



Together, Improve the Health of the District

By

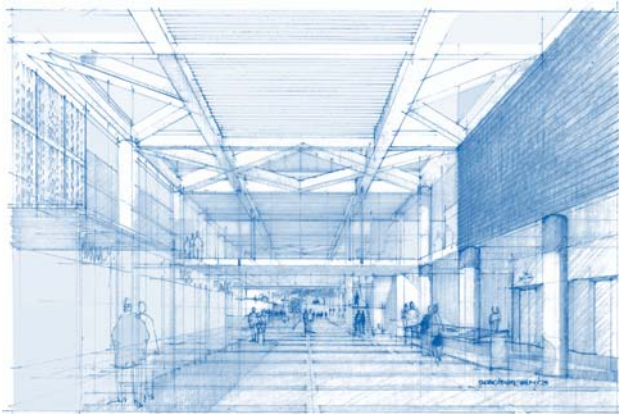
- Acknowledging and reducing disparities
- Supporting people to fulfil their potential
 - People with disabilities feel included, participate and are independent
 - Mental health services continue to improve
- Developing partnership with Māori
- Investing in Communities
- Being innovative
- Working with others
- Developing and maintaining the quality of existing services
- Identifying and realising efficiencies

This year, the Board has given high priority to developing and strengthening, the primary health sector.

The highlight of this work was the creation of five Public Health Organisations by July 1 2003. This means PHOs now cover 86% of people in this region.

As part of our emphasis on primary health care, we have also made progress on projects to help improve the skills and resources of health professionals working in the community. We are focusing particularly on developing the skills and resources of Maori and Pacific providers.

Progress has also been made on systems to share information and resources between those working in hospital level services and those working in primary healthcare. This closer co-operation and exchange of information is an important aspect in developing a 'continuum of care', ensuring that the treatment of patients at primary, secondary and tertiary levels is handled as seamlessly as possible.



(Architect's impression of the atrium of the new regional hospital in Newtown)

I am delighted to report that the DHB came in slightly ahead of budget forecasts for the 2002/03 financial year and with a significantly smaller deficit than in recent years, \$560,000.

C&C DHB has achieved this through more efficient use of resources and technology, and through the dedicated efforts of managers and other professional staff to do their vital work as efficiently and effectively as possible.

The government's approval in May 2002 of a \$303 redevelopment of hospital facilities and services in this region will help us to adapt to the future needs of the people in this district. Significant progress was made in 2002/03 and we are

confident that the proposed facilities will meet the needs of the communities they serve.

Work is now almost complete on the first of three facilities covered by this massive project, with the Kapiti Health Centre in Paraparaumu due to open in October 2003.

Meanwhile Wellington Hospital and Kenepuru Community Hospital have now moved into the 'developed design' stage where detailed plans are prepared for construction. This will include ward and room design layouts and fine detail on the engineering and construction design.

It's been a good year for Capital & Coast DHB and our successes all come as a result of intelligent, dedicated and sustained work of our staff and those in the community who work with them. It is through their work that our vision is being realised. I would like to acknowledge the commitment and drive of my fellow Board members and the executive team who support us. To all staff, my sincere thanks for a great year and I look forward, with confidence, to even greater achievements during 2003/04.

Bob Henare
Chairman
Capital & Coast DHB

Foreword from the Chairman and Chief Executive

The 2002/03 financial year was a time of considerable progress for Capital & Coast DHB. The Chairman's Preface highlighted the most significant achievements from the perspective of the Board. In this foreword we will focus on progress in some areas we have identified as our priorities.

The focus on these priority areas demonstrates the continuing commitment of both Board and staff to making the health services in this district the best they can be.

The Board's priorities for serving the people of the District are driven by what we know about populations with high health needs.

Three populations require concentrated, sustained attention: Maori, Pacific Island people, and people on low or very low incomes.

Reducing disparities - Maori Health

On average, Maori develop congestive heart failure at a younger age than is found among non-Maori populations, by a factor of around 20 years.

This is just one example of the high incidence and early onset of a range of debilitating and life-threatening conditions that affect the health of Maori far more severely than other populations. Addressing this disparity is a key focus for C&C DHB.

Our Maori Health Strategy developed in the past year will shape the way the Board engages with Maori in the community to help remedy and over time eliminate health-related disparities. The strategy has been developed through extensive consultation and has already gained widespread support from Maori organisations in this District.

C&C DHB is committed to developing and sustaining productive partnerships with Maori organisations in the community, including Maori providers of a wide range of health services. Building the numbers, confidence and skill levels of Maori health service providers is critical if we are to create benefits for Maori that extend far into the future.

Last year we:

- Completed a survey of the staffing levels and training requirements of Maori providers, including the development of a 'best practice model';
- Distributed a self-audit tool for Maori providers, aimed at helping them to target improvements in infrastructure, governance and management systems;
- Confirmed the availability of \$260,000 in Ministry funding for provider development.

- Made real progress on our commitment to close partnership with Maori at all levels from the governance level, where we support the establishment of a strong Maori Partnership Board, to the establishment of an operational liaison role within community based services - Te Ara Reo;
- Were strongly influenced on our implementation of the He Korowai quality framework by our closer understanding of Maori concepts of health.

Reducing disparities - Pacific Health

Pacific peoples, as a whole, do not share equally high health status with other populations in our District.

As part of our active commitment to improving this, C&C DHB:

- Took part in and funded important discussions at a Cook Island Health Day in Porirua, a Pacific Health Fono in Newtown and a two-day Pacific Health Fono jointly funded by C&C DHB and Hutt Valley DHB;
- Held two seminars on Pacific health workforce development, one for the community and one for hospital staff, to provide information on the opportunities such as funding for training and scholarships.



A draft Pacific Health Action Plan was released in October 2002 and we are now in the process of consulting with Pacific communities and provider groups on this.

We have developed a close working relationship with Vai Ola, a Pacific organisation which has received establishment funding from the Ministry of Health to build networks and support Pacific community participation in the governance and management of Pacific provider organisations, health workforce networks and community meetings on health issues.

- Pacific Provider Development Funding was made available in the past year, enabling Pacific health service providers to

build capacity, workforce development, information management and technology, strengthen quality in their service provision and to support business and strategic planning.

- Additional funding for Pacific Primary Care Service is helping to strengthen primary care provision for Pacific populations in the Wellington area.
- Additional funding will be contracted to strengthen Pacific clinical capacity in mental health, and to strengthen Pacific child and youth mental health services in the community.

Reducing disparities – People on low and very low incomes (low socio-economic localities)

The Health Needs Assessment carried out in this District in 2002 showed that in general the health of our people is relatively good compared to the rest of New Zealand.

However there are significant “pockets of deprivation”, particularly in areas where household incomes are low or very low. The Board is committed to improving the health status of people in these local areas of serious deprivation.

Large parts of Porirua experience high deprivation, and our focus on that city in the past year has created some positive results.

- We worked in close consultation with Porirua Healthlinks on the selection of Primary Health Organisations for their communities. The result is that there are now two PHOs providing services which cover almost the entire Porirua population.
- We supported Porirua Healthlinks when that local organisation established a Porirua Health & Information Communication System (PHICS), which will improve the flow of health information.
- We helped community providers improve access to primary healthcare in Porirua, with results such as reduced GP co-payments, extended GP clinics, mobile and outreach nursing and community health worker services.

South-east Wellington is another low-socio-economic locality, and our work there has assisted in improving access to primary care services, and establishing a PHO for those communities.

Investing in Primary Health Care

One of the most important responsibilities of the Board is to extend its work beyond the traditional scope of past health management structures to include the whole range of primary, secondary and tertiary health services.

Under previous public health systems the focus was more directly on hospitals and hospital-related health services. Since 2001, however, District Health Boards are intimately involved with the full range of healthcare, and have an important role to

play in establishing and maintaining a continuum of care. Primary care is an essential element in that equation.

The need to plan for, support, contract with and invest in primary health care services is a massive shift in our thinking.

It requires a significant change in the way we plan for and manage clinical services; it means we all have to review our approach to professional practice.

In particular, it means we must aim to shift resources into the primary sector so that all the people in this District experience a well thought out, well resourced continuum of care.

A major step towards this has been the establishment of five Primary Health Organisations, three before the end of the last financial year and two more since then. This means that by July 1 2003 the Beard had created PHO coverage for an estimated 90% of the people in our District.

PHOs are part of a wider commitment to helping the primary care sector achieve the best results possible. Health professionals working in this sector have a wealth of skills which can assist in helping people to manage their health conditions; from detection of illness to management of chronic conditions and more.

In the past year we increased our investment in primary care in a wide range of areas, including:

- Inequality funding,
- Improving access,
- Youth health,
- Community radiology,
- The Primary Care Nursing Network

Working with others

We work with others across a wide spectrum of central government, local government, corporate and voluntary sectors groups and agencies.

- Our relationships with community groups and providers are continually developing, and these links have grown stronger and closer in the past year.
- Our relationships with other DHBs nationally, regionally and locally have also grown stronger, and there are many existing and potential areas of improved cooperation and coordination.
- Major progress has been made on a joint IT project with Taranaki DHB. This will allow us to share the risks as well as the benefits of rapid changes in technology, systems design and the support services needed at all levels from primary to tertiary care.
- We continue to work with many DHBs through established channels such as forums for Chairs and CEOs

in the central region, the regional mental health network, and the Technical Advisory Service.

- Planning for the New Regional Hospital has provided the chance to work closely with the Wellington Regional Council and the three city and district councils in this District
- We have signed agreements with Nelson Marlborough and Central Region DHBs on payments for Inter-District Flows.
- Many practical benefits have come from a much more active relationship with external providers. These continue to strengthen, and we have now developed an auditing process to ensure that money which we contract to those providers is used appropriately.

Much can be learned from those outside the health sector as well. We held a number of intersectoral forums, which are an opportunity to share experiences and tactics with other agencies in fields such as education and housing, who share similar challenges and work in areas which have a direct impact on the health of the district.

Maintaining quality

Our commitment to providing clear guidance on issues related to quality created a range of benefits in the 2002/03 year, including the creation of a Consumer Involvement Policy and a Risk Management Policy.

A Reportable Events policy has been put in place, and has been generally well received by staff. It has already been used to investigate several sentinel events, and feedback and lessons from those investigations has been used to help fine-tune the policy.

During 2002/03 staff completed the amalgamation of thousands of patient records from Wellington and Kenepuru. It was a mammoth task but it was important in terms of ensuring that health information about patients is complete and reliable.



Our commitment to achieving formal, nationally recognised accreditation in 2004 remains firm, and work on this is progressing well. A preliminary visit by the Quality Health New Zealand accreditation surveyors was completed with useful outcomes and a 'gap analysis' has been completed.

A credentialling process for new SMOs has been completed and has been put to use by anaesthetics and radiology. Work on establishing a process for credentialling existing SMOs has progressed well and is now close to sign off, so that the public can become fully confident about the qualifications and experience of the Board's clinical staff.

In terms of clinical practice a clinical audit committee, with multidisciplinary membership, is now in place, as is a death review committee, which has already completed its first audit.

Our commitment to staff is also firm. Industrial relations were generally very stable in the 2002/03 year, the systems for managing annual leave were improved, recruitment and retention figures have improved and the number of work related injuries was pleasingly low.

Creating more efficient hospitals

A number of successful developments in the 2002/03 year have focussed on more efficient use of resources:

- A project to reduce Did Not Attends at outpatient services saw the number of no-shows at Main Outpatients drop from 14% to around 7%.
- The number of outpatient clinics has been increased, resulting in quicker and more convenient service to patients.
- This has been matched by a general reduction in waiting lists and waiting times for most forms of surgery: colposcopy is a recent example of a service where staff have turned a difficult situation around through their dedication to ensuring that waiting times come down.

Disability Support

Planning for the devolution of Disability Support Services from the Ministry of Health to DHBs is well advanced, and we are now developing a work plan for C&C DHB to implement the New Zealand Disability Strategy. In addition:

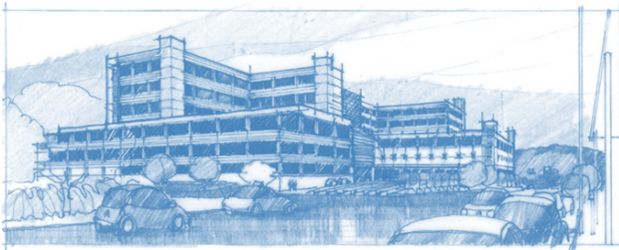
- A scoping study on Disability Support Services and the Health of Older People has been completed.
- In 2002/03 we began the process of setting up a Service Advisory Group on the Health of the Elderly.

These areas will become of increasing significance as DHBs assume responsibility for the funding of services for these population groups.

Regional Hospital Project

In April 2002 Cabinet approved the Business Case for the \$303m building and renovation project on our three sites; Newtown, Kenepuru and Paraparaumu. Much has been achieved since that time:

- Construction is well underway on the Kapiti Health Centre which is due to open in October 2003.
- Design work has progressed well for the other two sites, with a Master Plan signed off by the Board in March 2003 and schematic designs approved by the Board in September 2003.
- The next stage is the detailed design, where the location of equipment and utilities within each room will be decided.
- Demolition of older dilapidated buildings on the Newtown site will begin toward the end of 2003. Site work will begin at Kenepuru Community Hospital in mid 2004



(Artists impression of exterior of new regional hospital in Wellington)



Margot Mains
Chief Executive Officer

A handwritten signature in blue ink that reads "Margot Mains".

- The new facilities have been designed to allow for improved models of care and more adaptable facilities. This should contribute to improved health outcomes for the region and an improved experience for both patients and staff.

Concluding remarks

Much has been achieved in the past year, but there are still many challenges ahead, and Capital & Coast DHB approaches those challenges as an organisation which is motivated, capable and determined to do well.

We will continue to set our sights and our standards high, and to find new ways to improve the health of people in our region.

We would like to express our thanks to C&C DHB staff for their commitment to the organisation and its goals and for their contribution to the health of the people of this district.



Bob Henare
Board Chairman

A handwritten signature in blue ink that reads "Bob Henare".

Highlights of 2002/03

Medical Services

- Improvements have been made to patient discharge management within the Internal Medicine Service. A pilot project was implemented by Internal Medicine, Respiratory and Community Health to improve discharge planning and community support for patients with chronic obstructive airways disease.
- Establishment of a non-invasive respiratory support service.
- Establishment of a heart failure clinic with portable echocardiography at Kenepuru.
- Provision of an acute thrombolysis service for patients in the Porirua/Kapiti area. ECG machines in Kapiti ambulances are used to help Wellington cardiologists determine whether patients being brought to the hospital would benefit from thrombolysis en route.



Demonstrating the ambulance-based ECG and thrombolysis service

- Further development of renal services within the community and the Hawkes Bay area.
- Development of the nursing and medical diabetes service provided in the Porirua area.

Surgical Services

- The production system for planning and monitoring surgical throughput was embedded as a core operating system.
- The Cardiothoracic service had a record year and completed the 530 procedures it was contracted to carry out – the highest number of cardiac surgery procedures ever done at

Wellington Hospital. We are also on track to meet the target to reduce waiting times for cardiac surgery to less than six months by the end of August 2003.



Celebrating the 500th cardiac procedure

- Theatre efficiency continued to improve with cancellations remaining low and controlled, theatre utilisation was within the target of 80-85%, and work hours per operating minute were within the minimum benchmark.
- A booking system for ICU beds was implemented for patients needing ICU care after cardiac surgery. This ensures efficient use of ICU beds.
- Access has been improved for specialist assessments and progress was made in achieving national standards for elective services. In particular, the national CPAC tools were implemented for all specialties, First Specialist Assessment (FSA) waiting lists were greatly reduced, active review processes have been introduced in most services, and Financially Sustainable Thresholds (FSTs) implemented in all key services. These guide the operation of the booking system process. In a number of services the improved processes for elective services have become 'business as usual'.
- Nursing staff levels improved with fewer recruitment problems for surgical wards.
- A perioperative nursing course for theatre nursing staff was introduced which attracted CTA funding.

Women's Health

- Development and implementation of a service specific Quality Improvement Model and Structure including risk management, clinical audit, policy development committees, and audit and quality forums.
- Implementation of an orientation and training programme for Resident Medical Officers.

- Implemented short term, shared-care programme to overcome issues for pregnant women unable to find a midwife in the community due to a shortage of independent midwives.
- Continuation of the Breast Feeding Hospital Initiative, our breast feeding policy and staff training programme. As a result the exclusively breast feeding rate on discharge rose from 70% to 77%.
- Development of an ultrasound imaging, archiving and reporting system within the perinatal ultrasound unit.
- Improved access to specialist endometriosis service.
- Colposcopy waiting time were compliant with National Cervical Screening Guidelines.
- Improved throughput of cancer surgery cases.
- Implementation and outcome evaluation of medical abortion under seven weeks using Mifegyne for termination of pregnancy. Also organised a national seminar on the use of this medication.
- Laboratory: Introduced new tests, technology and services, including the D-dimer test, which is a marker for deep vein thrombosis and pulmonary embolism. The Mortuary upgrade was completed, and the phlebotomy service extended.
- ICU: Staff retention strategies combined with enhanced coordination and production planning with Surgical Services have resulted in the achievement of elective cardiac surgery targets.
- Pharmacy: implemented WinDose information system which will lead to more efficient work practices and improve prescribing and cost information; also participated in National Procurement Project involving PHARMAC contracts for hospital pharmaceuticals.
- Radiology: commissioned a new multi-dimension CT scanner, implemented retention strategies for medical radiation technologists, began a project to introduce new digital radiology system (PACS) at local and regional levels.

Child Health Services

- Three more beds have been added to the paediatric day ward and the hours of care were extended resulting in improved waiting times for children booked for elective surgery.
- Wellington Paediatric Oncology Service has achieved membership of the Children's Oncology Group, USA. This is a large and prestigious group within paediatric oncology circles.
- Additional funding of \$422,000 from the Ministry of Health's Disability Support Services for child development services. The recruitment of specialist staff to fill positions has been successful, and with the expanded service waiting lists will be reduced.
- Successful recruitment of experienced genetic staff. After several years of staff shortages, experienced staff from the United Kingdom have been recruited, enabling pro-active rather than reactive decision making and planning. Considerable improvement in staff morale.
- Funding for a nurse-led eczema clinic obtained.

Clinical Support Services

- General physiotherapy in-service programme was accredited by the NZ Society of Physiotherapists.
- Capital Coast Rehab is reducing the number of falls through falls prevention programmes.
- Capital Support has established the Regional Intellectual Disability Co-ordination Agency.
- Emergency Management: participated in two public threat operations as well as national exercises.
- Infection Control: set up regular ward rounds at Kenepuru, set up environmental audits of various wards, introduced alcohol-based hand rubs.



(The new CT scanner)

Nursing and Midwifery

- The 36 week New Graduate Programme's content, structure and policy have been reviewed and a handbook developed to ensure the programme supports nurses/midwives to RN/M2 on the Career Pathway on completion of the first year of practice. Fifty-six nurses completed the programme this year, with 49 enrolled for 2003.
- The Nursing and Midwifery Model of Care Project is nearing the pilot stage. This project will see the introduction of an organisation-wide model which is patient and family focused, collaborative in nature, spans the continuum of care (from community, through to ambulatory and inpatient settings and then back to community care) to give the patient a smooth transition through the care process.
- A number of C&C DHB programmes and specialty practice programmes underwent redevelopment during the

year to achieve Advanced Practice level. During 2002 the speciality Perioperative programme began with 14 students. The total number of nurses and midwives participating in the Clinical Training Agency programmes for 2002 was 107.

- Nurse-led Waste Minimisation Project: Further reductions in both general and clinical waste have been achieved. There has been a 50% increase in paper and cardboard recycling throughout the DHB.
- Initiation of the Blood Body Fluid Exposure prevention programme following an increase in disposal related sharps injuries, improving segregation and recycling awareness.
- The Health Care Assistant programme began in October 2002 to introduce health care assistants to the organisation. To date, 111 HCA have attended the two-day programme. An evaluation of the programme is currently underway to ensure the provision is appropriate and meets the needs of the patients, organisation and staff.

Mental Health Services

- Expansion of Consumer Advisor positions and networks.
- Establishment of secure transitional unit for people with Intellectual Disabilities who have offended and present an ongoing risk to others.
- Establishment of Mental Health Line.
- Commissioning of Rangatahi/Adolescent Inpatient Service.
- Successful development of acute services with the establishment of home based treatment and expansion of crisis-respite and acute day programmes.
- Continuing success and enrolment of 200+ consumers in the Primary Care Liaison Programme with the Wellington IPA.
- Full complement of psychiatrists achieved and waiting list established of others wanting to work for C&C DHB Mental Health Services.
- Established and appointed DHB/NZ-funded clinical training placement coordinator in Child and Adolescent Mental Health Services.
- Community liaison with CYFS and school guidance counsellors by Child and Adolescent Mental Health Services.
- Partnership between Child and Adolescent Mental Health Services and Maternal Mental Health to develop protocols addressing infant mental health issues.
- Commenced delivery of two-year contract with Ministry of Social Development in pilot project "employABLE" with related appointment of an employment consultant and mental health consumer in employment assistant position.
- Improved coordination of services to children and adolescents experiencing Aspergers Disorder through improved liaison with Child Development Team.

Quality

Policy development has focused on reviewing, updating and developing clinical policies and procedures, eg. informed consent, blood transfusion, and consumer involvement. This has involved many staff in the development and consultation process.

- Patient safety is of prime importance and several projects have focussed on areas for improvement. Nurses led the development of a falls prevention and management project, which included the development of a new patient-risk assessment tool.



(As part of the new initiative, a nurse attaches a bright green wrist label to a patient to identify her as being at high risk of falling.)

- A Reportable Events policy has been put in place, and has been generally well received. It has already been used to investigate several adverse events. Feedback and lessons learned from those investigations have been used to help fine-tune the policy and improve our processes and systems.
- Improved reporting structures now allow us to provide a quarterly report to the Health Advisory Committee of the Board, including incidents, complaints, patient/customer satisfaction surveys.
- In terms of clinical practise, a clinical audit policy group with multi disciplinary membership was formed to develop the clinical audit policy. The Death Review Committee set up in 2002 has developed audit criteria and completed its first audit. The committee has sponsored the development of a database to improve data collection and reduce audit time for clinicians. This is a joint project with Information Systems.
- The credentialling process for new SMOs has been completed and put to use by anaesthetics and radiology. Work on establishing a process for credentialling existing SMOs is progressing well.

Operations Group

- Implementation of a safety induction process for all contractors known as “Tailgate”
- Indoor air quality testing regime refined and extended.
- Energy and water consumption reduced.
- Participation in lower North Island buying group led to successful initiatives in combined capital purchasing and regional contracts for contrast media (savings 30%) and pressure care mattresses (savings 31%).
- Developed concept of Central Store for radiology and cardiology supplies.
- Consolidated service agreements for Radiology led to savings of \$200,000 and continued rationalisation of medical consumable products in Theatres and Cardiology, and made savings through bulk purchases and standardisation.
- Print room set up in-house to produce high quality printing, pamphlets, brochures that reduced costs for the organisation.
- Strong focus on Laundry quality improvement with policies and procedures developed and auditing implemented. Some Laundry facilities upgraded.
- Initiated “Shared Services” monthly meetings with other lower North Island DHBs to improve leverage in contractual negotiations, shared knowledge, and external relationships with key suppliers.
- Saving on medical equipment CapEx expenditure estimated at \$1.67million and savings made on clinical supplies estimated at \$700K

Directorate of Information Management and Planning

- A shared service has been set up with Taranaki DHB to provide joint information and communications technology services, such as email, management of Intranet and Internet sites. This minimises the costs of these services to the two DHBs and is a significant development in health technology.
- Planning was completed for the implementation of an Internet portal that will allow local health care providers access to DHB health information systems. The portal is expected to provide the initial foundation for consumer-accessible health records and will allow many staff to access DHB systems from their homes, private practise or other outside offices.
- Opportunities are being explored in collaboration with other DHBs to improve information communications and technology services and to maximise the efficiency of workforces. Projects to share research and services, and to compare DHB performance in these areas are being actively pursued.

Human Resources

- Completion of the first in-house leadership and management programme series. This will become an on going feature of the DHB’s staff development process
- Constructive outcomes in all collective agreement negotiations. Participation in the Central Region District Health Board’s first ever multi-employer agreement developed for nurses and midwives.
- Development of an on-line performance review process and successful completion of pilots.
- Implementation support for key change management projects associated with the New Regional Hospital.
- Development of comprehensive management information reporting to assist with analysis and planning in relation to staffing profiles and levels, workforce costs, health and safety, and turnover.
- Accreditation under the ACC’s accredited employer Partnership Programme.

Maori Health

This has been an eventful year for Maori Health with the successful completion of a review that proposed a change in the structure and function of Maori health services. The reconfiguration of these services is intended to support Capital & Coast DHB in achieving the goals set out in its District Annual Plan and the Maori Health Strategy - Te Plan. Those goals include providing a leadership model to champion Maori health and develop an infrastructure that supports patient / whanau care.

One of Maori Health’s major achievements has been to collaborate with other Maori managers in DHBs in the central region to identify common issues and develop a regional workforce plan.

Initial discussions recognised the importance of locally owned and driven initiatives that support planning at a national level, identify workforce development as a high priority area, and endorse the need to develop a comprehensive Māori workforce plan. This joint approach ensures the alignment of workforce development projects across the region, builds on intra-sector collaboration, reduces duplication of initiatives and allows each district health board to capitalise on critical mass.

In a joint venture with Te Waananga o Aotearoa, Maori Health was able to offer staff at C&C DHB and their whanau the opportunity to learn a basic course in Maori language - Te Ara Reo. This course began in late February and has proved very popular with over 130 staff members enrolling.

Highlights of 2002/03

Primary Health

Primary Health Organisations: Almost everyone living in the C&C DHB district who has a GP they see regularly is now also part of a Primary Health Organisation. Three PHOs were established in 2002/03 with a further two launched in July 2003. The government has committed all new primary health funding to PHO services. The first three PHOs to be established within the C&C DHB area will care largely for Maori, Pacific or low income peoples. These people have higher health needs than the general population and as a result attract more funding. Their health is also a key priority for the DHB. For many of these patients the cost of going to a doctor is likely to have already been reduced as a result of the introduction of PHOs.

The two newest PHOs cover a broader range of people in Wellington and on the Kapiti Coast and will not receive the same level of funding. However over time these patients can also expect to pay less for their care as new government funding will target those under 18 (from October 2003) and those with multiple and chronic illnesses (from early next year) with other targeted funding for over 65 year olds to follow.

The five PHOs now operating are: Porirua Health Plus, Tumai Mo Te Iwi, South East and City PHO (SECPHO), Capital PHO and Kapiti PHO.



(Prime Minister Helen Clark takes part in events to celebrate the Newtown Union Health Services Te Wana Quality award and one year of PHOs)

Primary health nurses network: Primary health care nurses from Wellington, Porirua and Kapiti have formed a network group to help the DHB respond to the future roles these nurses will take in the changing healthcare environment.

Primary health nurses work with GPs and as Well Child nurses as part of Community Health, from hospices, within prisons and a variety of other organisations. The country's DHBs are now responsible for funding many primary care organisations which employ nurses and C&C DHB is drawing on the group's expertise as part of its planning processes.

Services for Older People

Preparations were put in place for the DHB to take over funding of disability services for the care of the elderly in October 2003. P&F has completed a scoping study on Disability Support Services and the Health of Older People to assist with the provision of services once this transfer of responsibility takes place.

Work is well underway to develop and improve the range of services available to the elderly to enable them to live in their homes for as long as possible.

A Service Advisory Group on the Health of the Elderly has also been established. It includes wide representation from the aged care sector.

Disabilities

A high point for the disability sector was the launch of the Capital Support report on the service needs of Pacific people with disabilities. It has been heralded as the first research project of its type to ask Pacific families for their views. Thirty Pacific people with disabilities and members of their families were interviewed and asked to evaluate the way Capital Support assessed their needs, and how they felt about the services that had been recommended. A key recommendation was for a study of the viability of 24 hour home-based and support-care options as Pacific families prefer not to use rest home care.

Meanwhile work is well underway to place the NZ Disability Strategy within the C&C DHB environment. This includes enhancing employment opportunities for disabled people, improving communication tools for the disabled and improving accessibility to buildings and facilities.

Diabetes

A key focus of our five-year strategic plan is to reduce the incidence of diabetes and improve services for people suffering from this disease. The DHB is funding several projects aimed at achieving these aims.

They include two initiatives that this year excelled in the inaugural national Health Innovation Awards, sponsored by the Ministry of Health and ACC. The Wellington regional retinal screening programme, won both the supreme award and popular choice award. Under the programme GPs and nurses refer diabetic patients to specific optometrists for a test that can enable treatment to prevent the loss of sight that can occur as part of the disease.

One of two runners up in the awards was the school-based diabetes clinic at Paraparaumu College run by the DHB/WIPA

diabetes nurse educator. The clinic helps young people monitor, control and understand their diabetic condition. Other DHB diabetes nurse educators in Wellington and Porirua schools hold similar clinics.



(Diabetes nurse educator Lindsay McTavish talks with a teenage client)

The recognised success and innovation of these two projects shows how effectively primary and secondary health sectors can integrate services to improve the health of patients.

C&C DHB is supporting the Diabetes cluster to develop more effective actions in Porirua through joint planning.

Low cost Podiatry services are now established for people with Diabetes.

Youth Health

C&C DHB is working with Regional Public Health on its Health Promoting Schools project. Several schools are now involved with a variety of projects underway. These include nutrition, anti bullying, and 'Sun Smart' programmes.

The DHB is also helping with the development of a unique youth health service in Wellington. This fits well with the DHB's District Strategic Plan's goal to improve services to young people. The service will offer primary care to young people and hopes to expand to include other services such as legal advice, counselling, and arts access and other opportunities from a youth-friendly venue. The Ministry of Health, the Wellington Tenth Trust and the Wellington City Council also support the project. The service is expected to be in place by the end of this year.

Mental Health

C&C DHB is supporting the Easy Access Housing Project which will provide four rental properties for homeless mental health consumers. The first house has been officially opened and each house will provide accommodation for people for up to six months. During this time the complex needs of the tenant

will be addressed, in the hopes of helping make it easier for them to access accommodation in the future. The project is run collaboratively by six agencies in central Wellington.

The DHB is also funding an extra clinical position at the Wellington Refugees as Survivors Trust to help young people adjust to their new country and deal with issues around past trauma. This will bring the number of clinical staff at the Trust to 4.4 FTE (full-time equivalents).

The Local Advisory Group of mental health stakeholders is now well established. The group has been meeting monthly to provide the DHB with expertise and local knowledge for the planning and funding of mental health and addiction services.

Pacific Health

Planning began for the introduction of a new service for Pacific people who are inpatients at Wellington Hospital. The service will work with ward staff to ensure that hospital care is culturally appropriate and fully understood by the patient. They will also offer each patient and their family help aimed at improving the patient's health and their access to health and support services once they are discharged. The intent is to reduce re-admission rates and length of stay.

Statement of Responsibility for the Period Ended 30 June 2003

1. The Board and management of Capital and Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.
2. The Board and management of Capital and Coast District Health Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.
3. In the opinion of the Board and management of Capital and Coast District Health Board, the annual Financial Statements for the year ended 30 June 2003, fairly reflect the financial position and operations of Capital and Coast District Health Board.

Bob Henare
Chairperson

Margot Mains
Chief Executive

Calum Laurie
Director of Finance

Date:

Date:

Date:



Statement of Accounting Policies for the Period Ended 30 June 2003

Reporting Entity

Capital and Coast District Health Board is a Crown Entity in terms of the Public Finance Act 1989. The financial statements of Capital and Coast District Health Board have been prepared in accordance with the requirements of NZ Public Health and Disability Act 2000 and Public Finance Act 1989.

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

Measurement Base

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

Accounting Policies

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

Joint Venture Company

Capital & Coast District Health Board holds a 31.6% shareholding in Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial, financial policy decisions.

Budget Figures

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

Goods and Services Tax

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

Taxation

Capital and Coast District Health Board is a public authority under the New Zealand Public Health and Disability Act 2000 and is exempt from Income Tax under Section CB3 of the Income Tax Act 1994.

Donation, Bequest and Trust Funds

Donations and bequests are recognised as revenue at the point when the donation is formally acknowledged. Those donations received, to which conditions are attached, are

acknowledged as revenue unless the conditions cannot be fulfilled and are lodged as DHB's Trust funds. The use of these assets must comply with the specific terms of the sources from which the funds were derived and are therefore accounted for separately through the DHB's Trust ledger.

Accounts Receivable

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

Inventories

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

Investments

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

Fixed Assets (or Property, Plant and Equipment)

Fixed assets other than land and buildings

Assets, other than land and buildings, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land and buildings

Land and buildings are revalued every three years to their fair value as determined by an independent registered valuer by reference to their highest and best use. Fair value is determined using market evidence or depreciated replacement cost where appropriate. Additions between revaluations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

Buildings were revalued at 30 June 2002. Land was revalued as at 30 June 2003.

Surplus Properties

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

Disposal of Fixed Assets

When a fixed asset is disposed of, any gain or loss is recognised

in the Statement of Financial Performance and is calculated as the difference between the sale price and the carrying value of the fixed asset.

Depreciation

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

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

Buildings and fitouts	5 to 60 years
Plant and equipment	5 to 15 years

Capital work in progress is not depreciated. The total cost of a project is transferred to freehold buildings and/or plant and equipment on its completion and then depreciated.

Employee Entitlements

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

Leases

Operating Leases

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

Financial Instruments

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

Statement of Cash Flows

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

Operating activities include all transactions that are not investing or financing activities. Cash inflows include all receipts from the sale of goods and services and other sources

of revenue which supports the Board's operating activities. Cash outflows include the payments made to employees, suppliers and for taxes.

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

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

Cost of Service Statements

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

Cost Allocation

Capital and Coast District Health Board has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2003, indirect costs accounted for 7.1% of Capital and Coast District Health Board's total costs.

Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements. All policies have been applied on a basis consistent with the previous period.

Statement of Financial Performance for the Period Ended 30 June 2003*

	Notes	Budget 2003	Actual 2003	Actual 2002
		\$000	\$000	\$000
Revenue		414,163	425,289	388,269
Expenses	1	410,908	422,765	463,799
Capital Charge	16	3,909	3,084	7,506
NET DEFICIT	1	(654)	(560)	(83,036)

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

Statement of Movements in Equity for the Period Ended 30 June 2003*

	Notes	Budget 2003 \$000	Actual 2003 \$000	Actual 2002 \$000
EQUITY AT BEGINNING OF THE PERIOD				
		85,907	85,907	82,288
Net deficit for the period		(654)	(560)	(83,036)
Revaluation of trust/endowment properties	2(c)	-	-	1,448
Revaluation of land		-	17,046	-
Reduction in revaluation reserve due to disposals	2(c)	-	(2,836)	(793)
Total recognised revenues and expenses for the period		(654)	13,650	(82,381)
OTHER MOVEMENTS				
Contribution from owners	2(a)	30,167	30,167	86,000
EQUITY AT THE END OF THE PERIOD		115,420	129,724	85,907

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

Statement of Financial Position for the Period Ended 30 June 2003*

	Notes	Budget 2003 \$000	Actual 2003 \$000	Actual 2002 \$000
EQUITY				
General Funds	2(a)	205,243	205,243	175,076
Retained Earnings	2(b)	(92,659)	(92,565)	(92,005)
Revaluation reserves	2 (c) and (d)	2,836	17,046	2,836
Total equity		115,420	129,724	85,907
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash		1,902	1,846	698
Receivables and prepayments	3	85,154	33,441	122,773
Inventories	4	4,100	4,197	3,669
Trust Funds		4,976	3,737	3,450
Endowment/Trust properties		-	-	8,749
Total current assets		96,132	43,221	139,339
Non current assets				
Fixed Assets	5	187,809	168,135	149,907
Endowment/Trust properties		-	-	1,539
Receivables and prepayments	3	-	70,500	-
Total non-current assets		187,809	238,635	151,446
Total assets		283,941	281,856	290,785
LIABILITIES				
Current liabilities				
Payables and accruals	6	41,288	37,182	39,863
Employee entitlements	7	15,586	24,816	23,626
Current portion of term loans	8	-	77,356	30,303
Total current liabilities		56,874	139,354	93,792
Non Current liabilities				
Employee entitlements	7	1,937	1,674	1,674
Term Loans	8	109,710	11,104	109,412
Total non current liabilities		111,647	12,778	111,086
Total liabilities		168,521	152,132	204,878
NET ASSETS		115,420	129,724	85,907

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

Statement of Cash Flows for the Period Ended 30 June 2003*

	Notes	Budget 2003 \$000	Actual 2003 \$000	Actual 2002 \$000
CASHFLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		400,057	427,340	375,605
Other revenue		11,319	12,507	9,367
Interest received		-	212	-
		411,376	440,059	384,972
Cash was disbursed to:				
Payments to Employees & Suppliers		386,426	397,633	361,679
Capital Charge		8,401	7,898	2,926
Interest paid		8,296	6,525	8,994
GST (Net)		950	(521)	111
		404,073	411,535	373,710
Net cash inflow/(outflow) from operating activities	9	7,303	28,524	11,262
CASHFLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Trust property sales cash released		9,989	9,387	5,222
Proceeds from sale of fixed assets		72	-	1,860
		10,061	9,387	7,082
Cash was applied to:				
Purchase of fixed assets		54,026	15,674	14,886
		(43,965)	15,674	14,886
Net cash inflow/(outflow) from investment investment activities		(36,662)	(6,287)	(7,804)
CASHFLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
New equity	2(a)	67,807	30,167	7,119
Proceeds from term loan		-	-	-
		67,807	30,167	7,119
Cash was applied to:				
Repayment of term loan		29,941	51,256	10,013
Net cash inflow/(outflow) from financing activities		37,866	(21,089)	(2,894)
Net increase in cash held		1,204	1,148	564
Add opening cash		698	698	134
Closing cash balance		1,902	1,846	698
Made up of:				
Cash		1,902	1,846	698
Closing cash balance		1,902	1,846	698

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

Statement of Contingent Liabilities as at 30 June 2003

	2003	2002
	\$000	\$000
Legal proceedings	741	100
Personal grievances	351	202

There are other claims that the DHB is currently contesting which have not been quantified due to the nature of the issues and/or the uncertainty of the outcome.

Statement of Commitments as at 30 June 2003

	2003	2002
	\$000	\$000
Capital Commitments including New Regional Hospital (NRH)	42,784	5,023
Less than one year	25,377	5,023
One to two years	8,423	-
Two to five years	8,984	-
	42,784	5,023
Operating Lease commitments		
Less than one year	5,569	5,650
One to two years	3,091	4,380
Two to five years	1,445	2,014
Over five years	772	1,120
	10,877	13,164

Other non-cancellable contracts

The Board has entered into non-cancellable contracts for the provision of services. Details of the commitments under these contracts are as follows:

Less than one year	23,020	29,287
Later than one year and not later than two years	8,285	9,428
Later than two years and not later than five years	9,374	12,919
Later than five years	349	-
	41,028	51,634
TOTAL COMMITMENTS	89,125	69,821

Notes to the Financial Statements for the Year Ended 30 June 2003

Note 1: Net Deficit

	2003 \$000	2002 \$000
Revenue	425,289	388,269
<i>Which includes:</i>		
Interest Income	212	20
Net gain on sale of fixed assets	3,871	1,044
Donations and bequests	1,195	662
Less: Expenses	422,765	463,799
<i>Which include:</i>		
Remuneration of Auditor		
Audit Fees	102	99
Assurance related services	-	12
Depreciation		
Buildings	8,395	6,196
Plant and Equipment	8,847	8,231
Total depreciation charge	17,242	14,427
Assets written down*	-	65,939
Board Member's Fees	342	301
Interest Expense	6,311	9,257
Rental and operating lease costs	6,176	6,767
Bad debts written off	253	50
Changes in provisions for doubtful debts	56	71
Less: Capital Charge	3,084	7,506
Net deficit, per Statement of Financial Performance	(560)	(83,036)

*The approval of a new regional hospital has had a significant impact on the value of buildings at 2002 balance date. This necessitated a write down in the value of a number of buildings and their fitouts to reflect reduced economic life due to their imminent demolition or change in future use.

Note 2: Equity

	2003 \$000	2002 \$000
(a) General Funds		
Opening Balance	175,076	89,076
Contribution from owners*	30,167	86,000
General funds at 30 June	205,243	175,076

*Contributions in 2003 were required due to the conversion of Crown Funding Agency subordinated debt see Note 8.

	2003	2002
	\$000	\$000
(b) Retained Earnings		
Retained earnings at 1 July	(92,005)	(8,969)
Operating deficit	(560)	(83,036)
Retained earnings at 30 June	(92,565)	(92,005)

	2003	2002
	\$000	\$000
(c) Endowment/Trust Property Revaluation Reserve		
Opening balance	2,836	2,181
Revaluation	-	1,448
Reduction in revaluation reserve due to disposals	(2,836)	(793)
Revaluation Reserve at 30 June	-	2,836

Movement in this reserve follows the sale or disposal of Endowment and Trust properties during the period.

	2003	2002
	\$000	\$000
(d) Land revaluation reserve		
Opening balance	-	-
Revaluation	17,046	-
Land revaluation reserve at 30 June	17,046	-

Note 3: Receivables and Prepayments

	2003	2002
	\$000	\$000
Trade debtors	14,482	33,802
Provision for doubtful debts	(418)	(362)
Crown equity due*	15,500	86,000
Accrued income	3,146	2,766
Prepayments	731	567
Total receivables and prepayments	33,441	122,773

*The write down in the value of a number of buildings has had a significant impact on the equity of the DHB and the Crown has recognised the need to replace this equity. This replacement is in the form of an irrevocable pledge of equity of \$86 million to be drawn as and when required. The DHB will use these funds as part of the payments from the Crown to construct the New Regional Hospital. The amount shown as outstanding as at 30 June 2003 is that portion expected to be drawn down in the current 2003/04 year. The balance of \$70.5m remains available 'on demand' but is shown as a non-current asset in the Statement of Financial Position to reflect the likely later draw down.

Note 4: Inventories

	2003	2002
	\$000	\$000
Pharmaceuticals	1,004	888
Surgical and medical supplies	3,101	2,683
Other supplies	92	98
Total inventory	4,197	3,669

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

Note 5: Fixed Assets

	2003	2002
	\$000	\$000
Land		
Land at cost	-	3,380
Land at valuation	21,722	-
Total Land	21,722	3,380
Buildings		
At valuation	86,829	88,252
At cost	1,666	-
Accumulated depreciation	(8,947)	-
Total Buildings	79,548	88,252
Plant and Equipment		
At cost	107,102	98,386
Accumulated depreciation	(59,029)	(51,584)
Total plant and equipment	48,073	46,802
Surplus Properties		
At cost	12,733	13,270
Accumulated depreciation	(3,627)	(3,397)
Total surplus properties	9,106	9,873
Capital Work in Progress		
At cost	9,686	1,600
Total Fixed Assets		
At cost and valuation	239,738	204,888
Accumulated depreciation	(71,603)	(54,981)
Total carrying amount of fixed assets	168,135	149,907

Restrictions

Capital & Coast District Health Board does not have full title to Crown Land it occupies but transfer is arranged if and when land is sold. The disposal of any property is subject to the provisions of S40 of the Public Works Act 1981 and Maori Protection Mechanism.

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

Valuation

Buildings are stated at fair value as determined by M.J. Bevin BPA, SNZPI (Registered Valuer) of DTZ Darroch as at 30 June 2002.

Land was revalued at fair value as determined by M.J. Bevin BPA, SNZPI (Registered Valuer) of DTZ Darroch as at 30 June 2003.

Surplus properties was revalued at fair value by EF Gordon FNZIV (Registered Valuer) as at 30 June 2003.

Note 6: Payables and Accruals

	2003	2002
	\$000	\$000
Trade creditors and accruals	31,287	24,251
Capital charge due to the Crown	537	5,351
Accrued Expenses	4,873	5,689
Revenue in advance	485	4,572
Total payables and accruals	37,182	39,863

Note 7: Employee Entitlements

	2003	2002
	\$000	\$000
Accrued pay	5,582	4,955
Annual leave	17,303	16,520
Retirement and long service leave	1,839	2,129
Other	1,766	1,696
	26,490	25,300
Made up of:		
Current	24,816	23,626
Non-current	1,674	1,674
	26,490	25,300

Note 8: Term Loans

	2003	2002
	\$000	\$000
Crown Financing agency*	-	30,167
Bank Revolving credit	14,385	25,490
Bond holders	9,865	19,712
Capital & Coast notes	64,000	64,000
Other loans	210	346
Total	88,460	139,715
Less current portion	77,356	30,303
Non current portion (repayable July 05)	11,104	109,412

Interest Rates Summary:

CFA	-	8.00%pa
Revolving Credit	5.52%pa	5.80%pa
Bonds (weighted coupon)	8.05%pa	8.04%pa

*This debt was converted to equity in July 2002 (see Note 2).

The CFA term liabilities were secured by a negative pledge. Without CFA's prior written consent Capital & Coast DHB could not perform the following actions in the following areas:

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

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

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

	2003	2002
	\$000	\$000
Net surplus/(deficit)	(560)	(83,036)
Add/(less) non-cash items		
Depreciation/assets written down	17,737	82,107
Donated/trust purchased assets	-	(208)
Total non-cash items	17,737	81,899
Add/(less) items classified as investment activity		
Net loss/(gain) on sale of fixed assets	(3,871)	(1,044)
Total investing activity items	(3,871)	(1,044)
Add/(less) movements in working capital items		
(Increase)/decrease in receivables and prepayments	18,409	(8,799)
(Increase)/decrease in inventories	(528)	182
Increase/(decrease) in payables and accruals	(3,566)	17,688
Increase/(decrease) in provisions	1,108	4,670
(Increase)/decrease in trust funds	(205)	(298)
Working capital movement - net	15,218	13,443
Net cash (outflow)/inflow from operating activities	28,524	11,262

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

Note 10: Related parties transactions

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

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

Related party transactions and balances

(a) Funding

Of total Crown revenue received, of \$412 million in the year ended 30 June 2003, \$389 million (94.4%) was received directly from the Ministry of Health. The amount outstanding to C&C DHB as at 30 June 2003 was \$9.7m.

(b) Joint Venture company

Capital & Coast District Health Board purchased services from Central Regional Technical Advisory Services Ltd of \$600,000 (\$316,000 in 2002) during the year ended 30 June 2003.

(c) Key management and Board members

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

Note 11: Financial instruments

Capital & Coast District Health Board is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.

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

Interest rate risk

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

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

The interest rates on borrowings are disclosed in note 8. There was \$58,000,000 of interest rate instruments in place at 30 June 2003. The valuation at this date was a \$164,018 benefit to Capital & Coast District Health Board that has not been taken to the financial statements.

Unused facilities

As at 30 June 2003, Capital & Coast District Health Board had available committed borrowing facilities of \$70m expiring on 30 November 2003. \$14.4m was drawn against this facility at 30 June 2003 leaving \$55.6m available.

Currency risk

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

Capital & Coast District Health Board undertakes transactions denominated in foreign currencies from time to time and exposures in foreign currency arise from these activities. It is the DHB's policy to hedge any such risks using forward and spot foreign exchange contracts to manage these exposures. There was one contract in place at balance date for 172,766 Euros worth approximately \$344,292, related to the purchase of the new CT Scanner. This benefit has not been taken to the financial statements.

Credit risk

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

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

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

The Board receives 94% of its revenue from the Crown through the Ministry of Health. Accordingly, the Board does not consider there is any risk arising from the concentration of credit with respect to accounts receivable.

Fair value

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

Note 12: Patient funds

Capital & Coast District Health Board administers certain funds on behalf of patients. These funds are held in a separate bank account and any interest earned is allocated to the individual patient balances. Therefore, the transactions during the year and the balance at 30 June 2003 are not recognised in the Statements of Financial Performance, Financial Position or Cash Flows of Capital & Coast District Health Board.

	2003	2002
	\$000	\$000
Patient Funds		
Opening balance	70	70
Monies received	191	185
Interest earned	2	2
Payments made	(181)	(187)
Closing balance	82	70

Note 13: Board Member's remuneration

The Board of Capital & Coast District Health Board as at 30 June 2003, and those who ceased to hold office during the year ended on that date, are set out below together with details of their remuneration (excluding expense reimbursement), received or receivable, for that period:

	2003	2002
	\$000	\$000
Bob Henare (Chair)	55	55
Margaret Faulkner (Deputy Chair and Chair - DSAC)	38	33
John Cody (Chair -CPHAC)	30	27
Ruth Gotlieb	29	16
Helene Ritchie	29	16
Karl Geiringer	28	16
Judith Aitken (Chair - FRAC)	27	14
Ian Shearer (Chair - HAC)	27	15
Tino Pereira	27	27
Chris Turver	26	14
Helmut Modlik	26	12
John Forman	-	13
Harley Gray	-	12
Beverley Lawton	-	13
John McEnteer	-	18
	342	301

Legend:

DSAC - Disability Support Advisory Committee

HAC - Hospital Advisory Committee

CPHAC - Community and Public Health Advisory Committee

FRAC - Finance and Risk Assurance Committee

Note 14: Employee remuneration

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

Total remuneration and other benefits \$000	Number of employees
100 - 110	30
110 - 120	21
120 - 130	20
130 - 140	21
140 - 150	21
150 - 160	15
160 - 170	15
170 - 180	13
180 - 190	10
190 - 200	4
200 - 210	9
220 - 230	6
230 - 240	1
240 - 250	1
260 - 270	2
270 - 280	1
290 - 300	2
300 - 310	1
350 - 360	1

The Chief Executive's remuneration and other benefits is in the \$350,000 to \$360,000 bracket.

Of the 194 employees shown above, 162 are or were medical or dental employees and 32 are or were neither medical nor dental employees.

If the remuneration of part time employees were to be grossed up to an FTE basis, the total number of employees with FTE salaries of \$100,000 or more would be 297, compared with the actual total number of employees of 194.

Note 15: Termination payments

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

Number of Employees	Amount Paid
1	3,418.08
1	9,642.50
1	10,494.00
1	12,500.00
1	13,938.00
1	19,792.50
1	20,000.00
1	21,029.49
1	22,000.00
1	22,500.00
1	63,750.00
11	<u>219,064.57</u>

Note 16: Capital Charge

The DHB pays a capital charge monthly to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the year ended 30 June 2003 was 11.0%.

Statement of Objectives and Service Performance for the Year Ended 30 June 2003

Summary of revenues and expenses by output class:

	Funding	Governance & funding Administration	DHB Hospital Provider	Elimination*	Total DHB
Revenue					
Crown	371,733	3,803	307,138	(270,192)	412,482
Other			12,807		12,807
Total Revenue	371,733	3,803	319,945	(270,192)	425,289
EXPENDITURE					
Personnel		1,684	192,159		193,843
Depreciation		14	17,228		17,242
Capital Charge			3,084		3,084
Other	371,733	2,688	107,451	(270,192)	211,680
Total Expenditure	371,733	4,386	319,922	(270,192)	425,849
Net surplus/(deficit)	0	(583)	23	0	(560)

Reconciliation to retained earnings:

	Funding	Governance & funding Administration	DHB Hospital Provider	Elimination	Total DHB
Opening retained earnings		(605)	(91,400)		(92,005)
Less deficit for the year		(583)	23		(560)
Closing retained earnings	0	(1,188)	(91,377)	0	(92,565)

* DHB's are required to differentiate their funding broadly into hospital and non-hospital activities.

To recognise and give effect to C&C DHB as a funder of both hospital and non-hospital activities two sets of books (ledgers) are maintained which require intra-DHB revenues and costs to be 'eliminated'.

Good Employer Policies

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

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

The Board acknowledges and supports the right to equal opportunities, privacy, fairness and equity in the management of the employment relationship. And recognises cultural differences and diversity and the needs of ethnic and minority groups.

Regular internal and external audits are undertaken to ensure legislative and policy requirements are met.



Statement of Service Performance

C&C DHB is required by the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 to report on its service performance. The level of performance to be achieved for the year to 30 June 2003 was detailed in the C&C DHB Statement of Intent.

C&C DHB's performance is organised around the outputs expected of the DHB. The three main outputs, which are expected, are:

- Governance and ownership of the DHB.
- Funding of health and disability services.
- Providing health and disability services.

Strategic Objectives

Strategic objectives (as outlined in C&C DHB Draft District Strategic Plan) are based on the Government's expectation, local health requirements (as identified in health needs assessment), and knowledge of making services effective.

The following table describes linkages of objectives in C&C DHB's Draft District Strategic Plan to the Performance measures as identified in the Statement of Intent for 2002/03 – 2004/2005

Objectives, Goals, Government and Performance Measures for 2002/2003

Objectives	High Level Priorities	Performance measures for 2002/03
Acknowledging & reducing disparity	Improving Maori Health	Maori Health Strategy and Plan
	Improving Pacific Health	Pacific Health and Disability Action Plan
	Prioritisation	Undertake prioritisation round and identify a list of funding options.
	Service Gaps	Responding and resolving service coverage issues.
	Organise integrated services for older people's health/Implement the New Zealand Disability Strategy	Build the capacity to manage Disability support services and Health of Older People after devolution in October 2003
Supporting people to fulfil their potential	Continue to deliver on Mental Health	Mental Health
	Continue developing community in Porirua	Improve access to Primary Care
Investing in communities	Start Community development in South-East Wellington	Improve access to Primary Care
	Continue to work towards Inter-sectoral collaboration	Introducing and reinforcing DHB priorities
	Develop new programmes for Diabetes and Cardiovascular disease	Service co-ordination and models of care for chronic diseases to improve outcome for patients.
Being innovative	Continue to work on improving Waiting times	Waiting times initiatives
	Quality Initiatives	Work towards achieving accreditation for the organisation by October 2004.
Developing & maintaining the quality of existing services	The New Regional Hospital Project.	Build the new Regional Hospital at Newtown and redevelopments at Kenepuru and Kapiti. Implement change management programme that focuses on new models of care for the new Regional Hospital.
	Coordination of Hospital services and service planning to improve efficiencies	Improve patient experience and efficiency by improving production planning, discharge planning and staff utilisation.
Identifying & realising efficiencies	Information Management	Upgrade the information technology infrastructure.

These objectives and priorities represent the health and disability areas, which C&C DHB, believes has the biggest potential for gains in health and wellbeing. In the tables below, C&C DHB's actual performance for the year ended 30 June 2003 is measured against the objectives detailed in the Statement of Intent.

Governance and Funding Administration

Introducing and reinforcing DHB priorities

The objectives for DHBs are different from the previous role as a hospital and health service provider. It is important to engage community and staff to communicate and advance the priorities of C&C DHB.

Performance Dimension	Progress Report
<p>Quantity: Develop and implement processes for introducing and reinforcing priorities into the organisation.</p> <p>Timeliness: Integrated care projects scoped between provider and funder arms of the DHB by 30 September 02.</p> <p>Operational planning process developed by 31 December 02.</p>	<p>Achieved</p> <p>Community Engagement Two advisory committees to the Board; the Community and Public Health Advisory Committee and the Disability Support Advisory Committee held three public forums during 2002/03; on inter-sectoral work¹, nutrition and prioritisation. Additional forums are planned for 2003/04 to involve the general public and interest groups in DHB planning and prioritisation processes. The forums planned for 2003/04 include workforce, models of care, public health, community and home support and a child health summit. During 2002/03, we held regular staff forums to communicate key messages.</p> <p>Operational Planning Process An operational planning framework was developed in August 2002. The operational planning process framework will be used for developing 5-year plans for the priorities identified in the District Strategic Plan.</p> <p>Integrated Care Projects Integrated care involves creating ways to share information between hospitals and community based providers, in order to ensure that the care which patients receive is well coordinated. An integrated care steering group was established in October 2002.</p> <p>During 2002/03, the following processes were established to support integrated care projects:</p> <ul style="list-style-type: none"> · An Integrated Care Steering Group to: <ol style="list-style-type: none"> (a) Oversee and monitor all projects that aim to support and improve the coordination of health services. (b) Provide project management and leadership support for project leaders and managers, to share international and national experience in integrated care (eg. Project management workshops, leadership seminars).

¹ Intersectoral work is based on projects that involve various sectors of society including central and local government agencies (health, education, welfare etc), community organisations and the private sector.

	<p>The following areas will be scoped, project plans agreed and services developed by 30 June 2004:</p> <ul style="list-style-type: none"> · Maternity/child health integration · Cardiovascular disease · Primary mental health <p>On 19 June 2003 a workshop was held with representatives of the community, community providers and DHB staff to improve coordination, in order to ensure patients receive an improved quality of care.</p> <p>All Integrated care projects will include a health promotion and public health approach, to ensure that prevention and education are included in service models.</p>
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Information Technology

The DHB has several functions that did not exist within a hospital and health service. The main implication for information management is the need to enable decision support functions for clinicians, service analysts, and funders.

Performance Dimension	Progress Report
<p>Quantity: Upgrade the Information Technology (IT) infrastructure to enable web-based desktop access.</p> <p>Timeliness: Undertake detailed project planning for infrastructure upgrade by 30 September 2002.</p> <p>Project planning complete including roll out plan by 31 December 2002.</p> <p>Commence roll out within organisation by 31 March 2003.</p>	<p>Partially Achieved</p> <p>In May 2003 project planning for an upgrade of the IT infrastructure was completed. Planning is ongoing to ensure the organisation adapts to the changing demands of its role as a DHB.</p> <p>The rollout of the upgraded infrastructure started in July 2003. The rollout of web deployed infrastructure is expected to be completed by June 2004. The new infrastructure will help with:</p> <ul style="list-style-type: none"> · Reducing information and communication technology costs. · Enabling access to the DHB information systems from outside the walls of existing hospital facilities. · Providing discharge summaries to all authorised participants in healthcare processes, including General Practitioners (GPs). · Providing access to the National Health Index for primary care providers such as GPs. · Providing services such as an Internet-based outpatient booking system – making it easier for patients to book outpatient appointments as a time convenient to them, and thereby reducing the number of people who do not attend these appointments. <p>The infrastructure project's objectives and activities align with the objectives of the Ministry of Health's WAVE Report.</p>

Progress on the implementation of a Maori Health Plan for the DHB Service Arm.

The health status of Maori requires a targeted approach to reaching these populations that are in need. That means developing innovative strategies with Maori/non-Maori providers that target services to these communities.

Performance Measure	Deliverable
<p>Deliverable Provide a report on progress achieved towards implementation of the Maori Health Plan.</p> <p>Timing 30 June 03</p>	<p>Achieved</p> <p>District Maori Health Strategy - Te Plan</p> <p>A single strategic document (Te Plan) for Maori health improvement has been developed over the past year, including extensive public consultation. The Board of C&C DHB approved Te Plan in June 2003. Te Plan is aligned to C&C DHB's Draft Strategic Plan, and is guided by the New Zealand Health Strategy, the Ministry of Health's He Korowai Oranga, Whakataataka and the C&C DHB Health Needs Assessment. An extensive consultation process further shaped the document to reflect Maori/whanau strengths in line with Maori beliefs, values and process.</p> <p>A social marketing approach is also being developed to effectively communicate strategies for a healthy lifestyle to a Maori audience.</p> <p>Plan Implementation</p> <p>Implementation of the Action Plan will commence in the 2003/04 year. To support the implementation of Te Plan the following work has been initiated:</p> <p>1. Provider Arm</p> <p>The Maori Health Unit within the Provider Arm of C&C DHB (hospitals and health services) has been reviewed, and plans made to restructure the unit in 2003/04 to provide improved services and care for Maori patients and their whanau.</p> <p>In order to better track the relationship between health and ethnicity the DHB is recording the ethnicity of patients, through admissions. This ethnicity project is now entering another phase, in which ongoing training and education will assist staff to effectively collect ethnicity data.</p> <p>2. Planning and Funding</p> <p>Investing in Maori Development</p> <p>During 2002/03, a further \$290k was invested in Maori provider development, and a further \$200k on improving the capacity of Maori providers.</p> <p>Negotiations have also been completed for the investment of \$695K in 'by Maori for Maori' service development.</p> <p>3. Primary/ Secondary Care</p> <p>Primary Care Services</p> <p>Funding has been allocated to a provider in South Wellington to develop whanau ora (family health), to improve the health of urban whanau in that location.</p>

	<p>4. Mental Health Services</p> <p>In 2002/03, negotiations were completed for a Kaupapa Maori Alcohol and Drug Service in Wellington, which will be implemented in 2003/04.</p> <p>Supported development of a Maori Model of Care for Mental Health.</p> <p>Four regional Maori specific projects are being developed. They are:</p> <ul style="list-style-type: none"> · Implementation of Te Puawaitanga, National Maori Mental Health Strategy. · Establishment of a Maori expert group. · Briefing paper on appropriate Maori governance models. · Development of a Treaty of Waitangi responsiveness framework. <p>5. DHB Networks</p> <p>C&C DHB is part of the national and regional Maori managers network. At this regional level, C&C DHB has led work developing a Central Region Maori Workforce Plan. This was agreed to in principle at the Regional Managers Forum in June 2003.</p> <p>6. Primary Health Organisations (PHOs)</p> <p>C&C DHB minimum requirements for PHOs explicitly state that a PHO must have iwi and Maori community participation at Board level.</p>
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Prioritisation

Prioritisation decisions involve determining what changes should be made to services, interventions and programmes. The type of change required will depend on the prioritisation issue and the trigger for the decision. There are three main types of change which prioritisation decisions may involve:

- Introducing new or increased resources or services.
- Reducing existing resources or services.

Replacement of existing resources or services.

Performance Measure	Deliverable
<p>Deliverable</p> <p>Undertake prioritisation round. Identify a list of funding options including planned sources of funding (which may include reprioritisation of current baseline expenditure) and provide the Ministry of Health with a one page summary of the results.</p> <p>Timing</p> <p>31 May 2003</p>	<p>Achieved</p> <p>A prioritisation report was provided to the Ministry of Health in May 2003, identifying the process used for prioritisation, and the results of that prioritisation. Also identified were areas where further investment will be required, on the basis of prioritisation.</p> <p>The prioritisation of new funding and of funding generated by savings from a review of the services, which are currently funded, has been completed. The prioritisation process is aligned to national processes.</p>

Responding to and resolving service coverage issues

As a funder of health and disability support services, it is critical that C&C DHB identifies gaps in services available in the District and resolve those gaps.

Performance Measure	Deliverable
<p>Deliverable Report progress achieved during the quarter towards resolution of gaps in service coverage identified by the DHB or the Ministry of Health.</p> <p>Timing: Quarterly</p>	<p>Achieved</p> <p>Quarterly reports have been provided to the Ministry of Health identifying gaps in service coverage. This information is also used as part of the prioritisation process. Identifying gaps allows additional services to be funded in the areas where gaps exist and further development of existing services to ensure timely and equitable access.</p> <p>Funding has been prioritised to resolve the gaps in service and unmet needs for youth and for refugee health services. Pacific Health services in Wellington received additional funding support to develop Pacific primary care services.</p> <p>Provider self-audits and full service audits have also been conducted to better understand how providers are performing against their contracts and whether gaps exist.</p>

Planning and Funding

This section highlights C&C DHB's achievements as a funder and purchaser of health and disability services.

Implement Maori Health Strategy

The health status of Maori requires a targeted approach to reaching these populations that are in need. That means developing innovative strategies with Maori/non-Maori providers that target services to these communities.

Performance Measure	Deliverable
<p>Quantity: Implement targeted actions from the Maori Health Strategy, He Korowai Oranga.</p> <p>Timeliness: Distribute self-audit tool that providers can use to review their current service / management infrastructure. Maori and Maori providers consulted on the draft Maori Health Strategic Plan by 30 September 2002.</p> <p>Review submissions on draft Maori Health Strategic Plan by 31 December 2002.</p> <p>Prepare a Maori workforce development plan that will signal gaps and investment opportunities. Develop analysis of key issues from the provider workforce. The Maori Health Strategic Plan finalised by 31 March 2003.</p>	<p>Partially Achieved</p> <p>Key work programs that are consistent with He Korowai Oranga and with our own Maori health strategy (Te Plan) include:</p> <p>1. Accountability/ Evaluation</p> <p>A self-assessment tool was distributed between April and May 2002 to allow Maori and non-Maori providers to review their performance.</p> <p>Ongoing monitoring of contracts has occurred throughout 2002/03, including site visits to contracted providers.</p> <p>2. Maori Health Strategy, Te Plan</p> <p>A consultation process occurred on Te Plan between the months of October 2002 and December 2002.</p> <p>In total, C&C DHB visited 22 locations and met with 259 people within the district. Hui were held in locations where Maori meet – runanga, marae committees, and management committees. Submissions were reviewed in December 2002, and Te Plan was finalised in June 2003.</p>

<p>Prepare an implementation strategy for Maori workforce development plan. Conduct site visits to monitor the effectiveness of “By Maori for Maori” by 30 June 2003.</p>	<p>3. Workforce Development Developing the capacity of Maori providers has been, and continues to be, a priority for C&C DHB. For the 2002/03 year C&C DHB has focussed on review and audit of the Maori Health Unit within the Provider Arm and the seven “By Maori for Maori” providers within the district. At a regional level, C&C DHB has led work developing a Central Region Maori Workforce Plan. This was agreed to, in principle, at the Regional Managers Forum in June 2003.</p> <p>4. Development of an Accountability Framework Research is underway towards the development of a Treaty-based accountability/evaluation frame-work for Maori.</p> <p>5. Future Developments</p> <ul style="list-style-type: none"> • Maori Investment C&C DHB will continue to increase the provider capacity fund to strengthen Maori providers accessing PHOs. • Workforce Development Target resources towards service gaps. For example, expanding the Whanau Model of Care to include heart disease and diabetes. Target resources towards increasing competency, capability and capacity within the health sector – including both Maori and non-Maori providers.
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Implement Pacific Health and Disability Action Plan

The health status of Pacific requires a targeted approach to reaching these populations that are in need. C&C DHB’s priorities for Pacific population reflects the draft District Strategic Plan and the Pacific Health and Disability Action Plan of the Ministry of Health.

Performance Measure	Deliverable
<p>Quantity: Implement targeted actions of the Pacific Health and Disability Action Plan.</p> <p>Timeliness: Establishing regional health networks in Pacific health to provide forum for quality improvement. Establish process for selecting Pacific Health Advisory Group to support Pacific development by 30 September 2002.</p> <p>Continue bi-monthly Pacific provider forums. Convene Pacific Regional Fono. Complete report on family based assessment tools and models for primary care service coordination. Implement projects agreed to in the Pacific Health and Disability Action Plan by 31 December 2002.</p>	<p>Partially Achieved Regional Health Networks The Central Region Pacific Health Fono was held on the 22 and 23 November 2003 at Pataka Museum and Cultures Centre. Over 150 people registered on Day 1 and over 100 people attended Day 2.</p> <p>The following provider meetings have been held in 2002/03:</p> <ul style="list-style-type: none"> • 11 July 2002 with Pacific Mental Health Providers. • 30 August 2002 to discuss potential collaboration on Information Technology projects. • 13 September 2002 to discuss Pacific provider development funding. • 13 February 2003 with Pacific health providers to discuss mental health service developments. • 11 April and 9 May 2003 for scholarship sharing from Health Research Council. • 24 April and 22 May 2002 “Meeting of Minds”.

Implement and confirm Pacific Health Advisory Group meeting by 31 March 2003.

Implement projects from Pacific Health & Disability

Action Plan

Service developments in progress include:

- Tendering process in 2002/03 for additional funding for child and adolescent mental health, to be implemented in 2003/04.

Priority 1

Improving access: A Pacific provider has been assisted to extend services to include GP services in Strathmore

A Child Health summit is planned for October 2003.

Priority 2

The Public Health service provider (Hutt Valley DHB) is in the process of appointing a Strategic Adviser to Regional Public Health. It is expected that strategies will be developed to cover the region's Pacific population public health education and promotion.

Priority 3

Improving Access Project in Porirua to ensure Pacific peoples have better access to primary care services.

Priority 4

Provider development and workforce development: Pacific support service will be established in the provider arm of the DHB.

Via Ola has appointed a Project Manager to establish the role of Via Ola within the region as a network for Pacific providers.

Priority 5

Promote participation of disabled Pacific people: Need assessment and service co-ordination for disability support services for Pacific peoples were reviewed.

Priority 6

Ethnicity data improvement project will begin during 2003/04.

Advisory group will be used to share information with the Pacific community.

Family Based Assessment Tools and Models

A project manager was appointed to oversee and coordinate a project to develop family-based assessment tools and models.

The following progress was achieved during 2002/03:

- A draft of the literature and an evidence review on family centred models of care has been received and is being considered.
 - A draft of the qualitative interviews conducted with Pacific families (and Maori families) with diabetes is due in July 2003.
 - A specification for family based assessment tools and models is currently being drafted and will be finalised during 2003/04.
- A family centred model of care is expected to be piloted during 2003/04.

	<p>Implement and confirm Pacific Health Advisory Group</p> <p>During 2002/03 the focus was on establishing a Pacific Health Unit within the Provider Arm. As a result, the establishment of a Pacific Health Action Group has been deferred to 2003/04.</p> <p>A five-year Strategic Operational Plan (SOP) for Pacific health and disability services is currently in draft form. The SOP outlines a suggested funding path for Pacific services targeting Pacific populations.</p>
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Improve Access to Primary Care services

C&C DHB supports the Primary Health Care Strategy as the strategic framework for delivering primary health care in the district; and also endorses the establishment of Primary Health Organisations (PHOs) as the mechanism for achieving the Primary Health Care Strategy objectives.

Performance Measure	Deliverable
<p>Quantity: Improve the access and continue to implement the Primary Health Care Strategy.</p> <p>Timeliness: Confirm process for selection and establishment of PHO/s in the district. Agree strategy and guiding principles for Accident and Medical Emergency services (for Kenepuru) configuration by 30 September 2002.</p> <p>Implement process for establishing PHO/s. Develop options for Accident and Medical Emergency services (for Kenepuru) through service advisory group and links to the new regional hospital development project team by 31 December 2002.</p> <p>Establish the first wave of PHO/s in the District that prioritise the health of Maori, Pacific peoples, and families living in high NZ Dep 8-10² areas by 31 March 2003.</p>	<p>Partially achieved</p> <p>PHOs</p> <p>The establishment of Primary Health Organisations (PHOs) is a major step in improving access to primary care and implementing the Government's Primary Health Care Strategy. The first wave of PHOs in the C&C DHB district were established on 1 April 2003. Areas with a high proportion of Maori, Pacific, and low-income populations have initially been targeted. Hence the first wave of PHOs were established in Porirua (2 PHOs) and South-East Wellington (1 PHO) to reduce inequality.</p> <p>A process for selection of PHOs was confirmed and a strategy was agreed to in September 2002. The Request for Interest process included any groups wishing to participate in PHO development and a total of 16 responses were received. District-wide discussion resulted in a consensus on the minimum requirements for a PHO in the C&C DHB district.</p> <p>A workshop on community participation, community meetings and the involvement of Healthlinks and Kapiti Community Health Group built more active engagement of communities in PHO development.</p> <p>Iwi representatives, the Maori Partnership Board and Maori provider networks were all involved in discussions about their aspirations for, and views on, PHOs.</p> <p>In December 2002, the Board agreed on six groups as first wave PHOs. Of these, three started in April 2003, two in July 2003 and a Pacific-led PHO is in development. All groups who registered interest have been recontacted and many have indicated that they will participate in existing PHO developments.</p>

²New Zealand Deprivation Index is a measure of deprivation calculated from Census data. It is a relative measure, and refers to the average level of deprivation of people living in an area at a particular point in time, relative to the whole of New Zealand.

	<p>Accident and Medical Emergency Services</p> <p>In July 2002 an overarching strategy and a set of guiding principles were agreed on, by a Service Advisory Group established to consider the options for a 24 hour/7 days a week Accident and Medical Service at Kenepuru Hospital.</p> <p>The Service Advisory Group completed its work in September 2002. An additional workshop with the wider community and provider representation was held in April 2003.</p>
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Service coordination and models of care for chronic diseases to improve outcome for patients

Services need to be coordinated for patients with chronic diseases to improve health outcomes.

Diabetes

The New Zealand Health Strategy has identified Diabetes as one of the 13 medium term priorities. Diabetes is growing rapidly, particularly amongst Maori and Pacific peoples.

Performance Measure	Deliverable
<p>Quantity: Coordination of services to ensure ease of access and efficient use of services. Develop services and workforce for both capability and capacity.</p> <p>Timeliness: Review mechanisms for managing coordination of diabetes services and implement any changes. Review current service and workforce capacity. Develop a plan to manage the projected growth in demand for services and determine areas of priority for future workforce development by 31 December 2002.</p> <p>Establish the diabetes workforce development requirements across the DHB. Establish the FTEs required for additional diabetes nursing services, especially in Porirua by 31 March 2003.</p> <p>Service models developed with special focus on Maori and Pacific peoples. Establish the diabetes workforce development requirements across the DHB by 30 June 2003.</p>	<p>Partially Achieved</p> <p>Service development has continued to help people with diabetes to access services.</p> <p>A review of patient coordination management for diabetes services has assisted with the identification of future directions.</p> <p>Models of care</p> <p>Work is progressing on developing and piloting a Model of Care for coordinating and delivering services to Maori and Pacific populations in a family centred setting.</p> <p>There have been two key developments in this project:</p> <ul style="list-style-type: none"> · Preparation of literature review on whānau/fanau centred approaches to health care (international and New Zealand based research); and · Active consumer research with whānau/fanau seeking information about current diabetes services and the perception on how well these services were meeting their needs. <p>Both projects commenced in March 2003, and reports have been received on both.</p> <p>The next stage of the project is to pilot the model with selected Maori and/or Pacific services (eg mobile nursing).</p> <p>After reviewing primary care contracts, funding was increased for two providers who employ nurses with a special interest in diabetes. Inequalities funding has also gone to a South Wellington provider, enabling it to form a Maori diabetes group and provide a community health worker to develop a more whanau oriented approach, utilising specialist diabetes nurses and GPs to support patients with diabetes and their families.</p> <p>C&C DHB has worked with the Porirua Diabetes Cluster and has assisted with the development a scorecard to track progress, and provide a focus on prevention.</p>

Performance Measure	Deliverable
<p>Diabetes, Data of Annual Review</p> <p>Deliverable Local diabetes team includes the full aggregated data provided by the Primary Care Organisation(s) in their annual report and a copy is sent to the DHB and the Ministry of Health.</p> <p>Timing 1 February 2003</p>	<p>Achieved Full diabetes data set detailed in Annual Report, which was provided to the Ministry of Health by Wellington Local Diabetes Team in March 2003.</p>
<p>Diabetes Case Detection Rate</p> <p>Deliverable The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, as at the end of the reporting period, compared to the expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of reporting period.</p> <p>Timing 31 March 2003</p>	<p>Not Achieved The following Diabetes Case Detection Rate information was provided to the Ministry of Health in March 2003:</p> <p>Target for Jan-Dec 2002: 57% Result for Jan-Dec 2002: 50.2%</p>
<p>Diabetes Case Management Rate</p> <p>Deliverable The number of people with type I or type II diabetes mellitus on a diabetes register that have had a HBA^{1c} blood test in the previous 12 months with an HBA^{1c} of more than 8%, as at the end of the reporting period, compared to the number of people with type I or type II diabetes mellitus on a diabetes register that have had a HBA^{1c} blood test in the previous 12 months, as at the end of the reporting period.</p> <p>Timing 31 March 2003</p>	<p>Achieved The following Diabetes Case Management Rate information was provided to the Ministry of Health in March 2003:</p> <p>Target for Jan-Dec 2002: 26% Result for Jan-Dec 2002: 26.3%</p>
<p>Retinal Screening of people with diabetes in the last two years</p> <p>Deliverable The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last 2 years, as at the end of the reporting period, compared to the numbers of people with type I or type II diabetes mellitus on a diabetes register, as at the end of the reporting period.</p> <p>Timing 31 March 2003</p>	<p>Achieved The following information regarding retinal screening of people with diabetes was provided to the Ministry of Health in March 2003:</p> <p>Target for Jan-Dec 2002: 77% Result for Jan-Dec 2002: 91.9%</p>

Cardiovascular

Cardiovascular disease is the leading cause of death in New Zealand, and for all people over 45 years of age in the District. There are variations in the pattern of disease the District based on gender and ethnicity.

Performance Measure	Deliverable
<p>Quantity: Develop cardiovascular services in a coordinated way to target high-risk groups.</p> <p>Timeliness: Identify gaps and strengths in current service provision and how the services are currently provided by 31 December 2002.</p> <p>Detailed analysis of current service provision and model of care based on the Ministry of Health toolkit by 31 March 2003.</p> <p>Develop strategic direction for congestive heart failure and commence work on ensuring the models of care that meet the strategic priorities by 30 June 2003.</p>	<p>Achieved</p> <p>During 2002/03 a review of the model of care for cardiovascular disease, with a particular focus on community-based specialised services, indicated some high need areas. As a result a specialist nursing service is being established at Kenepuru to improve community management of congestive heart failure. Specialist nurses work with a cardiologist / physicians at Kenepuru Hospital to improve access to diagnostics and cardiology review, and to improve support for primary care providers and patients/families. This initiative also includes a health promotion/education aspect; aimed at promoting the benefits of physical activity, and improving access to it. A particular emphasis of this project is on Maori, Pacific and other low-income families in Porirua.</p> <p>A community based acute thrombolysis service was set up in the last quarter of 2002/03 to improve community management of cardiac infarction. This service enables cardiologists to monitor the ECG of a patient who is in transit to hospital with a suspected heart attack. In appropriate cases this enables treatment with blood thinning agents to begin while the patient is still in transit, increasing their chances of recovery.</p> <p>A thorough service planning review will be performed during 2003/04. This will include reviewing and planning the model of care for cardiovascular services.</p>

Waiting Times Initiatives

It is imperative to provide more timely and appropriate access to elective secondary services, and to coordinate care across primary and secondary service areas to ensure equity of access and ability to provide certainty of care plans within available resources.

Performance Measure	Deliverable
<p>Quantity: To improve patients' access to elective services and reduce waiting times to meet national standards.</p> <p>Timeliness: Implement services work out plans in accordance with Elective Services Project plan. Implement systems to monitor performance to contract and waiting times by 31 December 2002.</p> <p>Review performance to contract. Initiate work out plans for services with numbers waiting for assessment or treatment greater than six months by 31 March 2003.</p>	<p>Partially Achieved</p> <p>C&C DHB has made significant progress in the management of booking systems in the last two years.</p> <p>A system to monitor performance to contract and waiting times was developed in November 2002.</p> <p>A monthly reporting template was developed, which has evolved to now report performance against Key Performance Indicators (KPIs) in a numerical, percentage and colour coded format. This new format shows performance for the month, previous month, and trend analysis. Variances are clarified through commentary, along with resolution actions. The KPIs reported on are:</p> <ul style="list-style-type: none"> · numbers waiting > 6/12 for First Specialist Assessment (FSA), · numbers waiting > 6/12 for surgery

Monitor performance including access levels and outcome from work out plans by 30 June 2003.

- numbers waiting > 6/12 for active review
- surgical performance against contract

Monitoring is reported monthly to the Hospital Advisory Committee, senior management and services.

Work out plans implemented by 31 March 2003 for General Surgery, Vascular, Neurology, Dermatology, Gynaecology, and Gastroenterology. Strategies are ongoing in these and other specialties. Ongoing monitoring and revised strategies for ENT, Ophthalmology, Respiratory, Urology, Neurology, Gastroenterology. Revised achievement date is 31 December 2003.

The work out plans are specific to the individual requirements of the specialty and involves combinations of improving clinic efficiency/ utilisation, additional clinics, waiting list review, implementation of financially sustainable thresholds. Work out plan also involves enhancing capability of primary care sector to provide ongoing care for patients, development of primary care management guidelines and funded reassessment of patients.

First Specialist Assessment (FSA) waiting list

The number of patients waiting longer than six months for their FSA has reduced from 1774 at the start of the financial year to 1444 (this figure also includes Endoscopy, which was not included in previous figures³). Some specialties have achieved significant improvement, most notably General Surgery, and Dermatology.

Certainty

The number of patients waiting longer than six months with certainty has reduced from 709 (including patients with a deferred status) at start of financial year, to 471 at end June 2003.

Active Review

At the start of the financial year there was a total of 407 patients waiting longer than six months for a review. At the end of June 2003 there were only 144 patients waiting longer than six months for review.

A plan to achieve key performance indicators (KPIs) has been developed for each specialty, focusing on resolving waiting lists and addressing access issues. These plans are being implemented in a staged process, by specialty, according to priority level. Systems are in place to monitor achievement of the KPIs.

³The Ministry of Health requested that C&C DHB report on Endoscopy waiting times figures from April 2003 onwards.

<p>Elective Services Level of publicly funded services delivered is sufficient to ensure access to elective surgery for all patients before they reach a state of unreasonable distress, ill health or incapacity.</p> <p>Deliverable Provide a report:</p> <ul style="list-style-type: none"> · Confirming that, for any surgical services 100 percent of people in active review have received a clinical review of their condition and eligibility for publicly funded treatment at least every six months. Report details any exceptions. · Confirming that, for any surgical services the number of patients in active review is not greater than 10% of the annual number of surgical discharges. Report details any exceptions. · Confirming delivery by the District Health Board hospital(s) of not less than the contracted surgical caseweighted volume of surgical caseweighted discharges in each speciality areas. Report details any exceptions. <p>Timing Quarterly</p>	<p>Partially Achieved The Ministry of Health amended the Elective Services reporting requirement by reducing the reporting frequency from quarterly to annual. Accordingly, a report was provided to Ministry of Health in July 2003.</p> <ul style="list-style-type: none"> · At the end of June 2003 C&C DHB had 819 patients with an active review status across all specialties. 144 of these patients had not been reviewed within the previous six months. 123 of the 144 patients who are overdue review are in Ophthalmology. A resolution plan has been developed to reduce this figure. Active review currently comprises 9% of 2001/02 annual elective discharges. Specialties with significant percentages are Dental - 27%; Vascular – 19%; General Surgery – 14%; Ophthalmology – 13%. · Completion of total surgical caseweights was in line with planned production for the financial year. Two specialty services under delivered by more than 5 percent. These were Ear, Nose & Throat (ENT) 87.6%, and Urology, 90.9%.
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Service	Timing	Target for 2002/03	Actual for 2002/03								
Number of people with certainty who have been waiting for more than 6 months for a coronary artery bypass graft (CABG).	6 Monthly & Annual	0	11 We have a plan in place that will achieve zero by the end of August 2003.								
Number of people with certainty who have been waiting for more than 6 months for an angioplasty.	6 Monthly & Annual	0	0								
100% of patients do not wait longer than six months for First Specialist Assessment (FSA).	Quarterly	0	<p>% of patients waiting longer than 6 months for FSA:</p> <table style="margin-left: 40px;"> <tr> <td>1st Quarter</td> <td>23%</td> </tr> <tr> <td>2nd Quarter</td> <td>23%</td> </tr> <tr> <td>3rd Quarter</td> <td>19%</td> </tr> <tr> <td>4th Quarter</td> <td>19%</td> </tr> </table> <p>At 30 June 2003, there was a total of 7563 patients waiting for their First Specialist Assessment (FSA), with 1444 waiting longer than six months.</p>	1 st Quarter	23%	2 nd Quarter	23%	3 rd Quarter	19%	4 th Quarter	19%
1 st Quarter	23%										
2 nd Quarter	23%										
3 rd Quarter	19%										
4 th Quarter	19%										

100% of patients who have been offered publicly funded treatment do not wait longer than six months.	Quarterly	0	The number of patients waiting longer than six months with certainty of treatment has fallen from 709 at the beginning of the financial year, to 471 at the end of June 2003. A strategy for validation and application of the FST has been developed. Once completed, strategies will be developed to further reduce numbers waiting.
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Disability

During 2002/03 preparation commenced for the devolution of disability support services to DHBs in October 2003. C&C DHB have reviewed the disability support services delivered by our provider arm.

In order to address the needs of older people, C&C DHB will establish a service advisory group to develop a strategy for the future purchasing and service developments in this area.

Performance Measure	Deliverable
<p>Quantity: Build the capacity to manage disability support services in future.</p> <p>Timeliness: Review disability support services delivered by our provider arm by 30 September 2003.</p> <p>Initiate a project to better understand disability needs of the district by 31 December 2002.</p> <p>Development of action plan to operationalise New Zealand Disability Strategy by 30 June 2003.</p>	<p>Partially Achieved</p> <p>Building capacity to manage the future funding and planning of disability support services has been a priority during 2002/03. In June 2003 a draft establishment plan for disability services for older people was forwarded to, and accepted by, the Ministry of Health. The plan focuses on developing an integrated continuum of care for older people and developing the capability to manage age related disability support services.</p> <p>A stocktake of the provider arm's disability support services provision was completed in April 2002, and a briefing paper considered by the Disability Support Advisory Committee. The disability services delivered by the provider arm included:</p> <ul style="list-style-type: none"> · Assessment, treatment and rehabilitation · Psychogeriatric services · Needs assessment · Service coordination · Accredited equipment assessments · Regional intellectual disability care · Child development services. <p>In October 2002 a scoping study on Disability Support Services and Health of Older People was completed by the Wellington School of Medicine and Health Sciences. The report prepared for District Health Boards includes discussion of the history, development, and future planning of disability support services in the central region, with particular emphasis on issues for older people.</p> <p>Work is well advanced on the development of an action plan to operationalise the New Zealand Disability Strategy. The final plan is expected to be approved by the C&C DHB Board by the end of 2003. The timeframe for development of the plan has been extended to ensure that people with disabilities are fully involved in</p>

	<p>the development of priorities and key actions. At this stage the plan will include consideration of C&C DHB's role in:</p> <ul style="list-style-type: none"> · Human resources (including enhancing employment opportunities for disabled people, and improving disability awareness among staff members). · Communication (including accessible and alternative formats for web sites and written documents). · Buildings and facilities (including accessibility and physical design). · Contracting and funding for health services (including minimum contractual requirements for accessibility, disability awareness training etc). <p>In addition we intend to:</p> <ul style="list-style-type: none"> · Ensure that planners and management understand the context and intentions of the New Zealand Disability Strategy. · Identify opportunities for disabled people. · Identify barriers for disabled people. · Involve the disability community and wider disability sector in the process. · Initiate projects to ensure that C&C DHB provides accessible and inclusive services.
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Mental Health

Improving the health status of people with severe mental illness is one of the 13 population health objectives identified by the NZ Health Strategy for implementation in the short to medium term. It is estimated that around 20%⁴ of the population will have a diagnosable mental illness (including alcohol and drug disorders) at any one time, and that approximately 3% of the population will have a serious mental illness requiring treatment from specialist services.

Performance Measure	Deliverable
<p>Quantity: Address the mental health service gap in the district. Improve the quality of service and workforce for mental health.</p> <p>Timeliness: Consult with local advisory group and other key stakeholders in order to confirm the above services as priority areas by 30 September 2002.</p> <p>Identify current service provision, gaps and service delivery issues for confirmed priority areas by 31 December 2002.</p> <p>Prepare a service development and implementation plan by 31 March 2003.</p> <p>Start implementation of the plan by 30 June 2003.</p>	<p>Achieved</p> <p>Consultation with the Local Advisory Group for mental health and with other key stakeholders to confirm our priority areas began in July 2002.</p> <p>The identification of service gaps and service delivery issues was completed.</p> <p>A paper recommending an approach to the allocation of new funding went to the Funding Management Committee in November 2002.</p> <ol style="list-style-type: none"> 1. On 1 February 2003 an additional Child and Youth Specialist position for refugee children and young people was purchased from the Wellington Refugees as Survivors Trust. 2. A contract was signed on 1 July 2003 for a Community Based Kaupapa Māori Drug and Alcohol Service for tamariki and rangatahi in Wellington. 3. The Pacific Mental Health Service is developing a 'by Pacific for Pacific' child and adolescent mental health service.

⁴ Estimated prevalence of mental health problems amongst adult New Zealanders (Moving Forward, 1997)

	<p>To complement this development a Request for Proposal (RFP) was recently issued to existing NGO Pacific Mental Health services for the development of community-based child and youth mental health services (RFP commenced 30 June 2003).</p> <p>4. In November 2002 funding was provided to the Easy Access Housing Project in central Wellington to provide easily accessible, short to medium term accommodation for people with a mental illness who have had difficulty in finding regular accommodation and are homeless.</p>
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Provision of Health and Disability Services

This section highlights C&C DHB's achievements as a provider of health and disability support services.

Quality

C&C DHB is working towards achieving accreditation for the organisation by October 2004. The Quality Improvement Group was established during 2002/03 to improve quality of services provides.

Performance Measure	Deliverable
<p>Quality: Progress the implementation plan for accreditation of the organisation by 2004.</p> <p>Timelines: Baseline self-assessment to the standards completed by all areas. Risk analysis completed on all criteria rated 3 and below by 30 September 2002.</p> <p>Quality action plans/projects agreed. Quality Health New Zealand self-assessment information updated to identify progress with meeting standards by 31 December 2002.</p> <p>Quality Improvement Group agree on standards to be assessed by Quality Health New Zealand. Review action plans and determine if survey date is a realistic target by 30 June 2003.</p>	<p>Achieved Preparation for accreditation in 2004 continues as planned. Self-assessment to Quality Health New Zealand (QHNZ) Accreditation Standards was completed by all services. All criterion which were rated 3 (fair achievement) or below were risk rated and action plans developed and implementation commenced. In April 2003 QHNZ completed a preview visit to provide extra guidance and to assess our progress towards achieving the standards, and to determine whether the survey date is a realistic target. Accreditation survey date confirmed for July 2004.</p>

New Regional Hospital at Newtown and redevelopments at Kenepuru and Kapiti

Implement change management programme that focuses on new models of care for the new regional hospital. New and renovated facilities will support the new models of care and will be sufficiently flexible to respond to future changes in health care delivery.

Performance Measure	Deliverable
<p>Quantity: Start development work for the new regional hospital and facilities development (including redevelopments at Kenepuru and Kapiti).</p>	<p>Partially Achieved During the year development work continued for the new regional hospital. A summary planning brief was developed. The Master Plan was reviewed and Board approval gained in March 2003, with provisional Government approval on the revised master plan in May 2003. Planning for Kapiti was completed during the year.</p>

<p>Timeliness: Newtown decanting implementation commences by 30 September 2002.</p> <p>Project plan for all 3 sites approved by 31 December 2002.</p> <p>Implementation of key milestones as outlined in approved project plan by 31 March 2003 and 30 June 2003.</p>	<p>The decanting strategy for Newtown was approved in March 2003 and temporary construction works needed to house some services were in the planning stage until the end of June 2003. Decanting (the temporary relocation of services to enable construction to proceed) of the 210 Block will be completed by December 2003. By 30 June 2003, construction at Kapiti was well underway. The building is scheduled to be completed in October 2003, and occupied as soon as possible thereafter.</p> <p>Schematic design for Newtown and Kenepuru will be finalised and approved in September 2003. Early site works will begin at Newtown in October 2003. Main construction at Kenepuru and Newtown will begin in the first quarter of 2004.</p> <p>The revised key milestones for the project are:</p> <ul style="list-style-type: none"> · Decanting of the 210 Block by December 2003. · Decanting of the Front Block by March 2004. · Approval of schematic design in September 2003. · Main contractors appointed in the first quarter of 2004. · Early site works at Newtown begin in October 2003: · Kenepuru community hospital is expected to be completed by December 2005.
<p>Quantity: Implement change management plan that focuses on progressing new models of care.</p> <p>Timeliness: Change management plan approved by Project Steering Committee and Management Team. Organisational change management group established by 30 September 2002.</p> <p>Implementation of key milestones as outlined in the change management plan by 31 December 2002.</p> <p>Implementation of key milestones as outlined in the change management plan by 30 June 2003.</p>	<p>Achieved Change Management work got underway in September 2002. Further developed Change Management delivery and governance structures were established by December 2002. Project coordinators were in place in January 2003.</p> <p>Change Management Steering Group established – change management plan to implement models of care and project priorities was approved by this Group in May 2003.</p> <p>Implemented new project reporting framework to enable monitoring of performance and reporting to the Ministry of Health, management and Board. This is fully operational.</p> <p>Key milestones in the plan have been met including:</p> <ul style="list-style-type: none"> · Initiation of detailed efficiency projects which have met overall savings targets for the year. · Change management of staff changes and model of care implementation to support decanting (programme on track). · Organisation review programme completed to timetable including second stage of the establishment of a single patient services coordination unit. · Structural Integration of medical and surgical divisions. · Initiation of clinical supplies and materials management review – on track to be completed in October 2003.

Efficiency

In-patient demand for service is growing, within the environment of fiscal and resource constraints. Coordination and planning can happen at many levels to improve the quality of care delivered and improve patient experience within the hospital and after discharge.

We aim to use resources optimally by eliminating duplication and waste. The outcomes sought are to maximise patient access, improve patient experience, and keep infrastructure costs as low as possible.

Performance Measure	Deliverable
<p>Quantity: Improve production planning across the Provider Arm. Enhance the patient experience by improving timeliness of access to services and improved discharge planning.</p> <p>Timeliness: Identify current processes and factors, which impact on referral, admission and discharge. Analyse patient flows/boarder volumes for last three years. Develop a throughput plan for all acute medical admissions by 30 September 2002.</p> <p>Identify areas where consistency can be achieved across the organisation for referral, admission and discharge planning. Confirm allocation of beds to ensure capacity is flexible to meet demands until work on the bed alignment project is complete by 31 December 2002.</p> <p>Identify area specific requirements for discharge planning. All team and clinical leaders have access to a production planning information that meets their needs for managing contract targets by 31 March 2003.</p> <p>Review resources and documentation to facilitate streamlining of services and improve the hospital community interface. Systems and process for production planning and monitoring are in place and working by 30 June 2003.</p>	<p>Achieved Production plans have been established and are in place for elective services. Patient admissions – both elective and acute - are coordinated through the Patient Services Coordination Unit to ensure all acute cases are accommodated and elective surgery is achieved.</p> <p>A throughput plan has been developed for acute medical admissions.</p> <p>Work has continued within Internal Medicine on improving the discharge management of complex cases. With the appointment of a hospital discharge planner, work has now begun to look at discharge processes across the organisation.</p> <p>All Team and Clinical Leaders have access to the throughput/production plans.</p> <p>Plans and performance against the production plans are monitored weekly and any remedial actions identified. Throughput plans for acute admissions are monitored monthly. Production plans for elective surgery are reviewed weekly. Occupancy reports are produced daily. Bed modelling has identified bed reductions and subsequent areas for decanting. Process for referral from GPs and patients discharge was analysed to understand factors impacting on smooth access.</p>
<p>Quantity: Improve resource utilisation. Contain costs within allocated budget particularly staff and high cost treatment material.</p> <p>Timeliness: Cost pressures for high cost treatment material and pharmaceuticals identified. Completed ward profiles, which identify complexity and acuity.</p>	<p>Achieved Performance against budget is monitored formally on a monthly basis and corrective actions are identified and taken.</p> <p>Fortnightly meetings have been held with the CEO, GM and management team to monitor progress against key efficiency projects.</p>

<p>Identify resource requirements in line with benchmark targets by 30 September 2002.</p> <p>Reports are provided to teams, which identify cost trends and assists with analysis by 31 December 2002.</p> <p>Strategies are identified to assist with containing costs. Implementation and ongoing monitoring of production plans by 31 March 2003.</p>	<p>Staff utilisation continues to be monitored. A policy for the redeployment of staff has been developed and implemented to assist with improving the management of staffing resources against demands.</p> <p>Cost pressures have been identified, regular reporting developed and fortnightly monitoring commenced.</p> <p>Information is available for the clinical teams and used to assist with variance reporting, identification of specific areas requiring investigation, identification of corrective actions and future forecasting.</p>
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Service Based Quantitative Measures

Service	Timing	Target for 2002/03	Actual for 2002/03
Repeat Admission for asthma in children under 5.	6 Monthly & Annual	4.7	10
Repeat Admission for asthma in children between 5 and 14.	6 Monthly & Annual	8.2	4.3
Repeat admissions for acute rheumatic fever in people under 30.	Annual	0	0

TO THE READERS OF THE FINANCIAL STATEMENTS OF Capital & Coast District Health Board FOR THE YEAR ENDED 30 June 2003

We have audited the financial statements on pages 14 to 53. The financial statements provide information about the past financial and service performance of Capital & Coast District Health Board and its financial position as at 30 June 2003. This information is stated in accordance with the accounting policies set out on pages 14 to 15.

Responsibilities of the District Health Board

The New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 require the District Health Board to prepare financial statements in accordance with generally accepted accounting practice in New Zealand that fairly reflect the financial position of Capital & Coast District Health Board as at 30 June 2003, the results of its operations and cash flows and the service performance achievements for the year ended on that date.

Auditor's responsibilities

Section 15 of the Public Audit Act 2001, section 43(1) of the Public Finance Act 1989 and section 43 of the New Zealand Public Health and Disability Act 2000 require the Auditor-General to audit the financial statements presented by the District Health Board. It is the responsibility of the Auditor-General to express an independent opinion on the financial statements and report that opinion to you.

The Auditor-General has appointed Rudie Tomlinson, of Audit New Zealand, to undertake the audit.

Basis of opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- The significant estimates and judgements made by the District Health Board in the preparation of the financial statements; and
- Whether the accounting policies are appropriate to Capital & Coast District Health Board's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with the Auditing Standards published by the Auditor-General, which incorporate the Auditing Standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and

explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

Other than in our capacity as auditor acting on behalf of the Auditor-General, we have no relationship with or interests in Capital & Coast District Health Board.

Unqualified opinion

We have obtained all the information and explanations we have required.

In our opinion the financial statements of Capital & Coast District Health Board on pages 14 to 53:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
 - Capital & Coast District Health Board's financial position as at 30 June 2003;
 - the results of its operations and cash flows for the year ended on that date; and
 - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 22 September 2003 and our unqualified opinion is expressed as at that date.

R L Tomlinson

Audit New Zealand

On behalf of the Auditor-General

Wellington, New Zealand

Matters relating to the electronic presentation of the audited financial statements

This audit report relates to the financial statements of Capital & Coast District Health Board for the year ended 30 June 2003 included on Capital & Coast District Health Board's website. The Chief Executive Officer is responsible for the maintenance and integrity of the Capital & Coast District Health Board's website. We have not been engaged to report on the integrity of the Capital & Coast District Health Board's web site. We accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

We have not been engaged to report on any other electronic versions of the Capital & Coast District Health Board's financial statements, and accept no responsibility for any changes that may have occurred to electronic versions of the financial statements published on other websites and/or published by other electronic means.

The audit report refers only to the financial statements named above. It does not provide an opinion on any other information which may have been hyperlinked to/from these financial statements. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and related audit report dated 22 September 2003 to confirm the information included in the audited financial statements presented on this web site.

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

Directorate of Service Planning & Funding

Known as Planning & Funding, this arm of the DHB is responsible for planning and funding the services provided by Capital Coast Health and other providers within the district, including primary, Pacific and Maori providers.

The staff focus largely on how best to address the health needs of the district. This response reflects the priorities identified during a health needs assessment of the district's various communities. Key priorities for C&C DHB are to improve the health of Maori, Pacific people and people on low incomes.

Planning & Funding staff commission and carry out the research and analysis needed to determine the services that are needed both now and into the future. They are also responsible for monitoring the performance of providers and for helping them to develop their capacity.

A key focus for this group is also to maintain, develop and improve community engagement and relationships.

Hospital & Health Services

The provider arm of Capital & Coast DHB is known as Capital Coast Health. It is the leading provider of inpatient and community-delivered specialist health, disability support and mental health services in the central region of New Zealand and it is one of the country's regional tertiary service centres.

With around 3,500 staff (3000 full time equivalents) and an annual payroll of almost \$200 million, Capital Coast Health is a major employer in the Greater Wellington region and one of New Zealand's largest providers of health and disability services.

Capital Coast Health operates hospitals in Wellington and Porirua, a small maternity and outpatient facility at Paraparaumu and a number of community bases.

The organisation provides primary (community) and secondary (hospital) health services to more than 250,000 people living in Wellington, the Porirua Basin and the Kapiti Coast.

Specialist tertiary-level care is provided to patients from the wider region, serving a population base of around 900,000. These services include cardiology and cardiothoracic surgery, neurology, neurosurgery, vascular surgery, renal medicine and

transplants, genetics, oncology, paediatric surgery, neonatal intensive care, obstetrics, endocrinology, gynaecology, orthopaedics, urology, and specialist forensic services.

Wellington Hospital

Wellington Hospital is the largest facility operated by Capital Coast Health. It provides a comprehensive range of specialist services. It is also the region's main emergency centre, and only trauma centre, with a rooftop helipad providing a direct link to surgical, intensive care and emergency services.

As a major teaching hospital, Wellington provides an educational environment for its staff and has particularly strong relationships with the University of Otago's Wellington School of Medicine and Health Sciences, the Malaghan Institute (medical research) and the Victoria University School of Nursing and Midwifery.

Kenepuru Hospital

This secondary facility caters to communities to the north of Wellington, including Porirua and Kapiti.

The hospital provides medical, surgical, maternity and child health services, plus services for the elderly, a specialist inpatient and rehabilitation service, and outpatient clinics. Mental health services are also delivered from the site, including the new Regional Rangatahi (Adolescent) Service, which has a 13-bed inpatient unit. The Forensic, Rehabilitation and Intellectual Disability Service has its own campus near Kenepuru Hospital as does the Puketiro Centre which offers multi-disciplinary services for children and adolescents with emotional, behavioural or developmental concerns. The centre also provides audiology services for people of all ages in the Porirua area.

Kapiti Health Centre

This small community health centre on the site of the old Paraparaumu Hospital provides maternity services and outpatient treatment clinics for the people of the Kapiti Coast. Multi-disciplinary assessment and treatment programmes for the community's elderly are provided from the site.

Community Services

In addition to hospital-based services, multi-disciplinary services are provided in the community. Community health services include general and specialist district nursing, specialist multi-disciplinary rehabilitation services, occupational therapy, speech language therapy, physiotherapy, dietetics, social work and home support services.

Mental health services are also provided extensively in the community. A wide range of crisis, assessment, treatment, consulting liaison and training services are delivered to consumers in the Wellington and Porirua areas, greater Wellington (including Hutt Valley) and throughout the central region. Included in the range of services is the Alcohol and Drug Service and the specialist Maori Mental Health Service that has a focus inclusive of child, adolescent, family, adult and day programmes.

Board and Committees

The following Board members were elected in October 2001 and currently hold office: Judith Aitken (North-Western) Margaret Faulkner (Porirua) Karl Geiringer (Lambton) Ruth Gotlieb (South-Eastern) Helene Ritchie (North Western) Ian Shearer (South-Western) Chris Turver (Kapiti Coast)

Members appointed by the Minister of Health in January 2002: John Cody, Bob Henare (Chairman), Fa'amatuainu Tino Pereira, Helmut Karewa Modlik

STATUTORY ADVISORY COMMITTEE MEMBERSHIP

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE		
John Cody (Chair) Tino Pereira Chris Turver Karl Geiringer Bob Henare (ex officio) or Margaret Faulkner (ex officio)	External Members	
	Stephen Palmer Kiri Parata Margaret Southwick Herani Demuth	Hutt DHB (Public Health) Kapiti Healthlinks Vai Ola Trust Board Maori Governance Partnership
DISABILITY SUPPORT ADVISORY COMMITTEE		
Margaret Faulkner (Chair) Helene Ritchie Bob Henare (ex officio)	External Members	
	Valerie Bos John Forman Tupu Ioane-Cleverley Grace Moulton Wendi Wicks Liz Mellish	Vai Ola Trust Board Maori Governance Partnership
HOSPITAL ADVISORY COMMITTEE		
Ian Shearer (Chair) Ruth Gotlieb Helmut Modlik Bob Henare (ex officio) or Margaret Faulkner (ex officio)	External Members	
	Marion Bruce Caren Rangi Don Mackie Hilda Broadhurst	Kapiti Healthlinks Vai Ola Trust Board Hutt DHB (Emergency Dept) Maori Governance Partnership
FINANCE & RISK ASSURANCE COMMITTEE		
Judith Aitken (Chair) Bob Henare Helmut Modlik	External Members	External Attendees
	Neil Stiles Harley Gray	Internal Auditors Audit New Zealand
STRATEGIC COMMUNICATIONS COMMITTEE		
Bob Henare Tino Pereira Chris Turver		
REGIONAL HOSPITAL COMMITTEE		
Bob Henare Chris Turver		
MAORI PARTNERSHIP		
Bob Henare Helmut Modlik		

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