arms-length transactions between the DHB and entities controlled or significantly influenced by the Crown. The effect of the revised standard is that more information is required to be disclosed about transactions between the Ministry and entities controlled or significantly influenced by the Crown.
  - ii) Provides clarity on the disclosure of related party transactions with Ministers of the Crown. Further, with the exception of the Minister of Accountability, the DHB will be provided with an exemption from certain disclosure requirements relating to transactions with other Ministers of the Crown. The clarification could result in additional disclosures should there be any related party transactions with Ministers of the Crown.
  - iii) Clarifies that related party transactions include commitments with related parties
- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014.

Basis of preparation

The financial statements for the year ended 30 June 2010 were approved by the Board on 29 October 2010.

The financial statements have been prepared for the period 1 July 2009 to 30 June 2010. Comparative figures and balances relate to the period 1 July 2008 to 30 June 2009.

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 land, buildings, 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.

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

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 comprehensive income. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- leasehold improvements
- plant and equipment
- fixture and fittings/other equipment
- 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, property, 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 comprehensive income. 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 comprehensive income.

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

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

Disposal of property, plant and equipment

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

Leased assets

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

Subsequent costs

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

Depreciation

Depreciation is charged to the statement of comprehensive income 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
Buildings structure	1 to 75 years
Building fitouts	1 to 25 years
Plant and equipment	1 to 25 years
Leasehold Improvements	1 to 50 years

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 comprehensive income as an expense as incurred. Other development expenditure is recognised in the statement of comprehensive income as an expense as incurred.

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
Software	10 years
Licenses	10 years

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 statement of cash flows.

Impairment

The carrying amounts of the DHB's assets other than investment property, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated. If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of comprehensive income.

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.

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 comprehensive income.

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 comprehensive income as incurred.

Defined benefit plan

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

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

The DHB's net obligation in respect of long service leave, sabbatical 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 are initially recognised at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments

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

Derivative financial instruments (continued)

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 comprehensive income. 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 comprehensive income in the same period or periods during which the asset acquired or liability assumed affects the statement of comprehensive income (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 comprehensive income in the same period or periods during which the hedged forecast transaction affects the statement of comprehensive income. The ineffective part of any gain or loss is recognised immediately in the statement of comprehensive income.

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 comprehensive income.

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.

Interest

Interest income is recognised using the effective interest rate method.

Rental income

Rental income from property is recognised in the statement of comprehensive income 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.

Expenses

Operating lease payments

Payments made under operating leases are recognised as an expense in the statement of comprehensive income 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 2010, indirect costs accounted for 2.00% of the DHB's total costs (2009: 1.83%)

Accounting estimates and judgements

Management discussed with the Finance Risk & 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 comprehensive income, 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

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.

in thousands of New Zealand dollars

1	Revenue	Note	2010 Actual	2009 Actual
	Ministry of Health contract funding		624,222	587,378
	Other government		18,459	18,159
	Inter district flows (other DHBs)		161,402	147,627
	Non government & crown agency sourced		27,653	15,884
	Gain on sale of property, plant and equipment		9,285	845
	Interest Income		425	1,022
	Decrease in provision of trade receivables (doubtful debts)	10	-	7
			841,446	**770,922**

2	Other operating expenses			
	Impairment loss on associate investment	9a	2,966	-
	Impairment of trade receivables (bad debts)		830	549
	Increase in provision of trade receivables (doubtful debts)	10	714	-
	Loss on disposal of property, plant and equipment		244	685
	Fees to auditor:			
	Fees for financial statements audit		191	237
	Fees for other assurance services		10	-
	Board members fees	20	380	391
	Rental and other operating expenses		3,262	3,450
	Litigation settlement		23	-
			8,620	**5,312**

in thousands of New Zealand dollars

3	Employee benefit costs	Note	2010 Actual	2009 Actual
	Direct staff costs (excluding increases in employee benefit provisions)		330,626	300,728
	Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)		12,828	14,362
	Contributions to defined contribution plans		6,279	4,107
	Increase/(decrease) in employee benefit provisions		832	2,555
			350,565	**321,752**

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		1,256	646
	Interest on term borrowings		19,595	12,079
	Interest on finance leases		89	8
			20,940	**12,733**

5	Capital charge			
	C&C DHB 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 2010 was 8 per cent (2009: 8 per cent)		6,763	5,915

in thousands of New Zealand dollars

6 Property, plant and equipment							
Cost	Freehold land	Freehold buildings	Lease improve-ments	Plant & Equip-ment	Furniture, Fittings & Equip-ment	Work in progress	Total
Cost							
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)	-	(290,156)
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(287,380)	-
Other movements	-	-	-	-	-	(294)	(294)
Balance at 30 June 2009	**30,850**	**422,028**	**2,685**	**68,176**	**21,780**	**26,878**	**572,397**
Balance at 1 July 2009	30,850	422,028	2,685	68,176	21,780	26,878	572,397
Additions	-	45,505	18	16,229	18,871	100,304	180,927
Disposals	(4,488)	(578)	-	(711)	(37)	-	(5,814)
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(99,319)	(99,319)
Other movements	-	-	-	-	-	-	-
Balance at 30 June 2010	**26,362**	**466,955**	**2,703**	**83,694**	**40,614**	**27,863**	**648,191**

Property, plant and equipment - cont'd							
Depreciation and impairment losses	Freehold land	Freehold buildings	Lease improve-ments	Plant & Equip-ment	Furniture, Fittings & Equip-ment	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)**

in thousands of New Zealand dollars

Property, plant and equipment - cont'd							
Depreciation and impairment losses	Freehold land	Freehold buildings	Lease improve-ments	Plant & equip	Furniture, Fittings & Equip-ment	Work in progress	Total
Balance at 1 July 2009	-	(37,670)	(1,211)	(15,376)	(10,597)	-	(64,854)
Depreciation charge for the year	-	(18,796)	(131)	(10,990)	(4,007)	-	(33,924)
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	319	-	309	20	-	648
Revaluations	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-
Balance at 30 June 2010	**-**	**(56,147)**	**(1,342)**	**(26,057)**	**(14,584)**	**-**	**(98,130)**
Carrying amounts							
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
At 1 July 2009	30,850	384,358	1,474	52,800	11,183	26,878	507,543
At 30 June 2010	**26,362**	**410,808**	**1,361**	**57,637**	**26,030**	**27,863**	**550,061**

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

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

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

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

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

Restrictions

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

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

in thousands of New Zealand dollars

Leased assets

The net carrying amount of property, plant and equipment held under finance leases is $1.048m (2009: $1.206m).

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $27.86m (2009: $26.88m) which includes $19.7m of refurbishment of existing buildings.

Property, plant and equipment acquired by finance leases

During the period the DHB acquired property, plant and equipment totalling $0.13 m (2009: $1.17m) by means of finance leases.

7. Intangible assets

Cost	Software	Licences	Total
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**
Balance at 1 July 2009	923	1,406	2,329
Additions	18,944	98	19,042
Disposals	-	(2)	(2)
Balance at 30 June 2010	**19,867**	**1,502**	**21,369**
Amortisation and impairment losses			
Balance at 1 July 2008	(143)	(1,049)	(1,192)
Amortisation charge for the year	(134)	(65)	(199)
Impairment losses	-	-	-
Disposals	-	-	-
Balance at 30 June 2009	**(277)**	**(1,114)**	**(1,391)**
Balance at 1 July 2009	(277)	(1,114)	(1,391)
Amortisation charge for the year	(3,981)	(78)	(4,059)
Impairment losses	-	-	-
Disposals	-	2	2
Balance at 30 June 2010	**(4,258)**	**(1,190)**	**(5,448)**
Carrying amounts			
At 1 July 2008	451	313	764
At 30 June 2009	646	292	938
At 1 July 2009	646	292	938
At 30 June 2010	**15,609**	**312**	**15,921**

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	2010 Actual	2009 Actual
Pharmaceuticals	1,186	1,269
Surgical & Medical Supplies	5,110	5,350
Other supplies	110	188
	6,406	**6,807**

The amount of inventories recognised as an expense during the year ended 30 June 2010 was $44.77m (2009: $44.82m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2009: $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

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 Information Technology needs. Impairment loss on associate investment was $2.966m which has been recognised in the statement of comprehensive income.

a) General information

Name of entity	Principal activities	Interest held at 30 June 2009	Balance Date
HIQ Limited	Owns and manages information systems	50%	30 June

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

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**

c) Share of profit of associate entities

	2009 Actual
Share of profit/(loss)	45

The share of profit or loss from HIQ Ltd was dependant upon activities performed for the DHB and did not necessarily reflect the percentage shareholding.

HIQ Ltd was a Public Authority in terms of the Income Tax Act 2004 and consequently exempt from income tax.

d) Investment in associate entities

	2010 Actual	2009 Actual
Carrying amount at beginning of year	27,641	20,032
Acquisition of new investments	-	-
Disposal of investments	27,641	-
Share of total recognised revenue and expenses	-	45
Dividends	-	-
Issue of shares	-	7,564
Carrying amount at end of year	**-**	**27,641**

e) Share of associates' contingent liabilities and commitments

	2009 Actual
Contingent liabilities	-
Contracted capital commitments	-
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

	2010 Actual	2009 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%)

	2010 Actual	2009 Actual
Non-current assets	38	27
Current assets	124	124
Non-current liabilities	-	-
Current liabilities	59	76
Net assets/(liabilities)	**103**	**75**
Income	509	498
Expense	484	491
	25	**7**

c) The DHB's share in contingent liabilities

Central Region TAS has no contingent liabilities. (2009: $nil)

d) The DHB's share in commitments

The DHB share of Capital Commitments for CR TAS is $0.07m 2010 (2009: $0.10m).

10. Trade and other receivables

	2010 Actual	2009 Actual
Trade receivables due from associates	-	8,948
Trade receivables from non-related parties	12,295	13,598
Ministry of Health receivables	17,420	30,728
	29,715	**53,274**
Accrued income	6,274	4,479
Prepayments	1,848	750
Crown Equity receivable	-	-
	37,837	**58,503**

Trade receivables are shown net of provision for doubtful debts amounting to $2.4m (2009: $1.6m)

The carrying value of receivables approximates their fair value.

As at 30 June 2010, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2010			2009		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	25,066	-	25,066	43,987	-	43,987
Past due 1-30 days	1,318	-	1,318	1,661	-	1,661
Past due 31-60 days	617	-	617	683	-	683
Past due 61-90 days	795	-	795	1,624	-	1,624
Past due > 91 days	4,282	2,363	1,919	6,968	1,649	5,319
Total	**32,078**	**2,363**	**29,715**	**54,923**	**1,649**	**53,274**

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:

	2010 Actual	2009 Actual
Balance at 1 July	1,649	1,656
Additional provisions made during the year	2,713	427
Provisions reversed during the year	-	(434)
Receivables written-off during period	(1,999)	-
Balance at 30 June	**2,363**	**1,649**

11. Cash and cash equivalents

	2010 Actual	2009 Actual
Petty cash	14	13
Bank accounts	2,854	-
Call deposits	-	-
Cash and cash equivalents	**2,868**	**13**
Bank overdraft	-	(32,727)
Cash and cash equivalents in the statement of cash flows	**2,868**	**(32,714)**

Patient funds

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 $ nil as at 30 June 2010 (2009: $32.7m).

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.

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

	Note	2010 Actual	2009 Actual
Surplus/(deficit) for the year		(47,483)	(66,049)
Add back non-cash items:			
Depreciation		37,979	21,526
Share of (profit)/loss from associate companies		-	(45)
Add back items classified as investing activity:			
Net loss/(gain) on disposal of property, plant and equipment		(9,043)	(160)
Interest income on financial assets		(425)	(1,022)
Add back items classified as financing activity:			
Interest expense on financial liabilities		20,940	12,864
Movements in working capital:			
(Increase)/decrease in trade and other receivables		20,134	5,792
(Increase)/decrease in inventories		401	(943)
Increase/(decrease) in trade and other payables		1,873	1,467
Increase/(decrease) in employee benefits		(1,529)	2,862
Increase/(decrease) in provisions		816	(456)
Net movement in working capital		21,695	8,722
Net cash inflow/(outflow) from operating activities		**23,663**	**(24,164)**

in thousands of New Zealand dollars

12. 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 comprehensive income.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the statement of comprehensive income, 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.

Non patient trust funds	2010 Actual	2009 Actual
Balance at beginning of year	6,710	5,682
Monies received	2,222	1,823
Interest received	267	357
Payments made	(1,957)	(1,152)
Balance at end of year	**7,242**	**6,710**
Patient funds	**2010 Actual**	**2009 Actual**
Balance at beginning of year	141	163
Monies received	229	825
Interest received	2	4
Payments made	(231)	(851)
Balance at end of year	141	141
Total Trust/Special funds	**7,383**	**6,851**

13. Interest-bearing loans and borrowings

	2010 Actual	2009 Actual
Non-current		
Secured CHFA loans	311,000	311,000
Finance leases	816	984
	311,816	**311,984**
Current		
Secured CHFA loans	-	-
Secured bank loans	28,000	24,000
Finance leases	279	240
	28,279	**24,240**

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:

Interest rate summary	2010 Actual	2009 Actual
Crown Health Financing Agency	5.16% - 7.13%	5.16%- 7.13%
Bank loan	3.17% - 3.22%	3.22%
Finance leases	6.50%	6.50%

Repayable as follows:	2010 Actual	2009 Actual
Within one year	28,000	24,000
One to two years	80,000	-
Two to five years	141,000	150,000
Later than five years	90,000	161,000

in thousands of New Zealand dollars

Analysis of finance leases	2010 Actual	2009 Actual
Minimum lease payments payable		
Within one year	350	320
One to two years	329	317
Two to five years	592	816
Later than five years	-	9
Total minimum lease payments	**1,271**	**1,462**
Future finance charges	(177)	(238)
Present value of minimum lease payments	**1,094**	**1,224**
Present value of minimum lease payments payable		
Within one year	328	300
One to two years	290	280
Two to five years	476	638
Later than five years	-	6
Total present value of minimum lease payments	**1094**	**1,224**
Term loan facility limits		
Crown Health Financing Agency	311,000	311,000
Bank loan	28,000	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

in thousands of New Zealand dollars

- 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.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2010 was $nil (2009: $8.0m)

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

14. Employee entitlements

Non-current liabilities	2010 Actual	2009 Actual
Liability for long-service leave	3,191	2,773
Liability for sabbatical leave	345	327
Liability for retirement gratuities	2,237	2,575
	5,773	**5,675**

Current liabilities	2010 Actual	2009 Actual
Liability for long-service leave	1,700	1,694
Liability for sabbatical leave	240	170
Liability for retirement gratuities	800	414
Liability for annual leave	31,513	29,979
Liability for sick leave	1,880	1,744
Liability for continuing medical education leave and expenses	7,225	5,779
Salary and wages accrual	5,958	11,162
	49,316	**50,942**

in thousands of New Zealand dollars

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%, (2009: 3.0%) and a discount rate ranging from 3.69% to 5.64% (2009: 3.49% to 6.35%) from 1-10+ years.

15. Provisions

	2010 Actual	2009 Actual
Current provisions		
ACC Partnership Programme	1,125	379
Non Current Provisions		
ACC Partnership Programme	160	90
Total Provisions	**1,285**	**469**

ACC partnership programme	2010 Actual	2009 Actual
Undiscounted amount of claims at balance date	1,108	404
Discount	50	18
Central estimate of present value of future payments	1,158	422
Risk margin	**127**	**47**
	1,285	**469**

The movement in provisions is represented by:

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	-	-
	563	**767**
Amounts used during the year	563	298
Total liability	-	469
Increase in provision for claims liability	**(563)**	**107**

2010	ACC Partnership Programme
Opening balance	469
Additional provisions during the year for the risks borne in current period	423
Additional provisions relating to a reassessment of risks in a previous period	693
Subtotal	**1585**
Amounts used during the year	300
Total liability	1,285
(Decrease) / increase in provision	**816**

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.

in thousands of New Zealand dollars

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

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

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

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

The DHB has chosen a stop loss limit of 250% of the industry premium. The stop loss limit means that the DHB will only carry the total cost of claims up to $3.9m.

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 4.5% has been used for the year ended 30 June 2010 and 4.5% 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.

in thousands of New Zealand dollars

16. Trade and other payables

	Note	2010 Actual	2009 Actual
Trade payables to other related parties	20	3,301	8
Trade payables to non-related parties		5,581	4,923
GST and other taxes payables		11,800	8,178
Income in advance		340	2,718
Capital charge due to the Crown		1,226	851
Other non-trade payables and accrued expenses		48,549	48,390
		70,797	**65,068**

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

17. Patient and restricted funds

Patient funds	2010 Actual	2009 Actual
Balance at beginning of year	141	163
Monies received	230	825
Interest received	2	4
Payments made	(231)	(851)
Balance at end of year	**142**	**141**

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 2010 are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as at 30 June 2010, both as an asset and a liability.

in thousands of New Zealand dollars

Holiday homes funds	2010 Actual	2009 Actual
Balance at beginning of year	54	46
Monies received	13	14
Interest received	1	2
Payments made	(8)	(8)
Balance at end of year	**59**	**54**
Hutt Valley DHB Portion ¼ of Holiday Homes total	**14**	**13**
Total Patient and Hutt Valley Portion of Restricted Funds	**156**	**154**

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 DHB, 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.

18. Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2010 Actual	2009 Actual
Less than one year	2,210	1,562
Between one and five years	3,825	1,697
More than five years	37	36
	6,072	**3,295**

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 2010, $2.8m was recognised as an expense in the statement of financial performance in respect of operating leases (2009: $2.5m)

in thousands of New Zealand dollars

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:

	2010 Actual	2009 Actual
Less than one year	162	2,292
Between one and five years	514	6,980
More than five years	1,363	165
	2,039	**9,437**

During the year ended 30 June 2010, $3.05m was recognised as rental income in the statement comprehensive income (2009: $2.67 m)

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 45 short term commercial leases all subject to 6 month notice of termination.

The DHB has 3 residential leases all subject to the Residential Tenancies Act.

19. 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.

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 balance sheet date and the periods in which they reprice.

	2010 Actual							2009 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	5.16	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*	6.37	62,000					62,000	6.37	62,000					62,000
NZD fixed rate loan*	6.295	20,000				20,000		6.295	20,000					20,000
NZD fixed rate loan*	7.13	12,000				12,000		7.13	12,000					12,000
NZD fixed rate loan*	6.57	11,000				11,000		6.57	11,000					11,000
NZD fixed rate loan*	6.95	19,400				19,400		6.95	19,400					19,400
NZD fixed rate loan*	6.39	8,600				8,600		6.39	8,600					8,600
NZD fixed rate loan*	3.47	28,000	28,000					3.22	24,000	24,000	-	-	-	-
Finance leases*	6.5	1,094	164	164	290	476	-	6.50	1,224	150	150	280	638	6
Bank overdrafts		-	-	-	-	-	-	3.30	32,727	32,727	-	-	-	-
		340,094	28,164	164	80,290	141,476	90,000		368,951	56,877	150	280	150,638	161,006

* These liabilities bear interest at fixed rates

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%). 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 borrowings 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 2010 was $nil (2009: $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 $0.1 m in 2010, (2009: $0.1m).

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 2010, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $5.13m (2009: $3.57m). 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 $4.29 m for the year ended 30 June 2010 (2009: $0.04m).

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
2010						
Creditors and other payables	70,797	70,797	70,797	-	-	-
Bank overdraft	-	-	-	-	-	-
Secured loans	339,000	418,712	47,797	97,115	173,769	100,031
Finance leases	1,094	1,271	350	329	592	-
Patient and restricted funds	156	156	156	-	-	-
Total	**411,047**	**490,936**	**119,100**	**97,444**	**174,361**	**100,031**
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**

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
2010						
Cash and cash equivalents	14	14	14	-	-	-
Bank accounts	2,854	2,854	2,854	-	-	-
Debtors and other receivables	37,837	37,837	37,837	-	-	-
Trust and special funds - bank	670	670	670	-	-	-
Trust and special funds – term deposit	6,300	6,386	6,386	-	-	-
Trust and special funds – debtors	413	413	413	-	-	-
Total	**48,088**	**48,174**	**48,174**	-	-	-
2009						
Cash and cash equivalents	13	13	13	-	-	-
Bank accounts	-	-	-	-	-	-
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**	**-**	**-**	**-**

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:

	2010 Actual	2009 Actual
Cash at bank and petty cash	14	13
Bank Accounts	2,854	-
Debtors and other receivables	37,837	58,503
Trust and special funds – bank	670	1,514
Trust and special funds – term deposit	6,300	5,100
Trust and special funds – debtors	413	237
	48,088	**65,367**
Counterparties with Credit Ratings		
Cash at bank and term deposits		
AA (Standard & Poors)	9,838	6,627
	9,838	**6,627**

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 US 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 2010 was $nil (2009: $nil), comprising assets of $nil (2009: $nil) and liabilities of $nil (2009: $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 comprehensive income. 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 2010 was $nil (2009: $nil) recognised in fair value derivatives.

Fair values

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

	Note	Carrying amount 2010 Actual	Fair value 2010 Actual	Carrying amount 2009 Actual	Fair value 2009 Actual
Trade and other receivables	10	37,837	37,837	58,503	58,503
Cash and cash equivalents	11	14	14	13	13
Bank accounts	11	2,854	2,854		
Secured bank loans	13	(339,000)	(359,346)	(335,000)	(350,868)
Finance leases	13	(1,094)	(1,094)	(1,224)	(1,224)
Trade and other payables	16	(70,797)	(70, 797)	(65,068)	(65,068)
Bank overdraft	11	-	-	(32,727)	(32,727)
		(370,186)	**(390,532)**	**(375,503)**	**(391,371)**
Unrecognised (losses)/ gains			**(20,346)**		**15,868**

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.

in thousands of New Zealand dollars

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 2010 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2010 Actual %	2009 Actual %
Derivatives	N/A	N/A
Loans and borrowings	3.17, 5.16, 6.075, 6.295, 6.33, 6.37, 6.39, 6.50, 6.57, 6.84, 6.95, 7.13.	3.22, 5.16, 6.075, 6.295, 6.33, 6.37, 6.39, 6.50, 6.57, 6.84, 6.95, 7.13.

20. Related parties transactions and key management personnel

Identity of related parties

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

The DHB has a related party relationship with its 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 the Director of the Commonwealth Bank of Australia who is the banker for the DHB. Sir John Anderson, who was appointed to the Board of C&C DHB on 13 December 2007, is also the Commissioner of Hawkes Bay DHB.

Ian Brown is the Deputy Commissioner of Hawkes Bay DHB. (Resigned as Crown Monitor in December 2009)

Ken Douglas is a Board member of two suppliers to the DHB, being Healthcare of New Zealand Ltd and New Zealand Post Ltd. He is also a councillor at Porirua City Council. (Left Capital & Coast DHB in November 2009)

Dr Donald Urquhart-Hay has an association with Wakefield Hospital and Mid Central Health.

Dr Selwyn Katene is the Chairman of Te Roopu Awhina. Dr Selwyn Katene is also the Director of MANU AO Academy at Massey University.

Helene Ritchie is a Councillor for Wellington City Council.

Dr. Peter Roberts is a Senior Clinical Lecturer at The University Of Otago Wellington School of Medicine. Dr Peter Roberts is also the President of the New Zealand Medical Association and Chairman of Royal Australasian College of Physicians.

Keith Hindle is a Board Member of Hutt Valley District Health Board. He is also a Consultant for the Wellington Tenths Trust and a Director of Metlifecare Palmerston North.

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

Jim Wicks' wife is an employee of Powerhouse People Ltd.

Cathy O'Malley is the CEO of the following suppliers, 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 a trustee of Wellington Free Ambulance.

Adrian Gilliland is a Clinical Tutor at The University Of Otago Wellington School of Medicine. He is also a member of the Clinical Advisory Group and a practicing GP at Ora Toa PHO.

Bryan Betty is a Board member of Porirua Health Plus and Porirua Union Health. He is also Clinical Tutor at The University Of Otago Wellington School of Medicine.

Taima Fagaloa is a councillor at Porirua City Council.

Debbie Chin is a Board member in Hutt Valley DHB.

Geoff Robinson is the Chair of The Medical Research Institute of New Zealand. He is also the President of Royal Australasian College of Physicians.

Vicky Noble is a Board Member of The College of Nurses Aotearoa.

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

Ken Whelan is the Chairman of CRTAS (joint venture).

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:

	2010 Actual	2009 Actual
Short-term employee benefits	2,949	2,558
Post-employment benefits	-	-
Other long-term benefits	-	-
Termination benefits	-	-
	2,949	**2,558**
Board members	380	391
Executive team	2,949	2,167
	3,329	**2,558**

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

Notes to the financial statements

in thousands of New Zealand dollars

The Board of the DHB as at 30 June 2010, 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 the year ended 30 June 2010.

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

			2010	2009
Sir John Anderson	Appointed	Board Chair	50	50
Judith Aitken	Elected	Chair DSAC	29	30
Ian Brown	Appointed	Crown Monitor to Dec 2009	16	31
Ken Douglas	Appointed	Deputy Chair (Board), Chair (FRAC) to Nov 2009	14	36
Margaret Faulkner	Elected	Deputy Chair (FRAC) to Oct 2009	33	33
Ruth Gotlieb	Elected		28	29
Virginia Hope	Elected	Deputy Chair (Board) and Chair (HAC) from Dec 2009	34	32
Selwyn Katene	Appointed	Chair (CPHAC)	28	31
Helene Ritchie	Elected		29	29
Peter Douglas	Appointed		28	30
Peter Roberts	Elected		28	31
Donald Urquhart-Hay	Elected		28	29
Keith Hindle	Appointed	Chair (FRAC) from Nov 2009	15	-
Debbie Chin	Appointed	Crown Monitor from Dec 2009	20	-
			380	**391**

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

in thousands of New Zealand dollars

Committee Members' (other than Board Members and Employees)	2010	2009
Finance, Risk and Audit Committee		
Maureen Gillon (until May 2010)	1	1
Community and Public Health Advisory Committee		
Herani Demuth (until March 2010)	3	5
Tavita Filemoni	1	2
Frances Hughes	1	1
Ken Patel	1	2
Stephen Palmer	1	1
Api Rongo-Raea	1	1
Disability Support Advisory Committee		
Nathan Bond	1	1
Tavita Filemoni	-	1
Margaret Guthrie (until May 2010)	1	1
Liz Mellish (until March 2010)	1	1
Judy Small	1	1
Hillary Stace	1	2
James Webber (from March 2010)	3	-
Hospital Advisory Committee		
Hilda Broadhurst (until March 2010)	4	7
Malakai Jiko	3	4
Lynn McBain	2	3
Karen Coutts (from March 2010)	1	-
	27	**34**

in thousands of New Zealand dollars

Sales to related parties	2010 Actual	2009 Actual
HIQ	-	308
CRTAS (joint venture)	20	23
Wakefield Hospital	25	32
Capital PHO	93	89
Tumai mo te Iwi	28	27
Kapiti PHO	22	22
Ora Toa PHO	2	7
MATPRO LTD	1	-
Te Roopu Awhina	116	90
Wellington School of Medicine	1,545	1,822
Royal Australasian College of Physicians	2	1
Wellington Free Ambulance	74	64
Compass Health Wellington Trust	110	62
Porirua Health Plus Ltd	3	3
Mid Central DHB	21,913	831
Wellington Hospital and Health Foundation	20	12
Hawkes Bay DHB	18,325	13,356
Massey University	197	-
Hutt Valley DHB	61,558	-
	104,054	**16,749**

Purchases from related parties	2010 Actual	2009 Actual
HIQ	-	20,771
CRTAS (joint venture)	898	41
New Zealand Post	130	421
Healthcare of New Zealand Ltd	719	7,328
Te Roopu Awhina	138	137
Wakefield Hospital	1,376	5,230
Maddison Projects	-	454
PowerHouse People Ltd	398	289

in thousands of New Zealand dollars

Wellington Independent Practices Association	-	-
Compass Health Wellington Trust	8,449	4,927
The Greater Wellington Health Trust	-	1,751
MATPRO Ltd	128	118
Capital PHO	11,255	22,991
Tumai mo te Iwi	4,559	8,287
Wellington City Council	1,180	885
Wellington Free Ambulance	-	17
Royal Australasian College of Physicians	10	21
Wellington Hospital & Health Foundation	82	84
Porirua Union Health	2	-
Porirua City Council	498	570
Massey University	133	-
Medical Research Institute of New Zealand	85	-
Wellington Tenths Trust	175	-
Metlife Care Palmerston North	1,104	-
Kapiti PHO	3,946	-
Ora Toa PHO	2,102	-
Porirua Union Health	737	-
Wellington School of Medicine	10	-
New Zealand Medical Association	2	-
Mid Central DHB	2,720	-
Hutt Valley DHB	42,825	-
Hawkes Bay DHB	1,627	1,309
	82,288	**87,471**

Outstanding balances to related parties	2010 Actual	2009 Actual
CRTAS (joint venture)	-	-
New Zealand Post	-	1
Healthcare of New Zealand Ltd	-	944
Te Roopu Awhina	11	1
Wakefield Hospital	53	-

Compass Health Wellington Trust	844	879
The Greater Wellington Health Trust	-	-
MATPRO Ltd	10	13
Capital PHO	153	194
Tumai mo te Iwi	89	347
Wellington City Council	17	35
Hawkes Bay DHB	3	85
Wellington School of Medicine	10	-
Hutt Valley DHB	1,740	-
Wellington Tenths Trust	27	-
Metlife Care Palmerston North	45	-
Kapiti PHO	-	325
Porirua City Council	21	13
Royal Australasian College of Physicians	-	3
Wellington Free Ambulance	-	1
Ora Toa PHO	223	190
Porirua Health Plus	55	391
	3,301	**3,422**

ASB Bank Ltd

ASB Bank Ltd is the DHB's banker and is a member of the Commonwealth Bank of Australia Group. During the year $1.4 m of interest and bank fees were charged to the DHB and the DHB earned $0.1 m of interest. The ASB Bank Ltd provides a working capital facility of $40m to the DHB. The facility Utilisation as at 30 June 2010 was $nil.

in thousands of New Zealand dollars

Outstanding balances from related parties	2010 Actual	2009 Actual
HIQ	-	8,948
CRTAS (joint venture)	-	2
Massey University	8	-
The Royal Australasian College of Physicians	3	-
Hutt Valley DHB	578	-
Midcentral DHB	126	-
Wellington Hospital and Health Foundation	8	-
Porirua Union Health	1	-
Te Roopu Awhina	20	51
Wakefield Hospital	2	5
Compass Health Wellington Trust	4	11
Hawkes Bay DHB	91	4
Wellington Free Ambulance	-	3
Wellington School of Medicine	265	140
	1,106	**9,164**

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 (2009: $nil).

Ownership

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

Associate company

On 1 July 2009 the DHB exchanged its interest in HIQ Limited (2009 shareholding: 84.98%) for assets owned by HIQ Limited, which were required for the DHB's Information Technology needs.

HIQ Ltd was jointly created with Taranaki District Health Board on 18 October 2004, and had a balance date of 30 June. The DHB and TDHB shared information services provision through HIQ Ltd. The Board of HIQ Ltd had equal representation from both DHBs. The DHB and TDHB owned class A and class B shares in the company.

in thousands of New Zealand dollars

	C&C DHB		TDHB		Shares on issue	
	2010	2009	2010	2009	2010	2009
Class A shares	-	1	-	1	-	2
Class B shares	-	27,915,360	-	4,935,560	-	32,850,920

The class A shares represented voting rights and were split evenly between the two DHBs. The class B shares conferred the level of contributions and ownership benefits of each DHB. The company was considered to be jointly controlled because of the equal sharing of voting rights conferred through class A shares and was therefore an associate of both the DHB and TDHB.

The interest in HIQ Ltd had been reflected in the financial statements on an equity accounting basis, which showed the share of surplus/deficits in the statement of comprehensive income 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.

21. 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:

in thousands of New Zealand dollars

	Number of employees 2010	Number of employees 2009
100 – 110	87	55
110 – 120	50	53
120 – 130	45	55
130 – 140	28	40
140 – 150	24	23
150 – 160	20	28
160 – 170	23	16
170 – 180	16	20
180 – 190	5	17
190 – 200	19	19
200 – 210	15	16
210 – 220	15	14
220 – 230	12	15
230 – 240	8	13
240 – 250	14	8
250 – 260	10	7
260 – 270	5	7
270 – 280	9	9
280 – 290	7	7
290 – 300	6	4
300 – 310	3	5
310 – 320	3	5
320 – 330	4	5
330 – 340	2	1
340 – 350	2	3
350 – 360	2	3
360 – 370	1	2
370 – 380	-	1
380 – 390	4	1

400 – 410	-	1
410 – 420	2	-
420 – 430	1	1
430 – 440	-	1
440 – 450	1	-
530 – 540	-	1
550 – 560	-	1
	443	**457**

Of the 443 employees shown above, 300 are or were medical or dental employees and 143 are or were neither medical nor dental employees. This represents a decrease of 14 staff in total over the previous year.

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 782, compared with the actual total number of 443.

22. Termination payments

During the year ended 30 June 2010, 52 (2009: 54) employees received compensation and other benefits in relation to cessation totalling $1,111,536 (2009: $1,227,273).

No Board members (2009: nil) received compensation or other benefits in relation to cessation (2009: nil).

23. 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 2010 are provided below.

Statement of comprehensive income

The DHB recorded a deficit of $47.5m compared with the budgeted deficit of $47.7m.

Revenue was below budget mainly due to the proceeds from the sale of land at Porirua being lower than expected.

Expenditure was higher than budget due to the cost pressures as noted below:

- Clinical supply costs were above budget due to higher levels of activity than what was budgeted for and continued price increases from suppliers.

in thousands of New Zealand dollars

- More outsourced services were contracted to cover for nursing vacancies and to complete projects including change management.
- These cost increases were partially offset by savings in payments to non-health board providers as targeted savings in this area came to fruition, and financing charges were lower than budget due to delays in the timing of funding received.

Statement of financial position

Major variances were:

- Trade and other receivables are under budget due to intensive collection activity and a change to processes leading to more timely invoicing and collection.
- The favourable bank balance is mainly due to the sale of land proceeds and deficit support.
- Trade and other payables reflect additional accruals.

Statement of changes in cash flow

The net cash flow was favourable to the budget. The major reasons were:

- Operating cash flows were better than budget, due to increased funding receipts which more than offset the increased GST payments.
- Investing cash flow, $27.3m adverse to budget, is due to lower than expected Porirua land sale proceeds and acquisition of HIQ information technology assets.
- Financing cash flows were close to budget with equity receipts offsetting repayment of borrowings.

24. 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.

25. Summary revenues and expenses by output class

	Public health Services		Primary and Community Services		Hospital Services		Support Services		Total DHB	
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget
Revenue										
Crown	7,997	9,820	206,490	204,081	499,837	498,225	89,759	92,383	804,083	804,508
Other	223	222	5,664	4,625	28,965	33,135	2,511	2,085	37,363	40,067
Total revenue	**8,220**	**10,041**	**212,154**	**208,706**	**528,802**	**531,360**	**92,270**	**94,468**	**841,446**	**844,575**
Expenditure										
Personnel	97	121	2,449	2,523	346,936	348,797	1,083	1,137	350,565	352,578
Depreciation	-	-	3	-	37,980	38,425	-	-	37,983	38,425
Capital charge	-	-	-	-	6,763	11,696	-	-	6,763	11,696
Provider payments	7,893	9,820	184,687	188,491	32,892	33,534	78,713	81,329	304,184	313,174
Other	255	134	25,642	18,391	150,785	145,521	12,752	12,317	189,434	176,363
Total expenditure	**8,245**	**10,075**	**212,781**	**209,405**	**575,356**	**577,973**	**92,548**	**94,783**	**888,929**	**892,236**
Net surplus/(deficit)	**(25)**	**(33)**	**(627)**	**(699)**	**(46,554)**	**(46,613)**	**(277)**	**(315)**	**(47,483)**	**(47,661)**

Actual revenue and expenditure has been mapped to the new output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid from the Funder Arm is matched to a purchase unit code, and then mapped to the relevant output class. This is done at a detailed transactional level and accounts for the majority of the DHB's revenue and expenditure.

The DHB's remaining activity is within the Provider arm, and as a result has been assumed to come under the Hospital Services output class.

The 2009/10 budget has been mapped to output class using the same methodology. However, given this was a backdated exercise and some of the information is not available in the same level of detail there are likely to be some minor classification differences between budget and actuals. Such issues will be resolved in the 2010/11 year.

The output classes disclosed within the table above have changed from 2009 to reflect the new output classes that better describe health sector activity as agreed by the DHB's and the Ministry of Health.

26. 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 2009/10 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 15 September 2010 from the Ministers of Health and Finance.

1. Operating and cash flow forecasts

   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 2010/11 and 2011/12 years related to operating cash flows will eventuate.

2. Borrowing covenants and forecast borrowing requirements

   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.

GLOSSARY

A&D	Alcohol and Drug
A&M	Accident and Medical
ACC	Accident Compensation Corporation
ASH	Ambulatory Sensitive Hospitalisations
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment Treatment Team
C&C DHB	Capital & Coast District Health Board
CCMHS	Capital & Coast Mental Health Service
CFA	Crown Funding Agreement
CPHAC	Community and Public Health Advisory Board
CQI	Continuous Quality Improvement
CWDs	Case weights
CYF	Children, Youth and Family
DHB	District Health Board
DNA	Did not attend
DSS	Disability Support Services
ECE	Early Childhood Centre
ED	Emergency Department
EHR	Electronic Health Record
ESPIs	Elective Services Patient Flow Indicators
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
GP	General practitioner
HEHA	Healthy Eating Healthy Action
HERC	Health Education Research Collaborative
HHS	Hospital and Health Services
HPV	Human Papillomavirus
HR	Human Resources
IDF	Inter District Flow
IM	Information Management
IS	Information Systems
ICT	Information Communication Technology
KPI	Key Performance Indicators
LDT	Local Diabetes Team
LMC	Lead Maternity Carer
MAPU	Medical Assessment and PlanningUnit
MHINC	Mental Health Information Network Collection
MOU	Memorandum of Understanding
MPB	Māori Partnership Board
MSD	Ministry of Social Development
NGO	Non-Governmental Organisation
NHI	National Health Index
NIR	National Immunisation Register
NMDS	National Minimum Dataset
NZDep	New Zealand Deprivation Index
OTS	Opioid Treatment Service
PBFF	Population Based Funding Formula