Mission Statement

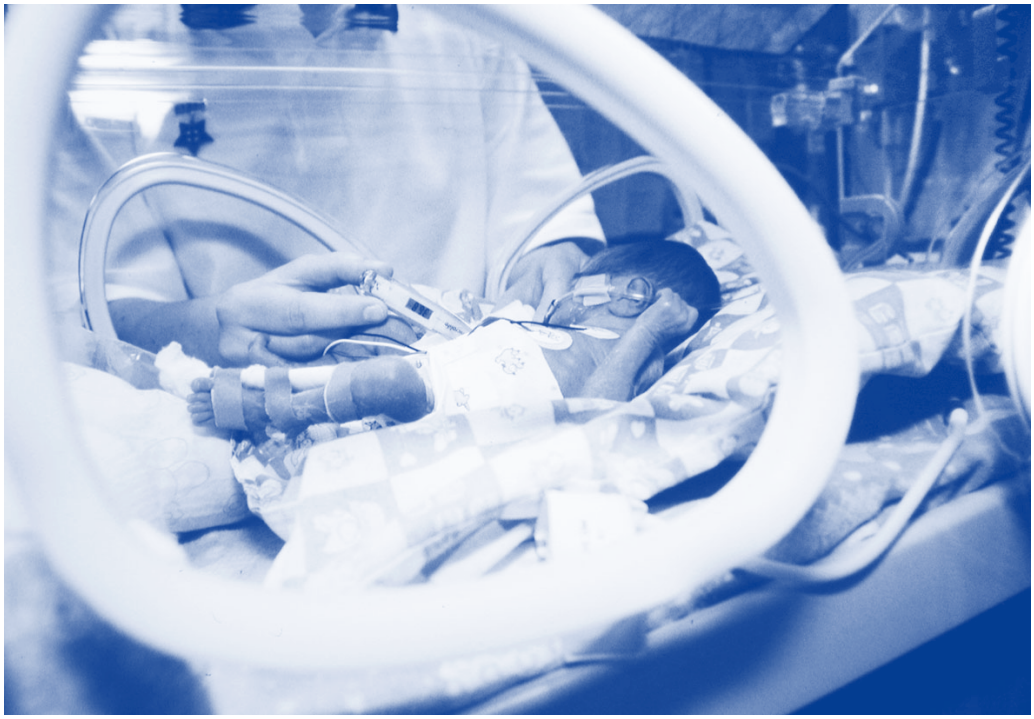


Photo courtesy of New Zealand Archives

OUR VISION

"He whakapakari, he panui i te rongopai o te hauora o to tatou rohe o Te Whanganui a Tara. He matua manaaki i te hauora a tangata he mahi tahi hoki i te taha o nga tangata katoa o to tatou rohe."

"In collaboration with our communities of interest, improving, promoting and protecting the health, independence and wellbeing of people within the Capital & Coast region."

Report from the Chairman and Chief Executive

It has been an exciting year for the Capital & Coast District Health Board – our first full financial year as a DHB.

Following the first elections for DHB members in October 2001, our new board met for its first official meeting in February. The board has seven elected members and four appointed by the Minister of Health. Four of those now serving on the board have come through from the transitional board.

During the year, after extensive research, we published our health needs assessment of the region. We also completed our five-year district strategic plan, received government approval for the regional hospital redevelopment project, signed a partnership agreement with Maori and began preparing for the introduction of Primary Health Organisations.

We look forward to an equally challenging period ahead.

Effective Treaty Partnerships

In September 2001, C&C DHB signed a partnership agreement with tangata whenua and local Maori.

The group established as a result of this process is now known as the Maori Partnership Board. They represent Te Runanga o Ngati Toa, Te Runanga O Te Ati Awa ki Whakarongotai, Te Ati Awa ki Poneke (Tenths Trust) and Nga Rauru Te Tere (Regional Maori Taurahere Group).

The group meets monthly to provide the Board with strategic advice on Maori health within the district.

Over the past year a key focus for the Maori Partnership Board has been to provide leadership and advice on the district's draft Maori Health Strategy and the regional hospital redevelopment project, including the addition of a wharenui at both Wellington and Kenepuru hospitals. They have also examined existing contracts with Maori and mainstream providers to determine that the services are as effective and as accessible as possible, and are culturally sound.

The group has also provided advice to the DHB Board on Primary Health Organisations. The DHB Board supports the group's desire for a Maori-led PHO that has an operational philosophy consistent with Maori values.

District Strategic Plan

Community consultation for the District Strategic Plan ended in April this year and the plan was adopted by the Board in June. The initial focus for the strategic plan is on improving the health of Maori and Pacific communities and people on low incomes, acknowledging and reducing disparities and improving access to services.

Key areas of concern within Maori health are the incidence of diabetes, heart disease, cancer and respiratory illnesses.

The strategic plan for Maori targets youth health and suicide prevention, primary health care and preventative services, provider and workforce development and improved ethnicity information to help research and the dissemination of information.

Priorities for improved Pacific health include targeting child and youth health, promoting healthy lifestyles and wellbeing, improving primary health care and preventative services, encouraging

provider and workforce development, and improving health and disability information and research.

Primary and Public Health Care

The government strategy to devolve primary health care and much of public health to DHBs is changing the outlook and focus of all DHBs. At C&C DHB the devolution of primary care funding and the extension of community based health services over the past year is just the beginning.

Work has also begun on broadening DHB involvement in public health programmes and the DHBs in the lower North Island are planning to develop a regional approach to public health planning. Work has begun on a regional plan which will address the public health needs of the people of the region; determine the level at which decision-making needs to be shared; and develop working relationships with the Ministry of Health, which still holds funds for the public health service.

The government's intention is for future primary health care to be delivered by Primary Health Organisations (PHOs). Over the year a great deal of work has gone into developing a framework within the DHB to foster the development of these organisations. In May this year the decision was made to focus initially on PHOs that met the strategic priorities for the DHB - to improve the health of Maori and Pacific peoples and people on low incomes.

C&C DHB is encouraging dialogue with all providers and community groups interested in PHOs with further PHO development planned for 2003. Communities and health providers are making considerable progress and are beginning to align themselves into potential PHO groupings. Feedback from the community tells us they want a simplified, patient-focused perspective to the organisation of their primary health services.

Diabetes

C&C DHB is committed to reducing the incidence and impact of diabetes. The number of people with diabetes is expected to increase rapidly over the next ten years, particularly within Maori and Pacific communities. Over the past year we have implemented a community-based retinal screening service and a diabetes podiatry service and we are developing a comprehensive project plan to reduce the incidence and impact of diabetes. The plan includes developing and piloting a service model which focuses on family assessment. Work is underway to develop an outcomes framework with health indicator targets to monitor progress toward our goal of reducing the incidence and impact of diabetes. We are also considering a project to find ways of preventing the disease from developing.

Disability

C&C DHB has taken significant steps to increase the influence of people with disabilities on decision making and policy development. Five people from the community with expertise in disability were appointed to the Disability Support Advisory Committee (DSAC) of the Board. We are very fortunate in the quality and the experience of the people appointed.

We have also established a Disability Forum. Over 70 representatives from the disability sector have taken part in meetings to discuss and define the issues for people with disability and identify ways forward. The result was a series of reports which are being used as a guide for future work and a summary of which was included in the District Strategic Plan.

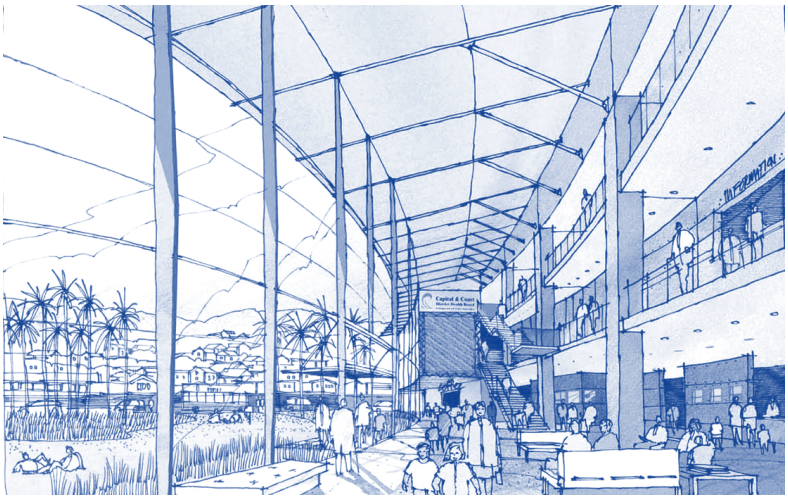
Representatives from the disability sector were also included in a number of C&C DHB projects and considerable effort was made by DSAC to establish inter-sectoral relationships with organisations such as the city and regional councils, the Ministry of Health and community agencies such as the Disabled People's Assembly and Age Concern.

Regional Mental Health Plan

This plan has now been adopted and covers the next two financial years. It focuses on cementing in place the many developments to services and structures that have been built up in recent years, following regular boosts in funding.

At present the central region has annual funding of around $145m for mental health services, with an extra $2.9m to come over the next two years for further developments. Priority areas for the extra funding are expected to be mental health services for young people, Maori and Pacific people and drug and alcohol services.

Key components of the plan are to provide for workforce development, quality improvement, piloting some consumer-led services and enhancing services for complex needs clients.



Community Input

The DHB has opened a wide variety of communication channels with the communities it serves. The Board has three advisory committees whose members include representatives from health and disability related community groups. These advisory committees make recommendations to the Board on policies relevant to their interest areas.

Two formal community-based groups that help us with feedback and guidance on local health-related decisions are the Porirua Reference Group and the Kapiti Community Steering Committee. We are also liasing with several service advisory groups, such as the Primary Care Advisory Group, which are made up of representatives from the community and providers. The Primary Advisory Committee helped develop ideas on PHOs. Throughout the year we have also hosted various community forums for discussion on our strategic and annual plans and the new regional hospital project, including forums in Kenepuru and Kapiti.

This broad base of communication with the community ensures that the DHB operates in a transparent and collaborative environment, and that its activities are a true reflection of the needs and desires of the public it serves. Particular attention is paid to our partnership with Maori and we have ensured there is representation by tangata whenua at all levels of the board structure and in the DHB's involvement with the community.

Regional Hospital Project

Following widespread consultation with the Kenepuru, Kapiti and Wellington communities in the latter part of 2001, the final business plan for services was prepared. It included an undertaking to maintain inpatient beds at Kenepuru Hospital and to increase many of our services at the hospital and in the surrounding community, including building up the number of outpatient clinics and introducing a 24 hour accident and medical emergency service. The plan also addressed the need for a new health centre for Kapiti and the need to build a new facility at the Newtown campus.

May 1st 2002 was a landmark day for C&C DHB - the day that Cabinet gave its approval to the regional hospital project business case. The business case includes a new hospital building at Newtown, the redevelopment of Kenepuru Hospital and the building of a new health centre at Paraparaumu. The push for a re-development of Wellington hospital goes back for over 30 years and there were widespread celebrations within the organisation following the news of the government's approval.

In June this year the Project Director was appointed. She is heading up the project on behalf of C&C DHB to ensure it is delivered on time, within budget and to an acceptable level of quality. As well as supervising the planning and building of the new facilities, the Project Director is providing advice and assistance to the management team as they plan and implement the organisational changes required in order to be ready for the new facilities.

Integrated Teaching Hospital

An integrated teaching hospital is a new concept for New Zealand, although similar models do operate in some parts of Australia and the United States. The concept is based on a managed, collaborative alignment of teaching, research, clinical and management resources. Its intent is to promote learning opportunities for all staff in the context of a multi-disciplinary, community and hospital health service. The result can be of huge

benefit to patients. At C&C DHB we are investigating the introduction of this concept as part of the new regional hospital project with input from representatives of Victoria and Massey universities, Whitireia Polytechnic and the Wellington School of Medicine and Health Sciences.

Annual Plan

The Annual Plan was endorsed by senior management in May and by the board in June. This plan describes the DHB's role as the funder and provider of health and disability services for the region. It also describes initiatives which will help progress the District Strategic Plan, the accreditation processes and the new regional hospital developments.

The Next Year

Over the next year our priorities will include: developing more projects and programmes to improve the health outcomes of Maori, Pacific people and people on low incomes: establishing PHOs: enhancing primary care developments: increasing our focus on public health: progressing the new regional hospital project: and building on community relationships.

We look forward to doing the work this coming year that will help us meet the targets identified in our annual and strategic plans as well as the Maori Health Strategy and the Pacific Health Action Plan. We will also continue to monitor our costs and ensure that our hospitals and health services are using resources efficiently and effectively.

Bob Henare
Board Chairman

Margot Mains
Chief Executive

Planning and Funding

PLANNING AND FUNDING

Planning and Funding manages the DHB's contracts with external providers, plans the configuration of services, and advises the Board on the health needs of the district's population and the allocation of resources.

Achievements in 2001/2002

- A comprehensive assessment of the health needs of Capital & Coast District has been completed. This revealed that overall Capital & Coast had a better than average health profile but there where significant populations with very high health needs.
- The direction and priorities set out in the District Strategic Plan were well received. The priorities reflect the Health Needs Analysis and Government priorities, particularly in reducing inequalities and establishing a focus on the health of the population as a whole.
- A series of disability forums were attended by about 70 people with an interest in disability issues and services. A helpful framework for analysing the strategic issues was developed and this contributed to the District Strategic Plan.
- A large number of forums were held with communities and providers on Primary Health Organisations (PHOs). The forums helped to ensure that interested providers had sufficient knowledge and understanding to take part in the process for developing PHOs.
- Government funding under the Intersectoral Community Action in Health programme for Improved Primary Care for Porirua has been invested in innovative programmes involving information services, increased community nursing and reduced barriers to access. This programme has already lead to increased cooperation between providers and greater awareness of issues for high health-need populations.
- A new podiatry and a retinal screening programme has been set up for people with diabetes. Work has begun on an integrated model of care and service delivery plan.
- A memorandum of understanding between C&C DHB and Porirua Healthlinks Trust has been signed, creating a cooperative framework for improving the health of the community.
- Decisions have been made, with the Ministry of Health, about how to invest $350,000 of Pacific Provider Development funding which has devolved from the Ministry.
- A Funding Management Committee has been set up to make funding decisions and advise the Board on the allocation of funding
- The Central Regional Mental Health and Addictions Network has been established, resulting in a Regional Mental Health Plan and decisions for the distribution of Blueprint funding.
- Staff have contributed to a range of national and regional programmes and meetings. Planning and Funding is committed to ensuring DHBs work efficiently in a cooperative environment that shares experiences and challenges.

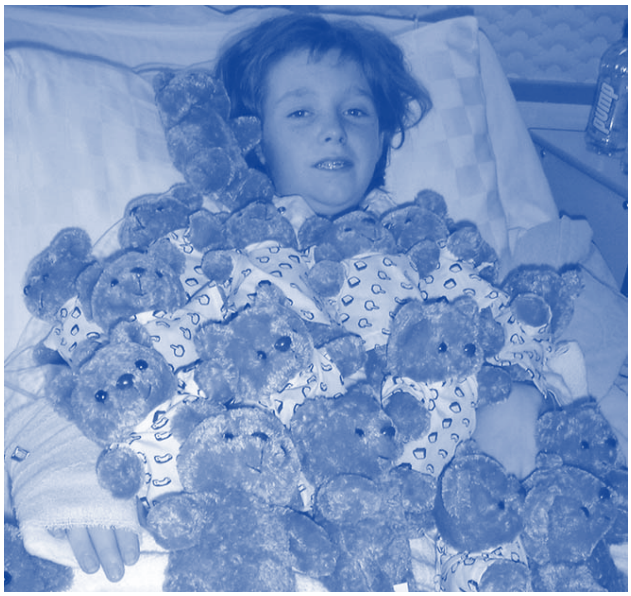
Key Initiatives During 2001/02
Hospital and Health Services

CHILD HEALTH SERVICES

Child Health Services provides an integrated mix of inpatient, outpatient, day patient and domiciliary services for children up to 16 years of age. Services are delivered in Wellington and Kenepuru hospitals, Puketiro Centre, outreach clinics (local and regional) and children's own homes.

Achievements in 2001/2002

- Day procedure bottlenecks have been eased by increasing day beds from six to nine and extending the day to 6pm on Monday to Thursday.
- A successful update/education session for GPs in the area was held, with GPs expressing keen interest in attending similar events in the future. This is being developed collaboratively with colleagues at Hutt Valley DHB.
- A new paediatric oncologist and an oncology data researcher have been employed, significantly increasing the strength of the service offered.
- Installation of HEPA air filtration into two paediatric oncology rooms has enhanced the care available for immuno-compromised patients.
- A surgical audit of paediatric practices relating to the insertion of central catheters has been completed and changed practices are expected to result.



- A new contract has been established with ACC for a new service providing assessments for children with suspected moderate brain injuries.
- Paediatric nurses have undertaken vaccinator courses, and many children are now immunised when being seen for treatment.

MENTAL HEALTH SERVICE

Some significant improvements have been made this year, including:

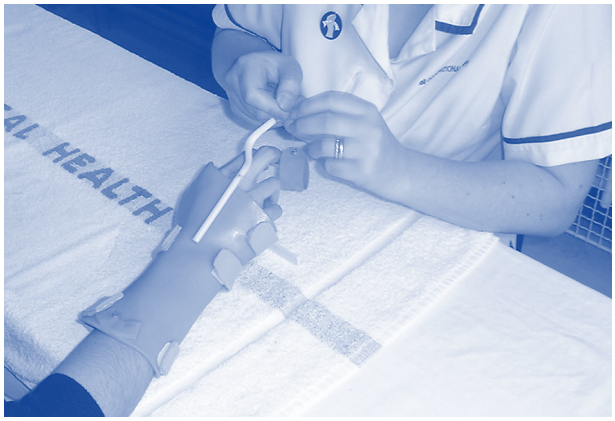
- Construction and opening of the Rangatahi (Adolescent) Service and its 13 inpatient beds at Kenepuru Hospital.
- The introduction of the Mental Healthline to take all after-hours calls to the MHS and ensure they are properly assessed and passed on to the correct service if urgent.
- The MHS Consumer Adviser has developed an instrument to measure consumer satisfaction and has begun developing processes for consumer participation throughout the services.
- A pilot project was introduced to test a new method for assessing whanau/family satisfaction.
- Staff turnover is now down to 13%.
- Continuing success and enrolment of 200 consumers in the Primary Care Liaison programme with the Wellington IPA.
- The completion of the new regional forensic and inpatient rehabilitation buildings, in collaboration with Operations. This project was finished on time and within budget.
- Development of a database to help with management of staff orientation, training, professional development, supervision and identifying recruitment needs across CCMHS.
- Return of four locally trained psychiatrists and successful overseas recruitment of another psychiatrist will result in the service having its full complement of psychiatrists by September 2002.
- The awarding of a contract by the Ministry of Social Policy to develop vocational options for consumers.

CLINICAL SUPPORT SERVICES

Clinical Support Services delivers a range of specialist services, including acute services, diagnostic and therapeutic intervention, specialist rehabilitation and professional community services. It also manages patient travel and retrieval as well as emergency management – coordinating the DHB's response to major incidents.

Achievements in 2001/02

- Capital Support won the Residential Intellectual Disability Care Agency contract for the southern North Island region. Capital Support will carry out needs assessments and undertake service coordination for people with intellectual disabilities who have high and complex needs, including people who need a secure environment.
- Radiology has addressed recruitment and retention issues for both MRTs and SMO radiologists. It led a demand management project to maintain service delivery in critical areas during the year when staffing was severely reduced.
- New information systems were successfully implemented in Pharmacy (WinDose) and the Emergency Department (EDIS). Upgrades to our Radiology and Laboratory information systems were also completed.
- Significant achievements were made in terms of better access to ICU for all patients due to improvements in recruitment and retention of experienced nursing staff.
- Recruitment and retention of anatomic pathologists in laboratory services was addressed. Also an extra CTA funded registrar training position was started.
- A laboratory-based infection control surveillance system was developed by the Infection Control Team.
- A falls prevention clinic pilot was started by Capital Coast Rehab in partnership with the Emergency Department.
- Relationships were strengthened with Victoria University in providing postgraduate nursing programmes. The Advanced Trauma and Emergency Nursing Programme is now run through Victoria University, and a moderation process is in place for entry to specialty practice programmes for Acute Care and Rehabilitation.



- The Emergency Department achieved accreditation as a training department by the Australasian College for Emergency Medicine for the next five years. Accreditation is critical in order to provide a Level 5 Emergency Service.
- A blueprint was developed for an integrated stroke service.
- Capital Coast Rehab prepared a Maori Health development plan which aims to improve access by Maori to AT&R services.
- Community Health Services took part in an MOH pilot programme to manage leg ulcers in the community. Better patient outcomes were achieved.

MEDICAL SERVICES

The Medical Services Clinical Group consists of six services: cardiology; endocrine/diabetes; internal medicine; renal medicine; respiratory medicine; and the Wellington Cancer Centre. The group's work is divided between outpatients (60 percent) and inpatients (40 percent).

Achievements in 2001/02

- Development of a renal dialysis unit in Porirua.
- Management of the Hawkes Bay renal dialysis services.
- Recruitment of a paediatric diabetes educator allowing improved management of service demands in paediatrics and in adults.
- Appointment of a discharge planning coordinator to facilitate and coordinate discharge planning within internal medicine.
- Establishment of an integrated service for older people at Kenepuru.
- Establishment of a non-invasive respiratory support service in the internal medicine wards.

- Highest ever angioplasty case numbers and acute admissions through the Cardiology unit.
- Establishment of implantable defibrillator service.
- Combined cardiology/paediatric clinic.

WOMEN'S HEALTH SERVICE

The Women's Health clinical group provides secondary and tertiary obstetric and gynaecology care and associated support services on an acute or elective inpatient, day patient or outpatient basis.

Achievements in 2001/2002

- Enhanced service capability in provision of uro-gynaecology.
- Consolidation of gynae-oncology outreach clinics in Hawkes Bay.
- No women waiting over six months for elective surgery.
- Decreased waiting time for first specialist appointments at Kenepuru.
- Improved management of theatre sessions to ensure optimal use.
- Significant reduction in missed appointments for colposcopy and gynaecology.
- Baby Friendly Hospital Initiative external audit completed, project plan developed and implementation commenced.
- Breastfeeding policy developed and implemented with increase in exclusive breastfeeding rates on discharge from 61% to 71% at Wellington Hospital.
- Development and implementation of a complaints process, with improvement in complaints response rate.
- External review of ultrasound service and development of KPIs, and of service policies and procedures.
- Recruitment strategy (short term) implemented to address midwifery shortage.
- Improved retention of staff – nursing, midwifery and clerical.
- Implementation of radio-telemetry cardiotocograph monitoring for delivery suite.

SURGICAL SERVICES

The Surgical Services Clinical Group is responsible for all surgical services provided by CCH, excluding paediatric and gynaecological surgery. Closely related non-surgical services are included within the group, and a wide range of secondary and tertiary assessment and treatment being provided on an outpatient, day case and inpatient basis.

Achievements in 2001/02

- All surgery brought in house and sub-contracting to other providers discontinued.
- Theatre 65 remodelled to bring it into service as a fully functioning theatre to accommodate current and future surgery volumes in the period leading up to the opening of the new Regional Hospital.
- Theatre cancellation rates reduced to an all time low of 0-3%.
- Cardiothoracic service and related services developed to enable the average weekly throughput of cardiac patients to be doubled in the period July 2001 – June 2002.
- Increased the ratio of elective patients being admitted on the day of surgery (DOSA).
- Began implementation of Worked Hours per Patient Day and Worked Hours per Patient Minute as key tools for utilising staffing resources.
- Started process to align staffing resources match to changing service requirements.

NURSING AND MIDWIFERY

The focus of this office is the professional practice of nurses and midwives. The director of Nursing and Midwifery provides strategic advice to Chief Executive Officer, Hospital Services General Manager, Executive Team, Quality Improvement Group and nurses & midwives.

Achievements in 2001/2002

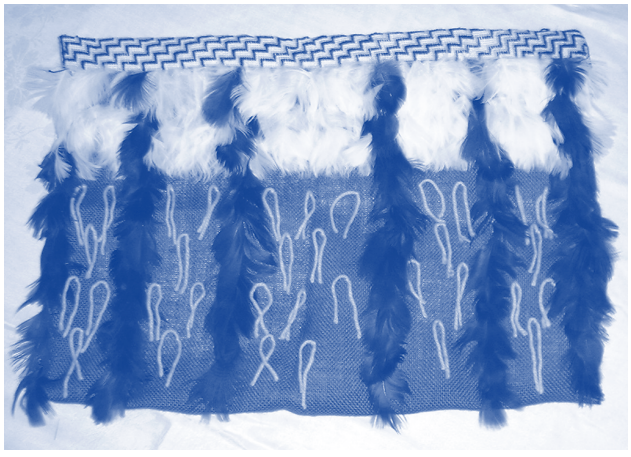
- The Nursing and Midwifery Strategic Plan has been drafted.
- The Centre for Midwifery & Nursing Education, Practice and Research, a collaborative initiative with Victoria University, has this year developed three new sub committees for education, practice and research.
- Linking the Nursing and Midwifery Career Pathway to pay in November 2001 has had a positive response, with an increase in applications for progression at all levels.
- A Management and Professional Development Programme was introduced over the year for nursing and midwifery specialists, educators, coordinators and other senior nurses.
- The Nursing and Midwifery Reference Group, made up of nurse/midwife representatives from the five Clinical Services, was set up early this year. The group takes part in the organisation's decision-making processes, strategic developments and issues of organisational interest.

MAORI HEALTH UNIT

Much of the work of the Unit over the past twelve months has been to work through the new structure under a District Health Board, while maintaining the initiatives already in place.

Achievements in 2001/2002

- **Te Pehi Parata Whanau Whare.** This whare provides a place at the hospital where people can stay while visiting family in hospital. It is highly valued by people of all cultures and provides a safe haven away from the hustle and bustle of the ward environment. This year, around 300 people from many parts of the country used this service.



- There has been a considerable rise in the numbers attending cultural awareness and Treaty of Waitangi training. Approximately 350 people participated in bi-cultural training during the year.
- The Maori Health Committee includes contracted health providers, services such as the police and the fire service who have Maori liaison staff, and a range of other health and non-health Maori service providers. It has met regularly to assist with the care offered to Maori who are patients in our hospitals.
- The Maori Health Unit led the implementation of He Korowai, the quality framework, which was successfully launched in June this year. He Korowai is significant because it portrays the symbols of respect, nurturing, encouraged improvement and achievement, integrity, honesty, transparency, partnership, accountability and harmony. He Korowai embraces the Treaty of Waitangi, C&C DHB values and our quality goals and allows them to interact with each other. He Korowai will lead us to accreditation over the next two to three years.
- A joint initiative between Medical Services and the Maori Health Unit has resulted in the implementation of a successful hospital-based smoking cessation programme. The Quit For Our Kids Programme provides assistance in the 'smokefree journey' for caregivers of children who are either inpatients or outpatients. Its high success rate has resulted in the programme being extended to include staff members.

OPERATIONS GROUP

The aim of the Operations Group is to deliver its services in a safe, efficient, effective and timely manner to enable health professionals to deliver the best possible health care to the public.

The Operations Group employs over 290 FTE internal and 150 contract staff. It has operating expenses of $40m per annum; in addition it

manages the purchase of over $20m worth of national supplies and controls around $35m of capital expenditure.

Achievements in 2001/2002

- **Technical Services:** Work continues to reduce the amount spent on utilities (water, electricity, gas, bulk oxygen) and savings are compensating for the increase in demand. Planned maintenance and capital investment is continuing to reduce the risk of critical infrastructure systems failure. Lift control upgrades in CSB have vastly reduced waiting times and frustration. Effectively, it is the equivalent of having a fifth lift in service - a 25% improvement.
- **Technology Assessment Group:** The work by staff within this group has led to savings of $1.2 million for the year. This includes leading a Surgical Services consumable product savings project which saved $400,000 by reducing theatre inventory by 300 product lines. This included cutting the number of suture products from 335 to 173. The group has established new minimum replenishment levels for products used in specialty theatres, and has also improved contract performance management.
- **Patient Services:** We have implemented the outpatient review recommendations to improve patient experience. We have joined a DHB telecommunications buying group, and mailroom equipment has been upgraded to enable external printing to be brought in-house.
- **Distribution Services:** We negotiated a three-year contract with Nuplex for the disposal of clinical waste. Stock reduction in supply-managed inventories between July last year and January this year saved $88,000. We earned additional revenue through supply of new barrier fabric orthopaedic packs to Hutt Valley DHB.

HUMAN RESOURCES

The team provides a mix of services including advice and consultancy services, policy development, information and analysis, systems management and coordination, and project implementation.

Achievements in 2001/2002

- Implementation of the first stage (practical skills) of a leadership and management development programme.
- Implementation of a new remuneration framework for senior nurse specialists and team leaders.
- Settlement of major collective agreements within reasonable timeframes, with sustainable outcomes and with good workplace relationships.
- Change management support for a range of organisation change projects, including the establishment of several key operational areas.
- Initiated a project which has led to major reductions in recruitment costs.
- Implemented a new process, in consultation with the services, to achieve substantial reductions in sick leave through improved monitoring, support and intervention.

DIRECTORATE OF INFORMATION MANAGEMENT

Following the endorsement of the District Health Board Strategic Plan for Information Management three key projects have begun:

- A major IT infrastructure upgrade project and exploration of shared services opportunities with Taranaki District Health Board.
- A review of all existing information systems with a view to compiling a comprehensive five-year plan for their upgrade or replacement (and the acquisition of new systems). A comprehensive business case for this infrastructure upgrade is being prepared.
- A review of the risks involved in three key

processes with a view to determining priorities and opportunities for change. These processes are: the healthcare process; the employment process from hiring to departure; and the goods and services requisition to payment process. This is helping us to focus on business process reform and data quality improvement through improved practice as well as providing input and impetus to the system review project.

QUALITY IMPROVEMENT GROUP

The year began with the newly established Quality Improvement Group (QIG) determining how best to move quality forward within C&C DHB. QIG membership includes Clinical Directors, Business Manager, Primary Care Advisor, Director of Nursing, Director of Operations, Medical Advisor. Director Quality and Quality Improvement Manager.

Achievements for 2001/2002

- **Accreditation 2004:** Further education of key staff during the year and completion of Phase I of the project which is a self-assessment to the Quality Health NZ standards – known as a 'gap analysis'. The management team and Board also received education in early 2002. A project timetable has been developed to take us to October 2004 - the date aimed at for the accreditation survey.
- **Clinical Audit:** The quality of service and care is being improved through clinical audit: e.g. a review of our falls prevention, management and risk assessment process has begun; a Mortality Review Committee has been established and methods developed to identify and analyse unexpected deaths. A no-blame philosophy underpins this. The credentialling committee has, through wide consultation, developed the credentialling policy and process. Credentialling of all new SMOs will start in July 2002.
- **Risk Management:** As part of the development of a clinical risk management framework, a draft policy and procedure for analysing sentinel events has been developed. The draft process will be trialled for three months.
- **Document Control:** In March 2002, a project began to update the organisation-wide clinical policy and procedure manual as the first part of implementing a robust document control system. The C&C DHB Document Control Policy and Policy on the Development and Review of Policies and Procedures has now been approved. This provides clinical staff with a pathway to initiate and contribute to policy development.

Statement of Responsibility for the Year Ended 30 June 2002

1 The Board and management of Capital & Coast DHB accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.

2 The Board and management of Capital & Coast DHB accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.

3 In the opinion of the Board and management of Capital & Coast DHB, the annual Financial Statements for the year ended 30 June 2002, fairly reflect the financial position and operations of Capital & Coast DHB.

Chairperson
Bob Henare
24 October 2002

Chief Executive
Margot Mains
24 October 2002

Director of Finance
Calum Laurie
24 October 2002

Statement of Accounting Policies for the Year Ended 30 June 2002

Reporting entity
Capital & Coast DHB is a Crown entity in terms of the Public Finance Act 1989.
The financial statements of Capital & Coast DHB 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 an 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 DHB holds a 16.7% shareholding in Technical Advisory Services Limited (TAS) and participates in its commercial and financial policy decisions.

Comparative figures
The Board was formed on 1 January 2001 and this is its first annual report for a full year. Accordingly, the comparative figures are for the six month period ended 30 June 2001.
The Board's operations combine the functions of the predecessor HHS and some of those of the functions previously performed by the Health Funding Authority.

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 part of the related asset or expense.

Taxation
Capital & Coast DHB 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.

Donations and bequest 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.

Endowment and trust properties
These properties have been acquired in trust to either maintain a future revenue stream, or for specific purposes. Capital & Coast DHB has full legal title to the properties but must comply with the original gifting trust deeds. These assets are principally land holdings, but also include certain buildings.
The properties are valued annually by E F Gordon (registered valuer) of E F Gordon & Co, independent valuers, and recorded at fair value.
On revaluation, movements are taken to a property revaluation reserve unless the reserve is insufficient to cover a deficit, in which case the amount of the deficit is included in the operating result.

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.

Surplus properties

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

Fixed assets (or Property, plant and equipment)

Fixed assets vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Capital Coast Health Limited (a Hospital and Health Service) vested in Capital & Coast DHB on 1 January 2001. Accordingly, assets were transferred to Capital & Coast DHB at their net book values as recorded in the books of the Hospital and Health Service. In effecting this transfer, the Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed assets acquired since the establishment of the District Health Board

Assets, other than land and buildings, acquired by the Board since its establishment, and other than those vested from the Hospital and Health Service, 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. 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 have been revalued at 30 June 2002. Land will be revalued in a future period.

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 at their estimated fair value.

Statement of cash flows

Cash means cash balances on hand, held in bank accounts, bank overdrafts, demand deposits and other highly liquid investments in which the DHB invests as part of its day-to-day cash management.
Operating activities include all transactions that are not investing or financing activities. Cash inflows include all receipts from the sale of goods and services and other sources of revenue which supports the Board's operating activities. Cash outflows include the payments made to employees, suppliers and for taxes.
Investing activities are those activities relating to the acquisition and disposal of current and non-current securities and advances and any other non-current assets.
Financing activities comprise the change in equity and debt capital structure of the DHB.

Cost of service statements

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.
For the year ended 30 June 2002, indirect costs accounted for 6% of Capital & Coast DHB's total costs.

Changes in accounting policies

The Board has revalued its buildings in line with the policy adopted last year. This is the first revaluation under the new policy and the effect in this financial period is a reduction in the value of buildings of $66 million.
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 Year Ended 30 June 2002

	Notes	Budget 2002 $000	Actual 2002 $000	Actual 2001 $000
Revenue		384,874	388,269	143,507
Expenses	1	389,062	463,799	148,001
Capital charge	16	8,485	7,506	4,475
NET DEFICIT	**1**	**12,673**	**83,036**	**8,969**

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

Statement of Movements in Equity
For the Year Ended 30 June 2002

	Notes	Budget 2002 $000	Actual 2002 $000	Actual 2001 $000
EQUITY AT BEGINNING OF THE PERIOD		82,489	82,288	0
Net deficit for the period		(12,673)	(83,036)	(8,969)
Revaluation of trust/endowment properties	2(c)	0	1,448	(374)
Reduction in revaluation reserve due to disposals	2(c)	(2,181)	(793)	0
Total recognised revenues and expenses for the period		(14,854)	(82,381)	(9,343)
OTHER MOVEMENTS				
Contributions from owners*	2(a)(c),17	0	0	80,127
Contributions from owners	3	8,588	86,000	11,504
EQUITY AT THE END OF THE PERIOD		**76,223**	**85,907**	**82,288**

*This represents the net assets of the HHS that were vested in Capital & Coast DHB effective 1 January 2001 (refer note 17)

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

Statement of Financial Position
As at 30 June 2002

	Notes	Budget 2002 $000	Actual 2002 $000	Actual 2001 $000
EQUITY				
General Funds	2(a)	88,896	175,076	89,076
Retained earnings	2(b)	(12,673)	(92,005)	(8,969)
Revaluation reserves	2(c)	0	2,836	2,181
Total equity		76,223	85,907	82,288
REPRESENTED BY:				
ASSETS				
Current ASSETS				
Cash		134	698	134
Receivables and prepayments	3	40,669	122,773	35,093
Inventories	4	3,793	3,669	3,851
Trust funds	2(d)	3,762	3,450	8,435
Endowment/trust properties		0	8,749	0
Total current assets		48,358	139,339	47,513
NON CURRENT ASSETS				
Fixed assets	5	229,047	149,907	217,154
Endowment / trust properties		0	1,539	10,195
Total non current assets		229,047	151,446	227,349
Total assets		277,405	290,785	274,862
LIABILITIES				
Current liabilities				
Payables and accruals	6	35,130	39,863	20,162
Employee entitlements	7	22,875	23,626	20,748
Current portion of term loans	8	77,125	30,303	60
Total current liabilities		135,130	93,792	40,970
Non current liabilities				
Employee entitlements	7	1,936	1,674	1,936
Term loans	8	64,116	109,412	149,668
Total non current liabilities		66,052	111,086	151,604
Total liabilities		201,182	204,878	192,574
NET ASSETS		**76,223**	**85,907**	**82,288**

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

Statement of Cash Flows
For the Year Ended 30 June 2002

	Notes	Budget 2002 $000	Actual 2002 $000	Actual 2001 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and patients		356,343	375,605	134,572
Other revenue		12,819	9,367	8,533
Interest received		0	0	2
		369,162	384,972	143,107
Cash was disbursed to:				
Payments to employees and suppliers		328,674	361,679	134,672
Capital charge		9,163	2,926	3,704
Interest paid		9,987	8,994	5,103
GST (net)		18,242	111	1,358
		366,066	373,710	144,837
Net cash inflow/(outflow) from operating activities	9	3,096	11,262	(1,730)
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Trust property sales cash released		0	5,222	0
Proceeds from sale of fixed assets		16,471	1,860	197
		16,471	7,082	197
Cash was applied to:				
Purchase of fixed assets		26,550	14,886	17,763
		26,550	14,886	17,763
Net cash inflow/(outflow) from investment activities		(10,079)	(7,804)	(17,566)
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
New equity		16,118	7,119	4,385
Proceeds from term loan		0	0	16,501
Cash vested from HHS		0	0	818
		16,118	7,119	21,704
Cash was applied to:				
Repayment of term loan		9,135	10,013	0
Capital Charge due from 31 December 2000 (HHS distribution)		0	0	2,274
Net cash inflow/(outflow) from financing activities		6,983	(2,894)	19,430
Net increase in cash held		0	564	134
Add opening cash		134	134	0
Closing cash balance		134	698	134
Made up of:				
Cash		134	698	134
Closing cash balance		**134**	**698**	**134**

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

Statement of Contingent Liabilities
As at 30 June 2002

	2002 $000	2001 $000
Legal proceedings	100	100
Personal grievances	202	290

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 2002

	2002 $000	2001 $000
Capital Commitments	5,023	8,599
Non-cancellable		
Operating Lease commitments:		
Less than one year	5,650	5,664
One to two years	4,380	3,394
Two to five years	2,014	3,421
Over five years	1,120	612
	13,165	**13,091**

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:

	2002 $000	2001 $000
Not later than one year	29,287	8,934
Later than one year and not later than two years	9,428	3,293
Later than two years and not later than five years	12,919	1,204
	51,634	13,431
TOTAL COMMITMENTS	**69,821**	**35,121**

Note 1: Net Deficit

	2002 $000	2001 $000
After charging		
Remuneration of auditor		
audit fees	99	99
assurance related services	12	0
Depreciation :		
buildings	6,196	2,622
plant and equipment	8,231	4,370
Total depreciation charge	14,427	6,992
Net loss on sale of fixed assets	0	44
Assets written down *	65,939	0
Board Members' fees	301	133
Interest expense	9,257	4,987
Rental and operating lease costs	6,767	3,064
Bad debts written off	50	111
Changes in provision for doubtful debts	71	(64)
After crediting:		
Interest income	20	2
Net gain on sale of fixed assets	1,044	0
Donations and bequests	662	323
Other trading activities	11,213	6,477

*The approval of a new regional hospital has had a significant impact on the value of buildings at 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

(a) General Funds	2002 $000	2001 $000
Opening balance	89,076	0
Equity vested from HHS (refer Note 16)	0	77,572
Contribution from owners (refer Note 3)	86,000	11,504
General funds at 30 June	**175,076**	**89,076**

(b) Retained earnings	2002 $000	2001 $000
Retained earnings at 1 July	(8,969)	0
Operating deficit	(83,036)	(8,969)
Retained earnings at 30 June	**(92,005)**	**(8,969)**

(c) Reserves	2002 $000	2001 $000
Endowment / Trust property revaluation reserve		
Opening balance	2,181	0
Revaluation reserve vested from HHS (note 16)	0	2,555
Revaluation	1,448	(374)
Reduction in revaluation reserve due to disposals	(793)	0
Reserves at 30 June	**2,836**	**2,181**

(d) Trust funds

Trust funds are funds donated or bequested for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived.

Revenue and expenditure in respect of these Trusts is recognised in the Statement of Financial Performance.

Note 3: Receivables and Prepayments

	2002 $000	2001 $000
Trade debtors	33,802	24,487
Provision for doubtful debts	(362)	(282)
Crown equity due*	86,000	7,119
Accrued income	2,766	3,087
Prepayments	567	682
Total receivables and prepayments	**122,773**	**35,093**

*The write down in the value of a number of buildings has had a significant impact on the equity of the DHB and the Crown has recognised the need to replace this equity. This replacement is in the form of an irrevocable pledge of equity of $86 million to be drawn as and when required. The DHB will use these funds as part of the payments from the Crown to construct the new regional hospital.

Note 4: Inventories

	2002 $000	2001 $000
Pharmaceuticals	888	757
Surgical and medical supplies	2,683	2,997
Other supplies	98	97
Total Inventory	**3,669**	**3,851**

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

	2002 $000	2001 $000
LAND		
Total land	3,380	3,380
Total land	**3,380**	**3,380**
BUILDINGS		
At cost	0	178,411
At valuation	88,252	0
Accumulated depreciation	0	(52,065)
Total buildings	**88,252**	**126,346**
PLANT AND EQUIPMENT		
At cost	98,386	101,154
Accumulated depreciation	(51,584)	(50,934)
Total plant and equipment	**46,802**	**50,220**
SURPLUS PROPERTIES		
At cost	13,270	13,308
Accumulated depreciation	(3,397)	(3,099)
Total surplus properties	**9,873**	**10,209**
CAPITAL WORK IN PROGRESS		
At cost	1,600	26,999
TOTAL FIXED ASSETS		
At cost and valuation	204,888	323,252
Accumulated depreciation	(54,981)	(106,098)
Total carrying amount of fixed assets	**149,907**	**217,154**

Restrictions

Capital & Coast DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the DHB's land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of s 40 of the Public Works Act 1981.
Titles to land transferred from the Crown to Capital & Coast DHB are subject to a memorial in terms of 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 (Registered Valuer) of DTZ Darroch as at 30 June 2002.

The Board Members consider the latest Government valuations shown below for land as at September 1999 (Paraparaumu) and September 2001 (Wellington, Porirua) are an indication of fair value.

	2002 $000	2001 $000
Land	**16,086**	**14,504**

Note 6: Payables and Accruals

	2002 $000	2001 $000
Trade creditors and accruals	24,251	12,274
Capital charge due to the Crown	5,351	771
Accrued expenses	5,689	6,209
Revenue in advance	4,572	908
Total payables and accruals	**39,863**	**20,162**

Note 7: Employee Entitlements

	2002 $000	2001 $000
Accrued pay	6,960	4,654
Annual leave	14,515	13,825
Retirement and long service leave	2,129	2,470
Other	1,696	1,735
	25,300	**22,684**
Made up of:		
Current	23,626	20,748
Non-current	1,674	1,936
	25,300	**22,684**

Note 8: Term Loans

	2002 $000	2001 $000
Crown Financing Agency *	30,167	30,167
Bank revolving credit	25,490	35,730
Bond holders	19,712	19,694
Capital & Coast notes	64,000	64,000
Other loans	346	137
Total	**139,715**	**149,728**
Less current portion	(30,303)	(60)
Non current portion	109,412	149,668
Interest Rates Summary:		
CFA	8.00%pa	8.00%pa
Revolving credit	5.80%pa	5.97%pa
Notes	8.04%pa	8.04%pa
Repayable as follows:		
One to two years	98,412	30,167
Two to five years	11,000	119,501
	109,412	**149,668**

* This debt was converted to equity in July 2002.

Borrowings are secured by a negative pledge. Without the lenders' prior written consent Capital & Coast DHB cannot 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) after taxation with net cash flow from operating activities

	2002 $000	2001 $000
Net surplus/(deficit)	(83,036)	(8,969)
Add/(less) non-cash items:		
Depreciation/assets written down	82,107	6,992
Donated / trust purchased assets	(208)	0
Total non-cash items	**81,899**	**6,992**
Add/(less) item classified as investment activity:		
Net loss/(gain) on sale of fixed assets	(1,044)	44
Total investing activity items	**(1,044)**	**44**
Add/(less) movements in working capital items:		
(Increase)/decrease in receivables and prepayments	(8,799)	(423)
(Increase)/decrease in inventories	182	348
Increase/(decrease) in payables and accruals	17,688	(1,173)
Increase/(decrease) in provisions	4,670	1,711
(Increase)/ decrease in trust funds	(298)	(260)
Working capital movement – net	**13,443**	**(203)**
Net cash (outflow)/inflow from operating activities	**11,262**	**(1,730)**

Note 10: Related Parties Transactions

Capital & Coast DHB is a wholly owned entity of the Crown. The Government significantly influences the role 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
Capital & Coast DHB received $367 million from the Ministry of Health to provide health services to the Capital Coast DHB area in the year ended 30 June 2002.
The amount outstanding at year end was $29 million.

(b) Joint venture company
Capital & Coast DHB purchased services from Technical Advisory Services Ltd of $316,000 during the year ended 30 June 2002.

(c) Key management and Board members
During the financial period there were no related party transactions.
No related party debts have been written off or forgiven during the year.

Note 11: Financial instruments

Capital & Coast DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, investments, accounts receivable, trade creditors and loans.
The Board has a series of policies providing risk management for 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 the group's borrowings are disclosed in note 9. CFA and other loans are at fixed interest rates. Interest rates on other loans are reviewed annually.

There is a $28,000,000 interest rate swap in place at 30 June 2002 which converts $28m of fixed debt (8.08%) to floating debt. The valuation as at 30 June 2002 was a $385,000 benefit to Capital & Coast DHB.

Unused facilities

As at 30 June 2002 Capital & Coast DHB had available committed borrowing facilities of $70m. $45.2m was committed against this facility at 30 June 2002 leaving $24.8m 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 DHB undertakes transactions denominated in foreign currencies from time to time and exposures in foreign currency arise from these activities. It is the DHB's policy to hedge any such risks using forward and spot foreign exchange contracts to manage these exposures. There were no foreign exchange contracts in place at balance date.

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB 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 DHB 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 are not recognised in the Statements of Financial Performance, Financial Position or Cash Flows of Capital & Coast DHB.

	2002 $000	2001 $000
Opening balance	70	62
Monies received	185	90
Interest earned	2	1
Payments made	(187)	(83)
Closing balance	**70**	**70**

Note 13: Board Members' Remuneration

The Board of Capital & Coast DHB as at 30 June 2002, and those who ceased to hold office during the year ended on that date, are set out below together with details of their remuneration, received or receivable, for that period:

	$000
Bob Henare (Chair)	55
John Cody	27
John Forman	13
Margaret Faulkner QSM	33
Harley Gray	12
Beverley Lawton	13
John McEnteer	18
Tino Pereira	27
Judith Aitken	14
Karl Geiringer	16
Ruth Gotlieb	16
Helene Ritchie	16
Ian Shearer	15
Chris Turver	14
Helmut Modlik	12
	$301

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	32
110 - 120	18
120 - 130	18
130 - 140	14
140 - 150	24
150 - 160	13
160 – 170	13
170 - 180	5
180 - 190	7
190 - 200	5
200 - 210	5
210 - 220	2
220 - 230	4
230 - 240	2
240 - 250	1
270 - 280	2
280 - 290	1
310 - 320	1
350 - 360	1

The Chief Executive's remuneration and other benefits is in the $350,000 to $360,000 bracket.
Of the 168 employees shown above, 140 are or were medical or dental employees and 28 are or were neither medical nor dental employees.
If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of $100,000 or more would be 245, compared with the actual total number of employees of 168.

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 $
1	2,462
1	3,000
1	3,105
1	3,731
1	3,794
1	4,406
1	5,641
1	6,437
1	8,254
1	10,000
1	10,642
1	10,875
1	11,000
1	19,251
1	19,678
1	20,000
1	21,299
1	21,500
1	23,932
1	26,874
1	28,995
1	32,000
1	35,416
23	**332,292**

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 2002 was 11.0%.

Note 17: Vesting of assets

Capital & Coast DHB was established on 1 January 2001 under the New Zealand Public Health and Disability Act 2000. On that date the assets and liabilities of the Capital & Coast Ltd vested in the DHB at their carrying values as recorded in the books of the HHS. The net value of the assets vested is recognised as a capital contribution by the Crown, the owner of both the HHS and the DHB.

Statement Of Objectives And Service Performance

Summary of revenues and expenses by output class

	Funding	Governance and funding administration	DHB Hospital Provider	Elimination	Total DHB
Revenue					
Crown	343,231	3,644	282,790	(253,291)	376,374
Other	0	0	11,895	0	(11,895)
Total Revenue	343,231	3,644	294,685	(253,291)	388,269
EXPENDITURE					
Personnel	0	1,356	181,951	0	183,307
Depn	0	12	14,415	0	14,427
Capital charge	0	0	7,506	0	7,506
Other	343,231	2,821	173,304	(253,291)	266,065
Total expenditure	343,231	4,189	377,176	(253,291)	471,305
Net surplus/(deficit)	0	(545)	(82,491)	0	(83,036)

Reconciliation to retained earnings

	Funding	Governance and funding administration	DHB Hospital Provider	Elimination	Total DHB
Opening retained earnings	0	(60)	(8,909)	0	(8,969)
Less deficit for the year	0	(545)	(82,491)	0	(83,036)
Closing retained earnings	0	(605)	(91,400)	0	(92,005)

Framework for Statement of Service (Performance for statement of intent)

Governance Capability

During 2001/02, Capital & Coast DHB developed the capability to be an effective funder by putting resources, systems, and processes in place so that it can fulfil strategic service planning, needs analysis and funding and contracting responsibilities.

Performance Dimension	Progress Report
Accountability	
Develop a District Strategic Plan, which will inform our prioritisation, resource allocation and service development in future. **(Due May 31 2002)**	**Achieved** The Board's advisory committees endorsed the draft District Strategic Plan in May, and the Board approved this as the final District Strategic Plan at its June 10 meeting. The priorities identified in the District Strategic Plan are incorporated in the prioritisation template and in all decision-making criteria.
Develop a Statement of Intent (SOI) and an Annual Plan for the 2001/02-year. **(Due September 30 2002)**	**Achieved** The Ministry of Health extended the time-line for all DHBs to supply the Annual Plan by 30 September and SOI to two weeks after the approval of the Annual Plan. The Board approved the Annual Plan at its October 4 2001 meeting and the SOI on December 4 2001.
Consultation	
Engage communities in planning and decision making. Develop new ways of relating to and working with communities, so that policies and services are developed which meet their needs. We will formally consult on the Needs Analysis and the District Strategic Plan. The District Strategic Plan will reflect communities needs and aspirations. **(Engagement by October 31 2001, Consult by March 2002)**	**Achieved** Established a number of new mechanisms for engaging with communities - Porirua and Kapiti Reference Groups and Maori Partnership Board. Via Ola (a consortium of Pacific providers) is being established as a reference group. Relationships with Wellington City Council and Newtown community are being developed as a preliminary to the establishment of a Wellington reference group. C&C DHB formally consulted on Health Needs Assessments and District Strategic Plan. Community needs, coupled with information from the Health Needs Assessment, formed the basis for the priorities established in the District Strategic Plan. Engagement with communities and reference groups regarding Health Needs Assessment began in November 2001 and formal consultation including public meetings, fono and hui for the District Strategic Plan occurred

	during March and April 2002. Formal consultation concluded in April 2002.
Needs Assessment	
Complete a Needs Analysis report to establish a comprehensive knowledge of the needs of our people. This Needs Analysis will be shared with communities and the shared interpretation will contribute to the Strategic Plan. **(November 1 2001)**	**Achieved** First version of the Health Needs Analysis was completed and considered by the Board's advisory committees in October 2001. This was made public via the internet in October 2001, and hard copies were distributed to external organisations and made available to any person on request. An updated version was published on the internet in February 2002, and a further update was placed there in May. Results of Health Needs Assessment were shared with communities and consultation started in November 2001. A complete reworking of the population profile was also performed on release of Census 2001 figures. The Health Needs Assessment is a 'living document', and will be continuously updated this year as further data is obtained. The priorities identified in the Health Needs Assessment have been incorporated into the District Strategic Plan.
Prioritisation	
Develop principles, processes and templates for prioritisation which are relevant to our resident communities. Consult with communities on these processes. A principle-based framework will be used for evaluating proposals, which utilises community knowledge and incorporates community values in decision making, effective utilisation of health funding and reduction in health disparities. **(November 1 2001)**	**Achieved** The Board approved a process for prioritising funding for new initiatives and service developments in November 2001. The prioritisation process takes into account the Government's health and disability strategies, and the priorities identified in the C&C DHB strategic plan. Communities were consulted on prioritisation principles along with the District Strategic Plan. The process considers the priorities of Maori and Pacific health. The purpose of this process has been to determine funding for services/initiatives that: • are aligned with the strategic priorities of C&C DHB; • are consistent with the decision criteria agreed to by the Board; • are cost-effective and financially sound; and • will improve or strengthen existing service provision to impact on health outcomes.
Risk Management	
A monthly risk report to the Minister and Ministry of Health. The risk management system complies with Aus/NZ standards for public	**Not achieved** C&C DHB does not provide a monthly risk report to the Minister and Ministry of Health.

sector SAA/NZS HB 143:1999. Risk management system which provides management discipline in identifying, managing and mitigating risks. The DHB functions are managed on a 'no surprises' basis.	The risk management policies, procedures, systems and reporting will be further developed during 2002/03 to comply with SAA/NZS HB standards. A framework for clinical risk management is under development. A Quality Improvement Group (QIG) is responsible for clinical risk management. Clinical risk management is currently focused on incident/accident/hazards (reported through the incident/accident/hazard system), complaints management, Health and Disability Commissioner and ACC investigations. As part of that framework a draft policy and procedure for dealing with sentinel events has been developed and was approved by QIG in June. The draft process has been trialed for three months. The Planning & Funding Unit reports risk on a monthly basis to the Community and Public Health Advisory Committee (CAPHAC) and the Disability Support Advisory Committee (DSAC).
Monitoring and Audit	
Monitor and audit selected services where contracts are devolved during 2001/02. Central TAS (Technical Advisory Service) will develop a local and regional audit plan in accordance with the priorities of C&C DHB. Service providers delivering safe, cost effective services with an emphasis on continuous quality improvement. **(audit planned before December 2001)**	**Not Achieved** Central TAS audit plan will be developed later than planned as audit staff were recruited later than anticipated. Processes for issue-based audits will be developed during 2002/03. An audit survey of providers was conducted with responses received from providers in July 2002. The purpose of this survey is to: • confirm organisational details (eg; physical addresses); • gather information on the workforce to help with workforce planning; • provide information on quality and audit activity; and • provide information on the use of computer technology. This information will be used to establish a fair and consistent set of criteria by which service quality can be measured across providers throughout the region. C&C DHB has requested 2 issues-based audits, which will be completed in November 2002.
Partnership with Maori	
Complete the setting up of a Maori Governance structure. Establish an infrastructure for engagement with Maori. Appoint a Maori development manager. Input from Maori into development of the	**Achieved** Agreement was signed in September 2001 with the Nga Iwi Tangata Whenua to establish a Governance partnership with Maori. The Maori Partnership Board provides strategic advice to

strategic plan and service plans to drive better health outcomes and reduce inequality in health status. **(October 2001)**	the Board on Maori health issues and has input into planning. A Maori Development Manager was appointed in October 2001. Input was sought from representatives of the Maori Partnership Board and their representatives on advisory committees of the Board on the development of District Strategic Plan and prioritisation.
Increased Community Participation	
Appoint community people to Statutory advisory committees **(by October 31 2001).** Appoint reference groups and develop engagement process. Work with Porirua group to develop new engagement processes. Appoint community representation to all operational working parties, steering and advisory groups. Widespread and meaningful involvement of community in policy and strategy development and decision making. A better informed community. Increased satisfaction with C&C DHB performance. **(by June 30 2002)**	**Achieved** Community representatives were appointed to Community and Public Health Advisory Committees on August 16 2001. Community representatives were appointed to Disability Support Advisory Committees on December 4 2001. Community representatives were appointed to Hospital Advisory Committees on October 15 2001. All groups (steering, advisory and operational working parties) have at least one community appointee. C&C DHB is one of four partners with Porirua City Council, Porirua Healthlinks and Ngati Toa to establish the Health Cluster. The Health Cluster has identified many projects, including diabetes, which is identified as a major issue and priority in the District Strategic Plan. C&C DHB has worked with Porirua Healthlinks and Kapiti Healthlinks for District Strategic Plan and with Porirua Healthlinks for 'Access to Primary Care'. C&C DHB meets bi-monthly to share information and seeks input from Porirua Healthlinks and Kapiti Healthlinks regarding Health Needs Assessment, District Strategic Plan, and service developments. C&C DHB also meets quarterly with wider Porirua and Kapiti communities and meets with the Maori caucus of Porirua Healthlinks and Kapiti Healthlinks on a weekly basis. C&C DHB is also funding Porirua Health Information and Communication Systems (PHICS) to improve information for the Porirua community.
Relationships with Providers	
Establish good relationships with present provider organisations and staff. Participate in Regional Hospital development. Establish transparent processes and clear	**Achieved** A Planning & Funding team representative is a member of Clinical Process Working Group (CPWG) established for input in service re-

strategy. Regular meetings, sharing of information, joint projects. **(June 30 2002)**	configuration for the Regional Hospital development. Regular forums have been established, which will continue in 2002/03 for information sharing with staff. The Executive Team and Senior Management Team of the DHB have representatives from both the Planning & Funding team and the Provider arm of the DHB.
Build Planning & Funding	
Build Planning & Funding team with necessary depth and experience. Put internal systems (performance management, budget control, personal and team development, and record systems) in place. An effective high performing team. Low turnover of staff. **(June 30 2002)**	**Achieved** Internal systems (for performance management, team and personal development, and budget control) have been developed. Record systems (both for hard copies and electronic) are now in place. Planning & Funding team members have relevant experience in service planning and development, contract provider management, and planning. There has been only one Planning & Funding team resignation during 2001/02.
Manage Sector Transition	
Provide leadership, and work with the Ministry of Health and other DHBs, on sector transition issues. In particular the development of implementable primary care and Well Child strategies. Influence development of Population Based Funding Formula and tertiary services. Successful transition with well-informed providers, systems in place and Board satisfied. Good relationships with Ministry of Health. Well-informed regional networks. Clarification of national and regional tertiary services planning and funding.	**Achieved** The Planning & Funding team contributed to the national projects including sector transition. The team contributed to Primary Care development and Well Child framework development with the Ministry of Health. The Planning & Funding team also contributed to development work for the Population Based Funding Formula (funding based on number and mix of resident population) and national work streams on managing demand driven expenditure (Laboratories and Pharmacy). C&C DHB's relationship with Ministry of Health, other DHBs and DHBNZ is good. Regular forums have also been established with the Ministry of Health to discuss issues and future workstreams (to develop a 'no surprise' environment). National and regional tertiary service planning is now part of the national clinical services review framework and will occur in 2002/03.
Service Quality	
Maintain and improve as much as possible current service quality. Understand contracts, monitor performance against contracts, develop relationships with providers, and contribute to the Provider prioritisation process. **(June 30 2002)**	**Achieved** Processes have been set up to manage and monitor performance of contracts and payments relating to same contracts. Ministry of Health has established a database for contracts, which is used extensively as a tool to manage contracts. All providers are paid through Health Payment and Contract Administration (HPAC) systems, which is part of the Ministry of

	Health. All providers are expected to send monitoring reports to HPAC, who then forward these to the DHB. All monitoring reports are copied to Portfolio Managers responsible for the contract. The Portfolio Manager follows up monitoring reports, which may indicate specific contract issues. Portfolio managers have established relationships with all providers. All providers are contacted regularly (at least once per annum). The representatives of the Planning and Funding Team are part of the group, which determines priorities of the Provider arm.
Manage Risk and Look for Efficiencies	
Review demand-driven expenditure. Participate in national initiatives. Good infrastructure, information systems and relationships for monitoring and managing lower growth in demand driven expenditure. **(June 30 2002)**	**Achieved** Considerable effort has been put into data collection and analysis. This enables Planning and Funding to build service utilisation profiles with regard to expenditure of services, which are referred by General Practitioners (GPs) and to better understand cost drivers. Trends are being examined on a regular basis. Access New Zealand Health Information Service (NZHIS) national data warehouses on a regular basis to monitor demand driven utilisation of GP, Laboratory and Pharmacy services. PHARMAC produces regular reporting on pharmaceutical expenditure, which is used to supplement C&C DHB's analysis. NZHIS produces regular laboratory expenditure reporting which is supplemented by C&C DHB's analysis. Access to DHBNZ and Ministry of Health national work streams is available and C&C DHB participates where required.
Operational Style	
Develop an operational style that reinforces the above strategies. Do the basics well, funding for the benefit of the community and the patient. Be commercially astute. Open and transparent within the limits of commercial sensitivity and the Privacy Act. Learn to listen. A reputation for fairness and effectiveness in improving communities. **(June 30 2002)**	**Achieved** Advisory Committee and Board meetings are open to the public. Funding decisions are based on recommendations of the Funding Management Committee, which uses community and patient based decision-making criteria. Providers are kept informed of funding decisions for the funding proposal forwarded by them. Reputation for fairness and effectiveness is difficult to measure.

Population Health Objectives

Performance Dimension

Reducing Inequalities

Focus on high needs populations. Develop programmes for Pacific Peoples' health.
Develop programme for Maori Health improvement.
Develop plans for disease state management and integration initiatives for those diseases responsible for high levels of illness (e.g. cardiovascular disease and diabetes).
Develop relationships with other sectors and use relationships and influence to improve health environment.

Progress Report

Achieved

The District Strategic Plan confirmed reducing inequalities for Maori, Pacific and low income populations as a priority for C&C DHB. This focus was reflected in the prioritisation process where criteria for ranking funding proposals needed to show impact on reducing inequalities.
Bi-monthly meetings with Pacific providers facilitate the dissemination of information, and workshops are held on Pacific provider development issues. In addition, a Pacific action plan was started for the district, to identify and prioritise initiatives in Pacific health (through family centred assessment models, Pacific mental health).
A draft Maori Health Strategic Plan has been developed. Consultation with Maori and Maori communities will take place during the second quarter of 2002/03. The Maori Health Team has discussed the draft Maori Health Strategic plan and sought advice from the Maori Governance Group.
Disease State Management plans for Diabetes and Cardiovascular disease will be developed during the second quarter of 2002/03.
A number of inter-sectoral relationships have been established in Porirua that include:

- partner in establishment of a healthcare cluster in Porirua;
- contribution to 'Achievement Porirua' (an education initiative);
- membership of a quarterly meeting of government agencies which provide services in Porirua;
- working with the Early Childhood Development Unit which is a co-funder of the Family Start programme;
- working with Porirua Healthlinks to build connections with other agencies and community organisations in Porirua; and
- establishing a Porirua Reference Group.

Several of the initiatives implemented in diabetes are to reduce inequalities. In particular the approach taken to the service development of both the retinopathy screening and podiatry

	services are based on the principles of integration and targeting at-risk, high priority patients.
Reduce Smoking	
Work with Public Health and primary care providers to support smoking cessation programmes.	**Partially Achieved** Hutt Valley DHB is a regional provider of the public health services and smoking cessation is part of these services. C&C DHB has established a working relationship with Hutt Valley Regional Public Health to strengthen the interface between services currently funded and managed by C&C DHB. The DHBs are working together to develop service plans for the 2002/03 year in the C&C DHB district, in which smoking cessation is one of the initiatives. No work was done with primary care providers to support smoking cessation programme.
Diabetes	
Project to implement a Wellington region podiatry service.	**Achieved** A primary diabetes podiatry service began in June 2002 following an open process to select providers. In conjunction with this development C&C DHB have re-configured their existing podiatry service to provide a secondary diabetes podiatry service. A Podiatry service for diabetics is developed and funded as lower limb amputation is a major problem.
Review regional and district co-ordination of diabetes and integration infrastructure and information collection.	**Partially Achieved** A comprehensive project has been developed to reduce the impact and incidence of diabetes in the district. The review of the integration infrastructure and information collection is due to be completed by the third quarter of 2002/03.
Project to implement sub-regional fundus screening service. Service coverage to include Wairarapa, Hutt and Wellington regions.	**Achieved** A primary based retinal screening (eye examination) service has been implemented for people with diabetes in these three DHB regions. The service is managed by Wellington Independent Practitioners Association (WIPA), and is provided through contracts with private optometrists. Primary based retinal screening enables early identification of, and intervention for diabetic retinopathy.
Cardiovascular	
Implementation of elective service booking system for cardiovascular services.	**Partially Achieved** There are systems in place for managing cardiovascular referrals to hospital for both assessment and treatment. A booking system to

	ensure that all patients are assessed and treated within six months has not been achieved. The waiting list of patients waiting longer than six months for cardiovascular surgery was 103 as at June 30 2002.
Primary Care	
Accident and Medical services for Porirua. Project to be scoped, terms of reference, structure and membership to be finalised.	**Achieved** Terms of reference and scope for the project for Accident and Medical services for Porirua were initially developed during February 2002. These were updated through the Service Advisory Group in June/July using Planning & Funding's new project template. The project will recommend an option(s) for a financially and clinically viable 24/7 Accident and Medical Service at Kenepuru Hospital. This project is considering the ownership/governance arrangements and required funding for the new service. The Service Advisory Group will be making a recommendation on the four options proposed at the next meeting at the end of September. This will be considered internally and presented to the Board for their consideration and sign off.
Project for Primary Health Organisations (PHOs) scoped. Terms of reference for steering committee and reference groups are endorsed. Skills and experience requirement of membership to these groups is being developed (see also workforce development, community service (below))	**Achieved** The project for PHO was scoped and terms of reference of steering committee and reference groups were developed between January and June 2002. The skill and experience required for the steering committee and reference groups were identified. The Board has agreed a process for PHO establishment for the 2002/03 year. Consumers and providers were involved in the process for exploring the nature of PHOs for the C&C DHB region through public forums and workshops. These forums and workshops informed the Board's priorities for PHO development. The DHB has drawn up a Registration of Interest (ROI) document, which is scheduled for release in September 2002. A process has been agreed by the Board to work with parties interested in becoming PHOs with joint planning towards, at the latest, a July 1 2003 start date for service. The DHB will also help interested parties to submit proposals for establishment funding from the Ministry of Health.

Workforce	
Tender to pilot new graduate nurse project with the main focus to be on primary/community nursing. This is a joint project with the Directorate of Nursing of the Provider arm of the DHB.	**Not Achieved** C&C DHB was unsuccessful with the tender to pilot a new graduate nurse project.
Intersectoral Collaboration	
Develop relationships with local authorities. Working towards better collaboration with other government agencies	**Partially Achieved** C&C DHB has developed a relationship with Porirua City Council. Both organisations, along with Porirua Healthlinks and Ngati Toa are partners in Health Cluster. Both organisations are also jointly participating in 'Achievement Porirua', an education initiative. C&C DHB is also developing a relationship with Wellington City Council and working with them to develop a joint consultation programme for both organisations. Some contact has been established with Kapiti District Council.
Continued support for inter-sectoral initiatives like Family Start programme, the Youth Suicide Strategy, and violence prevention programmes.	**Achieved** C&C DHB has established a relationship with the Early Childhood Development Unit (ECDU), who are the funders of the Family Start programme in Porirua. C&C DHB is receiving performance monitoring information from the Ministry of Health for the Family Start Programme. C&C DHB has been involved in developing these guidelines in an inter-sectoral project. The chief responsibility for this now sits with the Provider arm and the DHB will take a keen interest in the pilot of liaison workers across five DHB sites, which the Ministry of Health is managing. Inter-sectoral relationships have been established in Porirua as a partner in the establishment of a healthcare cluster, involvement in 'Achievement Porirua' (an education initiative), and relationship with co-founder of Family Start programme.
Community Services provided by C&C DHB Hospital & Health Services	
Joint project with the Provider arm to review service from a funding perspective. The project will explore viability of the Provider arm and primary/community capacity.	**Not Achieved** The group convened by the Ministry of Health to refine and standardise service specifications at national level has done considerable work. C&C DHB is project leading this group. These projects are slow to develop due to resource and information issues.

Strategy for consultation discussed with key stakeholders and agreement reached on key processes, which are being developed.	**Not achieved** Strategy for consultation will be developed and discussed with key stakeholders after review of community services. This project, now part of the national work on review of community services, is lead by C&C DHB.
Maternity	
Managing relationship with Ministry of Health for Lead Maternity Carer contract transition. Managing LMC/Provider arm interface.	**Achieved (Ongoing)** Planning & Funding has been involved in the negotiation process for the changes to the Section 88 Notice as well as the dissolution of the non-section 88 maternity contracts. These have been completed and were initiated from July 1. Devolvement of maternity contracts from the Ministry has been delayed and it is unknown at this stage when contracts will come across to DHBs.
Investigating and identifying inter-regional flows and extra volumes falling to C&C DHB by default from other DHBs.	**Not achieved** A national project on inter-regional/inter-district flows is currently under way. Maternity volumes will be included in this analysis.
Develop Maternity strategy. Establish maternity services reference group.	**Not achieved** C&C DHB has established a maternity service advisory group, which was put on hold due to changes in staff and a lack of resource in the interim. A strategic plan for maternity services is now to be developed during 2002/03.
Mental Health	
Implementation of the Central Region Mental Health and Addiction Planning Network. Contribute to the development of a regional mental health plan that addresses mental health funding priorities for the next three years in the Central region by December 31 2001. Representation on mental health planning workgroups to provide direction and input in the areas of forensic and drug and alcohol services.	**Partially Achieved** The Central Regional Mental Health and Addictions Network (CRMHAN) has been established and its inaugural AGM was held in August 2001. A 5-year central regional mental health strategic plan was completed in July 2002. The Senior Portfolio Manager represented C&C DHB on National Forensic Planning group and Regional Reference Group. A preliminary Forensic Services Implementation Plan has been drafted by a group led by the C&C DHB Senior Portfolio Manager.
Maori Health	
Regular engagement with Maori Health Committee. Relationship and trust building with providers. Maori governance developed. Maori Development Manager appointed.	**Achieved** A Maori Development Manager (October 2001) and dedicated analyst to support Maori Health are appointed. Maori Partnership Board (MPB) is

	established (September 2001). MPB has appointed representatives on all three statutory advisory committees of the Board. The Maori Development Manager meets with Maori providers monthly to strengthen relationships, build trust and provide support.
Pacific Health	
Ongoing programme of provider development activities in leadership, management and governance development. Ethnicity reporting project to improve recording of ethnicity in hospital, primary and community based providers. Establish framework for analysis and reporting of Pacific utilisation of health services. Establish process/infrastructure to engage with Pacific communities. Research and Development project to strengthen the knowledge base of effective interventions in Pacific health.	**Partially Achieved** Planning for provider development is completed and funds for provider development is obtained. Bi-monthly meetings with Pacific providers were established to facilitate the dissemination of information. Workshops were held on provider development issues. A project to improve recording of ethnicity has been scoped and will be implemented in the 2002/03 year. An analysis of Pacific utilisation of maternity and Well Child services has been scoped. Progress is constrained by the availability of information from the Maternity Database and Well Child providers. Vai Ola is to be established and developed as a Pacific Health consortium, which will include community engagement. A Pacific Health Reference Group will be established in the 2002/03 year. A Research and Development project is to be established in the 2002/03 year to assess the evidence for family focused interventions and develop a model of care for Pacific families.
Ethnicity Data	
Improve the ethnicity recording based on issues identified by the Provider arm. Identify options to address various problems identified including awareness and education.	**Partially Achieved** An ethnicity project has been scoped for implementation in the 2002/03 year. The project identified three key objectives for Planning & Funding: • to set standards for how ethnicity data is collected in the district, which includes the census ethnicity question as the standard; • to clarify user needs for Planning & Funding in the collection and use of ethnicity information; and • to implement an education and information campaign for providers and consumers on the importance of recording ethnicity information. Within the Provider arm ethnicity collection

	rates have improved significantly. The non-compliance rate has decreased to 6% in outpatient ethnicity collection, while in-patient non-compliance rates are running at 0.3%. Tools used to achieve these improvements included education for ward staff and development of information sheets for all staff.
Waiting Times Initiative	
Work with the Provider arm of the DHB and primary care providers to further this initiative.	**Partially Achieved** An elective services project, focusing on improving access to elective services and reducing the waiting times for assessment and treatment, has been in place over the past year. The project working group has been made up of representatives from Planning and Funding as well as representatives from primary care providers and the Provider arm.
Demand Side Management	
Radiology: Extension to the community referred radiology service pilot programme in the Wellington region.	**Achieved** The community referred radiology pilot has been extended for a further year to enable free (or heavily subsidised) access to community referred radiological tests for referrals that adhere to the national referral guidelines. The contract is essentially an uncapped fee-for-service arrangement. C&C DHB has incurred a significant funding deficit (approximately $600,000) in the 2001/ 02 year maintaining this level of access. A budget bid has been submitted to the funding management committee and the Board to secure additional funding in the 2002/03 year to maintain the level of service.
GMS: Work on national projects for review of primary care funding.	**Not Achieved** C&C DHB could not contribute to the Primary Care funding review, instead resources were utilised to understand the drivers of demand in primary care and referred services.
Labs: Risk managed for this year by national risk pool. Work with national organisation and locally to develop effective demand management process and infrastructure.	**Partially Achieved** All DHBs had agreement with the Ministry of Health regarding risk pool (expenditure over budget) for 2001/02. A wash up for 2001/02 expenditure will be completed during September 2002. Work is progressing nationally by the Ministry of Health. C&C DHB worked during 2001/02 locally with DHBNZ and other DHB working groups to understand the drivers of

	demand. Demand management processes will be developed during 2002/03.
Pharmacy/Pharmaceuticals: Risk managed for this year by national risk pool. Work with national organisation and locally to develop effective demand management process and infrastructure.	**Partially Achieved** All DHBs had agreement with the Ministry of Health regarding risk pool (expenditure over budget) for 2001/02. A wash up for 2001/02 expenditure has been completed during September 2002. Work is progressing nationally by the Ministry of Health. C&C DHB worked during 2001/02 locally with DHBNZ and other DHB working groups to understand the drivers of demand. Demand management processes will be developed during 2002/03.
Integration	
Primary care project and PHO development, services for elderly and reducing inequalities in health status.	**Partially Achieved** C&C DHB has appointed a Director of Integration. Work on older people is delayed due to lack of resources and will progress during 2002/03. A process for establishing PHOs was agreed by the Board, including the work programme for Primary Care. During 2002/03 C&C DHB will develop the family centred assessment model which aims to integrate and better case manage serious high need families. This project will be targeted at Maori and Pacific families to reduce the inequalities in health status.
Well Child	
Contributing to draft strategy. Improve immunisation rate.	**Achieved** C&C DHB is working with the Ministry of Health to implement the Well Child Framework. A project plan was agreed with the Ministry of Health for doing this. Immunisation rates in C&C DHB district are better than national average. Implementation of Well Child Framework will further improve the Immunisation rates.
Health of Older People	
Project to explore potential for better integration of services and to prepare for Health of Older People Strategy and the transfer of DSS funding for services for older people.	**Not achieved** A project to explore potential for better integration of services for older people is now part of the 'models of care' development for new Regional Hospital. Capability criteria for devolution of (care for elderly) to DHBs were not clear until July 2002, hence work to develop preparedness for devolution of funding for services for older people will progress in 2002/03 year.

Oral Health	
Joint project to develop service plan for regional oral health.	**Partially Achieved** C&C DHB contributed to the draft Oral Health strategy and a joint project to develop service plan may be initiated during 2002/03.
Porirua	
a) Improving Access to Primary Care in Porirua. The purpose of the project is to allocate funding for the purposes of improving the uptake of primary care services, with particular regard to Maori, Pacific and low-income populations in Porirua. b) Co-ordinate and monitor various projects in Porirua area – A&M services, Community, Iwi and Porirua Healthlinks relationship, Regional Hospital Development, access to primary care project, implementation of primary health care strategies.	**Partially Achieved** The Improving Access to Primary Care in Porirua project established a Framework for Proposal process, and provider proposals were considered. A preferred package of services has been agreed and negotiations are in process to establish services and allocate funding. A Virtual Porirua Project was established to co-ordinate internally the activities that impact on the Porirua region. Regular reporting on progress in these projects have been established and a number of achievements have been made including: • establishment of a Service Advisory Group to examine the co-ordination of Accident and Medical Services in Porirua; • Memorandum of Understanding (MoU) with Porirua Reference Group. The Porirua Healthlinks Trust facilitated this MoU; • extensive consultation on the Business Case for the new Regional Hospital, establishment of Community Steering Committees to inform the developments in Kenepuru; and • clarifying a process to establish Primary Health Organisations.

Disability Support Services

The New Zealand Disability Strategy encapsulates a vision of a non-disabling society that will enable people who experience disability to feel their capacity to contribute and participate in every aspect of life is continually being extended and enhanced. C&C DHB considered the following actions during 2001/02 in respect to the New Zealand Disability Strategy.

Implementing the NZ Disability Strategy. Commence processes for the implementation of NZDS within the Provider arm.	**Not achieved** Joint work was carried out between the Funder and Provider arms of the DHB to identify the disability services provided within the hospital and health services, and to identify issues for people with disabilities accessing health services and how these could be enhanced. This work will continue during 2002/03.
Care for Elderly: Preparing for the devolution. Integration of care across the range of services to provide continuum of care. Capability assessment criteria will be developed in conjunction with the Ministry of Health.	**Not Achieved** Capability criteria for devolution of care for elderly to DHBs were not clear until July 2002, hence work will progress in 2002/03 year.
Build the capacity to manage disability services in future: Reviewing all contracts to ensure adequate provision for people with disability. Clarify responsibility for developing and monitoring disability support service providers.	**Not Achieved** Contracts were not reviewed to ensure adequate provision for people with Disability. Responsibility for developing and monitoring Disability Support Service providers remained with the Ministry of Health during 2001/02 and was not devolved to DHBs.
Devise effective mechanisms for monitoring all disability support services within the district. Clearly identify range of services provided within the district vis a vis those funded through our DHB, and clarify processes for monitoring and reporting.	**Not Achieved** The DHB does not currently fund Disability Support Services. Responsibility for funding and monitoring Disability Support Service providers remained with the Ministry of Health during 2001/02 and was not devolved to DHBs.
Inter-sectoral collaboration: Liasing with city councils, ACC and regional services such as transport on disability issues and putting the New Zealand Disability Strategy in effect.	**Not Achieved** Funding responsibility and resources to manage Disability Support Services are not devolved to the DHB so C&C DHB was unable to liaise with city councils and regional services on disability issues.

Public Hospital Governance and Management

Quality

Improve the quality of service delivered by conducting clinical audits, credentialling senior medical staff and provide culturally appropriate services for Maori.

Quantity:

Credentialling of senior medical staff using the accreditation standards provided by Quality Health New Zealand.
Accreditation of all health facilities at C&C DHB with a target date of October 2004.
Provide a culturally appropriate service by providing bi-cultural education programme to all service leaders, clinical leaders and team leaders and developing the action plans that address all requirements of Maori Health Quality Audit Plans.
Improve quality of service by clinical audits e.g.; medication errors, falls mortality and quality initiatives developed in each service in response to complaints. Hazard controls initiatives will be maintained.

Timeliness:

Q 1
Presentation of accreditation process to the Quality Improvement Group by Quality Health New Zealand.
Education to third tier of staff about how they will be participating in the accreditation process and further timetable developed.
25% of nominated staff from medical services complete bi-cultural education.
100% of medical services have completed audits for Mäori health quality plans.

Q 2
Policy and processes for credentialling senior medical staff developed.

Q 3
100% of medical services have completed action plans for Maori health quality plans.

Q 4
Process for credentialling senior medical staff implemented.

Achieved

Credentialling: The Credentialling committee has developed a credentialling policy and process based on standards provided by Quality Health New Zealand. The policy was approved by QIG in last quarter of the year. Credentialling of all new SMOs started in July 2002.

Accreditation: Quality Health New Zealand (QHNZ) is the preferred accreditation agency through which C&C DHB will implement a quality management framework to achieve accreditation by October 2004. The QHNZ accreditation standards include the Health and Disability Sector Safety Standards 2001. This legislation replaces Hospital Licensing.

In September 2001, the accreditation process was launched. QHNZ and C&C DHB quality facilitators educated over 300 staff. Education continued in 2002. All teams also completed Phase 1 of the project – self-assessment to the QHNZ standards – known as a 'gap analysis'. The Management Team and Board also received education in early 2002. A project timetable through to October 2004 was presented at all sessions so that staff know the needs and their responsibilities for each phase.
Self-assessment at service levels started in February 2002. Teams were formed and self – assessment to the QHNZ standards began. This phase has been well supported by the quality facilitators and was completed on August 31 2002.

Bi-cultural education: 56% of nominated staff from Medical Services have completed bi-cultural training. In total 258 staff members completed bi- cultural training (37 in Quarter 1, 93 in Quarter 2, 44 in Quarter 3 and 84 in Quarter 4).

Maori Health Quality Plans: The bi-cultural audit was completed in September 2001. Action

50% of nominated staff from medical services complete bi-cultural education.

plans have been documented and distributed to the services in February 2002 for implementation.

Hazard Control: C&C DHB has a process for assessing hazards and implementing controls. This process is documented in the Health and Safety Manual and recorded on the Incident / Accident / Hazard (IAH) database. Compliance in this area is reported to the Executive Team. C&C DHB has initiatives to improve employee safety and how significant hazards are controlled. The Safety Officer worked on hazards associated with chemicals and their controls. C&C DHB successfully met the New Zealand standard for the first time. Manual Handling training/ processes were introduced, which brought C&C DHB in line with international trends. Hazards and controls in the Laundry have also been assessed as part of Quality initiatives.

Clinical Audits: The quality of service is being improved through clinical audit activities eg Falls, Mortality Review

Falls: The overall aim of the falls project is to reduce in-patient falls at C&C DHB. The project is a part of the Health Roundtable initiative and C&C DHB is one of nine hospitals in Australasia taking part. The policy on Falls Prevention and Management is in the process of review along with the Falls Risk Assessment process. The project is continuing during 2002/03.

Mortality Review: The aim of the mortality review is to ensure that C&C DHB is regularly evaluating and improving the quality of service. Methods to identify unexpected deaths and analyse them will be developed. A no blame philosophy underpins this. The Mortality Review Group was formed and terms of reference of this group were finalised in July 2002.

Leadership:

Improve the quality of leadership, management and strengthen accountability systems for line managers.

Quantity:

Strengthen the responsibility and accountabilities within the line management structure.
Leadership development training continues in mental health.
Restructured monthly financial reporting and monitoring process. Development training and support for budget holders with clear accountabilities.

Timeliness:

Q 1
KPIs and tools developed. Appropriate information is available to appropriate level of staff. Improved processes in place for planning, budget monitoring, monthly reporting and forecasting. Programme of staff training underway. Mental health team participates in organisational training.

Q 2
Mental health service specific training continues till June 2002. Action taken to improve clinical coding processes.

Q 3
All service leaders, clinical leaders and team leaders attends training programme.

Q 4
Systems and process for financial reporting and monitoring reviewed.

Achieved

Key Performance Indicators for the services within the Medical Services have been identified and are reported upon as part of the monthly reporting process – the monthly reporting template has been updated to reflect this. These include average length of stay, occupancy, variance to budget, variance to contract target, Sick leave, FTE analysis actual to budget, work hours per patient day and Radiation Therapy waiting times.

Relevant information is made available relating to finances, contractual performance, bed days, occupancy and average length of stay, and average waiting times for outpatient services. Human Resources reports relating to sick leave and annual leave are also provided to the Service Leaders on a monthly basis.

Monthly financial and contract monitoring meetings have been formalised and are outcome focused. This has led to an increased understanding of cost pressures and issues within service and a focus on identification of corrective actions.

Fortnightly forums have been held for Service Leaders and Team Leaders. These have been used to clarify roles and responsibilities and for education/updates relating to budgeting and financial reports and responsibilities, Human Resources issues and changes in legislation ie the Employment Relations Act, Health and Safety and Quality. Service Leaders and Team Leaders are also participating in the leadership training programme that is currently being run by C&C DHB.

The Mental Health team is participating in the organisation-wide leadership training for service leaders, clinical leaders, and team leaders. The Mental Health Service conducted six courses and these courses will discontinue in 2002/03 as Mental Health Team Leaders are encouraged to participate in the organisational leadership programme.

Service Change:

Configure services to improve the way they are delivered and in a way that best meets patients needs and improves the outcome.

Quantity:

Configure models of stroke services so that they address the needs of clients through effective service delivery.
Develop mental health services for older people to address the needs of clients through effective service delivery.
Review maternity help at home and patient travel services.

Timeliness:

Q 1
Options paper for patient travel developed.
Consultation process initiated for patient travel.
Implement pilot for stroke services in Ward 2 at Newtown hospital.

Q 2
Notify supplier of change in contract for maternity help at home.

Q 3
Evaluate outcome of pilot and confirm models of care for the delivery of in-patient stroke services.

Partially Achieved

Stroke Services:
A stroke services blueprint was completed in early 2002. Targeted stroke services at Wellington Hospital were set up in September 2001. An outcome evaluation was not completed as the Model of Care for Stroke Services is now being developed in relation to the new Regional Hospital.

Review Maternity Help at Home:
Maternity help at home service exited with effect from 16 November 2001 due to change of requirement by the Ministry of Health. Providers were notified of the change. Lead Maternity Carers input was sought in replacement of help at home service.

Review Patient Travel:
The Ministry of Health provided more information about how it was proposing to manage the budget/policy for 2001/02. As the Ministry of Health provided further information, we did not review Patient Travel services and therefore the options paper and consultation process were not required.

In-Patient Psycho-Geriatric Unit:
Progress on the plans for service development is dependent on resolution of alternative site for delivery of in-patient services in advance of development of Kenepuru campus. Planning for the new Regional Hospital and Kenepuru sites and the project to review care of elderly has now overtaken the development and relocation for psycho-geriatric in-patients.

Service Change:

Development of uro-gynaecology service with advanced laparoscopic surgery with pelvic floor technique to improve quality of care and outcome for women.

Quantity: Evaluate the clinical and business case for further development of uro-gynaecology with Urology department, advanced laparoscopic surgery with pelvic floor surgical techniques. Timeliness: Q 1 Set up working party comprising service and clinical leaders of gynaecology with clinical director to look at feasibility, viability and requirements of such a service. Q 2 Financial analysis completed. If feasible then preparation of business case for presentation. Q 3 Implement training and development. Q 4 Review progress and develop implementation strategy for 2002/03.	**Achieved** C&C DHB identified clinical need within Women's Health Service for specific specialty clinics and surgery for women referred with complex pelvic floor conditions this was done within current referral volumes to improve quality of care, reduce waiting times and improve outcomes. A specialist undertook specific training between January and March 2002. A pelvic floor clinic commenced in April 2002 and works closely with on-site physiotherapists, and joint consultation can be provided as required. C&C DHB also commenced fortnightly urodynamics sessions in conjunction with a urologist to provide continuity of care for women undergoing urodynamics. This provided urologists an opportunity for joint consultation on complex cases.

Reducing Waiting Times

Reduce the waiting times and improve access for First Specialist Assessment (FSA) to meet 100% compliance with the best practice guidelines for FSA.

Quantity: Each service works to a plan to align with the Ministry of Health elective services contractual requirements and milestones. Timeliness: Q 1 GP liaison clinician appointed and role developed. Q 2 Milestones as per project plan agreed with steering group and the Ministry of Health.	**Partially Achieved** GP liaison clinician was appointed on October 1 2001. The project plan included three objectives agreed with the Ministry of Health. **Objective 1:** All services increase to 100% compliance with 'best practice' FSA processes (including supporting documentation), and meeting MoH requirements for all 'appropriately' referred patients to receive an FSA within six months. It was agreed that ENT, Gynaecology,

Q 3
Milestones as per project plan agreed with steering group and the Ministry of Health.

Q 4
Ministry compliance targets met.

Dermatology, Urology, Vascular, Neurology will be compliant by 30 June 2002 and Ophthalmology, Gastroenterology, General Surgery, Respiratory will be compliant by December 31 2002.

Performance Measure – FSA report, Manual count, reduced Did not Attend (DNA) rate.

Progress report:
The services listed are the non-compliant services, which are in 'workout' to achieve the objective.

While the MoH requires compliance with the standards set down in the plan, a robust plan has been developed to achieve the objective, and this plan is being implemented in each service with support from the Project Manager and the GP liaison manager and with oversight by the Elective Services Joint Steering Committee.

Significant progress has been made towards compliance with the objective, but 11 of the 23 services (48%) did not reach compliance at the end of year and progress is continuing.

Objective 2:
All MoH and local guidelines are developed with primary and secondary sector involvement and are appropriately implemented by June 30 2002.

Performance Measure – Referral Audit
Progress is rated satisfactory. The referral audit is in process and not yet completed. The referral audit will be complete by September 2002.

Objective 3:
All surgical services increase to 100% compliance with 'best practice' National Booking Reporting System processes (including supporting documentation), and meeting MoH requirements that all patients given certainty of treatment receive within six months, and all patients placed in Active Review are clinically reassessed at least once every six months.
It was agreed that Cardiology, ENT, Vascular, Gastroenterology, General Surgery, Orthopaedics, Paediatric Surgery will be compliant by June 30 2002 and Cardiothoracic, Gynaecology, Ophthalmology, Dental, Urology will be compliant by December 31 2002.

	Performance Measure – NBRS reports – wait list summary, progress reports Implementation of booking system process, which will support appropriate use of Active Review is progressing satisfactorily.

Efficiency

Bring all surgery in-house to reduce the cost of out-sourced services.

Quantity: Bring all surgery in-house. Timeliness: Q 1 Throughput planning and monitoring system implemented. Cardiothoracic surgical cases in Newtown hospital increased to 9 per week. Q 2 Approximately 50% of Ophthalmic surgery moved to Kenepuru hospital. Cardiothoracic surgical cases in Newtown hospital increased to 12 per week. Q 3 Cardiothoracic surgical cases in Newtown hospital increased to 13 per week. Q 4 Cardiothoracic surgical cases in Newtown hospital increased to 13 per week.	**Partially Achieved** C&C DHB has achieved the overall objective of bringing all surgery in-house in 2001/2. This required significant changes in systems, processes and attitude, and coordination of resources throughout the hospital. However, the targets set for this objective around cardiac surgery proved to be too optimistic. Issues in the first two to three months of the year affected all surgical throughput, and recovery in the next three quarters has not been 100% possible. Issues impacting have been: • winter overload of medical patients reducing surgical patient bed numbers, requiring elective surgery to be postponed; • demand on ICU requiring elective surgery to be postponed; and • the plan was affected by a complication in valuing the year's workload due to the WIES valuation system being changed for the third time in three years. The conversion from WEIS 5 to WEIS 8 caused a variance in some specialities, including cardiothoracic surgery and ophthalmology, which meant that some of our production targets, which translated case weights into estimated patient throughput, were erroneous. The standard of zero tolerance to sub contracting of elective surgery has been achieved. (In 1999/2000 and 2000/01, sub contracting is adopted as a major strategy to maintain surgical production as Wellington Hospital could not meet the demand). Throughput planning and monitoring systems were implemented in Q3 instead of Q1. The delay was mainly due to problems with being

	able to obtain reports to update production plans weekly. Outpatient services plans updated manually in services as it was difficult to obtain reports to update production plans from the system. Cardiothoracic surgical cases in Newtown hospital increased to 6.5 (against target of 9) per week in first quarter. Plans and projections were revised down for the first two quarters to take account of problems with access to ICU and a vacancy in the surgeon team. The second quarter target of approximately 50% of Ophthalmic surgery being moved to Kenepuru hospital was not achieved. Implementation date changed to align with completion of remodelling Theatre 65 and acquisition of equipment. By February 02 approx 30% of Ophthalmic surgery had moved to Kenepuru. During Q2, Cardiothoracic surgical cases in Newtown hospital increased to 6.6 (against target of 12) per week. During Q3, Cardiothoracic surgical cases in Newtown hospital increased to 7 (against target of 13) per week. During Q4, Cardiothoracic surgical cases in Newtown hospital increased to 9.5 Cardiothoracic surgical cases in Newtown hospital (against target of 13) per week.

Efficiency

Improve the staff utilisation and reduce the cost by aligning nursing staff numbers to benchmark.

Quantity: Commence the collection of operational KPIs which measure relevant work hours in each patient care area and express these as a ratio against the numbers of patients per day in that work area. Improved utilisation of nursing staff and reduction of costs by aligning to benchmarks.	**Achieved** Work Hours Per Patient Day (WHPPD) was defined as the primary Key Performance Indicator (KPI) for managing staff utilisation in the patient areas within the DHB and was implemented across the organisation in August 2001. This KPI can be viewed from an organisational perspective down to individual department levels and is based on the calculation of departmental work hours/departmental patient days.

Timeliness: Q 1 Implement templates and data capture process. Report weekly/monthly ratios. Q 2 Identify comparable hospitals for benchmarking. Set targets for team leaders to manage resources to. Q 3 Review techniques for flexing hours with a view to adopting further workplace changes as may seem appropriate.	Work has progressed to ensure a consistent approach to the development and implementation of WHPPD across the clinical services within the DHB. A tool has been developed and implemented across the organisation to capture the information and provide monthly reports on performance against targets at a service level. Further work is currently underway to develop the summary reports from an organisational perspective. Cost pressures relating to the hospital aid watches, utilisation of casual staff and orientation have been identified and strategies implemented to assist with containing these. The focus has now shifted from WHPPD to Nurse Hour Per Patient Day (NHPPD). This work has demonstrated that the NHPPD actual results are close to benchmark targets when the impact of watches is taken into account. The monitoring of actual utilisation of resources against budgeted targets over the past year (2001/02) has improved our performance in this area and assisted with identifying areas of cost pressures. The next steps will include the implementation of a patient acuity system, which will help ensure our resources are aligned to meet patient need.

Accountability Indicators

Governance Indicator

Responding to and resolving service coverage issue Narrative report (Quarterly) describing progress achieved during the quarter towards resolution of gaps in service coverage identified by the DHB or Ministry.	**Achieved** No gaps have been identified in meeting our regulatory requirements with regard to service coverage. However, we are aware of the health issues identified in the DHB's Health Needs Assessment, which subsequently have been reflected in our District Strategic Plan. The 'improving access to primary care' project is aimed at reducing barriers for those who require primary care services and who currently experience difficulty in accessing such services.
Effective Health Needs Assessment A copy of Health Needs Assessment Report. **Timing** 1st November 2001.	**Achieved** A copy of Health Needs Assessment was provided to the Ministry of Health in October 2001.

Prioritisation Summary report identifying a list of funding options including planned sources of funding developed by May 31 2002.	**Partially Achieved** The process for prioritisation including the Funding Management Committee was established during 2001/02. C&C DHB have identified a list of priorities to be funded during 2002/03 and a list of funding options will be provided to the Ministry of Health during October 2002.
Local Iwi/ Maori are engaged and participate in DHB decision making and the development of strategies and plans for Maori health gain.	**Achieved** Agreement was signed in September 2001 with the Nga Iwi Tangata Whenua to establish a governance partnership with Maori. Maori Partnership Board provides strategic advice to the Board on Maori health issues and has input into planning. Input was sought from representatives of Maori Partnership Board and their representatives on advisory committees of the Board on the development of District Strategic Plan and priorities.
A narrative report at the end of year which gives sufficient detail and/or evidence to determine the extent to which: • the DHB meets with it's Treaty Partner(s) on a regular basis in order to review and monitor planning and funding for Maori health gain; • a process is in place to ensure Iwi/Maori are engaged in Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring and Evaluation of Services. **Timing** June 30 2002	**Achieved** A narrative report was provided to the Ministry of Health on 26 July 2002. Agreement was signed in September 2001 with the Nga Iwi Tangata Whenua to establish a governance partnership with Maori. The Maori Partnership Board provides strategic advice to the Board on Maori health issues and has input into planning. Input was sought from representatives of Maori Partnership Board and their representatives on advisory committees of the Board on the development of District Strategic Plan and priorities. There have been one-on-one meetings between Chairman of the Board and Nga Iwi Tangata Whenua.
Provide a narrative report which gives sufficient detail and/or evidence to determine whether by 31 March 2002 the DHB has a human resource policy in place. The policy should provide for the recruitment, development and retention of Maori staff within the DHB.	**Not Achieved** A human resource policy for recruitment, development and retention of Maori staff within the DHB will be completed during 2002/03.
Provide a narrative report which gives sufficient details and/or evidence to determine the extent to which: • a process is in place to ensure Pacific	**Not Achieved** C&C DHB did not provide a narrative report to the Ministry of Health.

people are engaged in Health Needs Assessment, prioritisation, planning, service delivery, monitoring and evaluation of services; • progress is made towards implementation of priority areas identified in the Pacific Health and Disability Action Plan and Programmes of Action. **Timing** Annual	
Provide a narrative report which gives sufficient details and/or evidence to determine whether: • by March 31 2002 the DHB has a Human Resource Policy in place which provides for the recruitment, development and retention of Pacific staff within the DHB; • progress has been made in the development of a Pacific workforce and the capacity of Pacific providers. **Timing** Annual	**Not Achieved** A Human Resource Policy for recruitment, development and retention of Pacific staff within DHB will be completed during 2002/03.

Quality Indicators

Performance Measure

Quality Systems **Deliverable** Provide a narrative report which gives sufficient details and/or evidence to determine the extent to which: • all new and renewed service agreements are consistent with quality requirements in applicable national service frameworks; • the DHB maintains the capacity/ resources to initiate issues based audits of both its Provider arm and contracted providers as necessary; • the DHB maintains appropriate procedures for reporting adverse incidents. For Personal Health services provide a report which gives: • a summary of audit activity of the Provider arm and contracted providers, by giving a list of all audited providers and the type of audit conducted (eg, routine, issues based), and the action(s) taken to ensure progress;	**Achieved** C&C DHB provided a narrative report to the Ministry of Health providing details of audits, including list, type and corrective actions identified and progress on the same.

• a high level summary (list) of key Quality Improvement initiatives and results, focusing on those that are effective and/or ineffective. **Timing** Annual	
Mental Health Quality Measures **Deliverable** Report providing: • a summary of audit activity of the Provider arm/NGOs, by giving a list of all audited providers, and the type of audit conducted (eg, routine, issues based), and the action(s) taken to ensure progress; • a high level summary (list) of key quality improvement initiatives and results, focusing on those that are effective and/or ineffective. **Timing** Quarterly	**Achieved** C&C DHB provided quarterly reports to the Ministry of Health summarising audit activity and quality improvement initiatives and results of the same.
Comprehensive and timely data is provided to Mental Health Information National Collection (MHINC) **Deliverable** A report to MOH confirming that the Provider arm of the DHB is providing timely and comprehensive information to MHINC. Report the number of contracted providers compared with the total who are providing timely and comprehensive information to MHINC. **Timing** Quarterly	**Partially Achieved** C&C DHB provides quarterly information to MHINC. The Ministry of Health has identified issues with timeliness and comprehensiveness of data. C&C DHB is continuing to work with the Ministry of Health and hopes to resolve the issue during 2002/03.
Nationally Consistent Clinical Assessment – Elective Services **Deliverable** Provide a report: • confirming each major surgical department[2] has developed an organised programme of clinical audit (including internal and external benchmarking) to improve the quality and consistency of clinical decision making and care pathways for patients, reporting details of any exceptions; • describing progress made towards full implementation of the programme of	**Partially Achieved** C&C DHB provided a report to the Ministry of Health describing the programme of clinical audit to improve the consistency of decision making. Some services such as Anaesthesia have a well established programme of clinical audit. The majority of services have auditing established for professional external requirements and an internal auditing process is in progress and will be established by the end of 2002.

[2]As a minimum, these departments including orthopaedics, cardiology/cardiothoracic , ENT, ophthalmology, gynaecology, and general surgery.

clinical audit for each major surgical department; • confirming the level of DHB participation in collaborative, multi-party projects to support the ongoing improvement of nationally consistent referral and assessment guidelines during the period; • confirming the level of DHB support for the ongoing improvement of nationally consistent referral and assessment guidelines during the period by describing the scope of these activities. **Timing** Quarterly	

Child Health

Progress in implementing the BFHI in maternity facilities **Deliverable** Describe the activities the DHB has undertaken to ensure the Baby Friendly Hospital Initiative is implemented in its maternity facilities. Include: • progress by each unit in the DHB, in becoming accredited; • expected deadlines for remaining units to become accredited; • commentary on progress of any issues identified in any audit reports (relating to the BFHI); • quantitative analysis, including the proportion of each major ethnic group, of 'hospital born' babies in an accredited baby friendly hospital. **Timing** Annual	**Partially Achieved** C&C DHB has appointed a lactation consultant. A multi-disciplinary working party has developed a Breast Feeding Policy, which is awaiting ratification by staff. Ante-natal and post-natal education programmes are developed and implemented. C&C DHB has purchased equipment (breast pumps and breast feeding chairs). Ministry of Health has completed a pre-audit of C&C DHB facilities for accreditation purposes. C&C DHB is actioning the recommendations of the 2001 Ministry of Health audit of facilities over a 3-year project plan, which is ratified. C&C DHB has developed breast-feeding information for women and disseminated this. Associated infant feeding protocols are currently being developed (eg storage of expressed breast milk and cleaning of breast pumps etc.) No quantitative analysis available.

Diabetes

Implementation of the Diabetes Minimum Data Set **Deliverable** Ensure that the Ministry is provided with a copy of the local diabetes team annual report including aggregated data set. **Time** Annual (February 1 2002)	**Partially Achieved** The local diabetes team provided an annual report to the Ministry of Health on April 16 2002 including aggregated data set.

Primary Care

Level of progress towards implementing the Primary Health Care Strategy **Deliverable** Report on progress made towards implementing the primary health care strategy detailing the following: • the communities and providers engaged in planning and establishing PHOs including the existing primary care providers involved; • new or proposed Primary Health Organisations (PHOs) explaining the stage of development of each and; • how it is proposed that PHO providers of the new or proposed PHO will be able to influence PHO decision making; • how the new or proposed PHO proposes to ensure Maori community and consumer participation, to focus on Maori Health gain priority areas and to meet the needs of Maori who will access the services; • identifying any new or proposed Pacific Primary Health Organisations; • the percentage of general practitioners in the DHB area who belong to a new PHO; • an estimate of the percentage of general practitioners in the DHB area who will belong to a proposed PHO. **Timing** June 30 2002	**Not Achieved** C&C DHB have not provided the Ministry of Health with the report on progress made towards implementing the Primary Health Care Strategy. C&C DHB convened various forums for providers and communities for the development of Primary Health Organisations (PHOs). Forums also discussed involvement of Maori and Pacific community and consumers in the development and governance of PHOs. Consumers and providers were involved in the process for exploring the nature of PHOs for the C&C DHB through public forums and workshops. These forums and workshops informed the Board's priorities for PHO development. PHO establishment is planned for selection from December 2002 and it will begin operating as soon as possible.
Progress in developing the capacity of primary care providers to impact on suicide prevention **Deliverable** Report on promoting and encouraging the use of the specified guidelines by its contracted providers. **Timing** June 30 2002	**Partially Achieved** C&C DHB is currently establishing a process to ensure that the DHB regularly meets with providers regarding contracting, monitoring, and other issues, such as the use of Ministry of Health guidelines (eg detection and management of suicide). C&C DHB will schedule provider meetings for 2002/03, with the DHB following up on the use of such guidelines.
Number of contracted providers of general practice services with an agreed Maori Health plan. **Deliverable** Number of contracted providers of general practice services with a Maori Health plan that has been agreed with the funder. **Timing** Annual	**Achieved** 2 (out of 4) providers of general practice services have completed Maori Health plans, which are agreed by C&C DHB. C&C DHB is continuing to work closely with the other 2 providers.

Maori Mental Health

Progress towards improving Maori Mental Health

Deliverable

Provide a narrative report which gives sufficient detail and/or evidence to determine the extent to which:

- a process is in place to ensure iwi/Maori are engaged in planning, design and purchase of mental health services for Maori;
- a programme is in place to review service delivery for Maori by DHB and community providers.

Timing

June 30 2002

Achieved

C&C DHB have provided the Ministry of Health with the report on progress made towards improving Maori Mental Health.

A local advisory group (LAG) has been formed to provide advice to C&C DHB on planning and funding of mental health services in the district. The advisory group includes Maori representation.

The Central Regional Mental Health and Addiction Network (CRMHAN) also has Maori representation. The CRMHAN is the key vehicle for achieving a collaborative approach to planning and funding within a regional context. The initiatives currently being discussed and developed through the network include:

- implementing the Maori Mental Health Plan (Te Puawaitanga) throughout central region services and aligning all initiatives to the plan;
- investigating establishment of a regional Maori expert group;
- supporting the development and implementation of Maori specific outcome measures;
- improving collaboration between Central region Maori health providers;
- developing collaborative relationships with external organisations e.g. Te Puni Kokiri, Massey University, Wellington School of Medicine and Health Sciences; and
- working with Mäori providers to ensure they receive adequate clinical supervision, peer support, training, access to evidence based guidelines and assistance in developing quality assurance and information systems.

Elective Services

Level of publicly funded service delivered is sufficient to ensure access to elective surgery for all patients before they reach a state of unreasonable distress, ill health or incapacity.

Deliverable

Provide a report:

- confirming that for any surgical services 100% of people in active review have

Not Achieved

Active review processes are being developed in specialties with compliance in 4 specialties anticipated.

Actual percentage not available.

received a clinical review of their eligibility for publicly funded treatment at least every six months. Report details of 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 of any exceptions. **Timing** Exceptions only	
100% of patients do not wait longer than six months for first specialist assessment. Target is zero people waiting outside best practice times at June 30 2002. <u>Proposed Target</u> Dermatology June 30 2002 ENT June 30 2002 Gastroenterology December 31 2002 General Surgery December 31 2002 Gynaecology June 30 2002 Neurology June 30 2002 Ophthalmology December 31 2002 Respiratory December 31 2002 Urology June 30 2002 Vascular June 30 2002	**Partially Achieved** For the following identified services, performance to target is currently being planned for, through the elective services project: **Progress** Dermatology (not achieved) ENT (not achieved) Gastroenterology (on target) General Surgery (on target) Gynaecology (not achieved) Neurology (achieved) Ophthalmology (on target) Respiratory (on target) Urology (not achieved) Vascular (not achieved)
100% of patients who have been offered publicly funded treatment do not wait longer than six months. Target is zero people waiting outside best practice times at June 30 2002.	**Not achieved** Booking system processes are being reviewed to achieve compliance by December 31 2002.

Nursing Practice and Development

Nursing Practice and Development **Deliverable** In respect to the Provider arms of the DHB describe the following: • how input is received from nurses[3] into decision-making; • how nursing involvement in quality and risk management decision-making is facilitated; • the lines of accountability for nurses in relation to the Director of Nursing and to Chief Executive;	**Achieved** C&C DHB provided a quarterly report to the Ministry of Health for nursing practice and development within the Provider arm of the DHB. Input from Director of Nursing and Midwifery (DONM) to the General Manager, Hospital & Health Services, Clinical Directors, and Business Managers occurs weekly and to the CEO as requested. Input from nurses and midwives to the DONM occur through regular meetings, nursing and midwifery summits.

[3] For Capital & Coast DHB nursing also assumes inclusion of Midwifery

• acuity systems and how nursing workload and staffing levels are benchmarked; • strategies in place to deal with both high and low staff turnover, recruitment, on-going training, performance management and staff retention; • measurable and auditable indicators that are in place to demonstrate achievement or remedy any nursing issues; • measures in place to support nurses in their first year of practice to ensure their development into more experienced and expert practitioners. **Timing** Quarterly	There is active involvement of nurses and midwives within the Clinical Groups through Quality Facilitators, Clinical Directors and DONM representation at Quality Improvement Group. The DONM reports to the General Manager, Hospital & Health Services (HHS). There is no direct reporting to the CEO. Nurses and midwives are professionally accountable to DONM. C&C DHB Provider arm is benchmarked with Christchurch and Waikato on nursing and midwifery workload. A draft nursing and midwifery strategic plan is being implemented by the DONM. Work Hours Per Patient Day (WHPPD) data is currently being analysed to reflect Nursing/ Midwifery Hours Per Patient Day (NHPPD). This and other data is used by Business Managers to establish target staffing and 2002/ 03 budgets. WHPPD does not reflect nursing intensity or patient acuity. The following measures are in place to support nurses in their first year of practice: 9 month new graduate programme – one study day per month within a structured programme. Preceptors in each area who work with the new graduate for the first 4 to 8 weeks along with access to clinical nurse/midwife specialists and educators. Performance reviews at 3 and 12 months (variably done). In addition to this there are specific orientation packages and education programmes.

Performance to Plan

Financial performance **Deliverable** Actual financial performance compared to the approved District Annual Plan. **Timely** Monthly	**Achieved** C&C DHB provided monthly reports of actual financial performance compared to the approved District Annual Plan to the Ministry of Health.

Service provided by Maori providers **Deliverable** The percentage of the DHB's total expenditure on services provided by Maori providers compared to the percentage of the DHB's total expenditure on services provided by Maori providers at July 1 2001. **Timing** Quarterly	**Not Achieved** While C&C DHB could calculate expenditure percentage of 'by Maori for Maori providers', to calculate the total DHB expenditure for Maori is inappropriate as accurate data is not collected consistently by all providers to enable accurate calculation. Expenditure 'by Maori for Maori providers' for 2001/2002 is 0.80% of total expenditure (includes health benefits and the Provider arm expenditure). Quarterly data does not vary significantly.

Service Based Measures (Quantitative)

Service	Timing	Actual	Target
Child Health			
Children fully vaccinated on their 2nd birthday	March 31 2002	Unable to measure	75%
Percentage of children passing school entry hearing screening test	Annual	Unable to measure	95.6%[4]
Repeat admission for asthma in children under 5	6 monthly and Annual	9.3	4.7[5]
Repeat admission for asthma in children under 5 to 14	6 monthly and Annual	7.2	8.2[6]
Percentage of babies born in public hospital with low birth weight	6 monthly and Annual	6.67	5.6[7]
Full breastfeeding rate at 6 weeks	Annual	76.57	73.7[8]
Full breastfeeding rate at 3 months	Annual	56.85	55.4[9]
Diabetes			
Diabetes case detection rate	December 31 2002	42%	70%
Diabetes case management rate	December 31 2002	34%	28%
Retinal screening for people with diabetes in the last two years	December 31 2002	74%	85%
Oral Health			
Mean MF Score at Form 2 (Year 8)	31 March 02	Unable to measure	1.1[10]
Percentage of children caries free at age 5	31 March 02	Unable to measure	66.2[11]
Cardiovascular			
Number of people with certainty who have been waiting for more than 6 months for a coronary artery bypass graft	6 Monthly and Annual	60	0
Number of people with certainty who have been waiting for more than 6 months for an angioplasty	6 Monthly and Annual	0	0
Repeat admissions for acute rheumatic fever in people under 30	Annual	0	0 (Within National Confidence Level)
Cancer			
Waiting times for radiotherapy	Quarterly	Less than 4 weeks (46 People) 4 –6 weeks (5 People) > 6 weeks (13 People)	Ministry of Health Target is to have zero people waiting outside best practice times at June 30 2002

[4] Target for ethnic groups are: 89.4 – Maori; 91.9 – Pacific Peoples; and 97.2 - Other
[5] Within 90% confidence interval level for all ethnicity groups.
[6] Within 90% confidence interval level for all ethnicity groups.
[7] Target for various ethnic groups are: 5.3 for Maori, 2.2 for Pacific Peoples, and 6.2 for others.
[8] Target for various ethnic groups are: 63.4 - Maori; 63.7 - Pacific Peoples; and 76.8 - other
[9] Target for various ethnic groups are: 40.8 - Maori; 45.9 - Pacific Peoples; and 58.8 - other
[10] Target for various ethnic groups are:1.2 for Maori, 1.4 for Pacific Peoples, and 1 for Other.
[11] Target for ethnic groups are: 48.5 – Maori; 41.9 – Pacific Peoples; and 74.0 - Other

Performance Measurement: Balanced Scorecard

The Balanced Scorecard concept is founded on the ownership interest of an organisation. The measurement framework can be used effectively to focus on the overall health of the Provider arm of the DHB. This framework is not an appropriate tool to measure funder outcomes in terms of health gain. The Ministry of Health has developed this performance measurement tool for all publicly owned hospitals in New Zealand. The measures are grouped under four broad categories, which are: patient and quality (measures safety and quality of service and satisfaction with the service); organisational health and learning (measures workplace safety and staff stability); process and efficiency (measures efficiency of the organisation and ability to improve processes); and financial performance of the organisation.

Balance Score Card Measures	Actual				Target			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient & Quality								
Patients' overall satisfaction (Good and Very Good)	83%	86%	83%	84%	55%	55%	55%	55%
Hospital acquired blood stream infections	0.94%	0.75%	0.98%	1.2%	4.47	4.47	4.47	4.47
Emergency triage times (Category 1)	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of complaints resolved/closed	74.2%	71.8%	57.5%	62%	64%	68%	72%	77%
Organisational Health & Learning								
Staff turnover (Voluntary)	4.6%	7.4%	5.3%	5.2%	5%	5%	5.8%	5.2%
Staff stability rate	97.6%	95.2%	97.5%	96.9%	97.5%	97.5%	97%	97%
Sick leave rate	3.9%	3.0%	2.5%	4.6%	3.3%	3%	2.7%	3%
Workplace injuries	7	2	2	3	12	9	6	12
Process & Efficiency								
Resource utilisation ratio	0.88	0.91	0.87	0.86	1.0	1.0	1.0	1.0
Performance to contract (% variance to contract volumes)	98%	97.8%	97.4%	97.5%	100%	100%	100%	100%
Inpatient ALOS x Patient admission rate[12]	3.47	3.24	3.22	3.06	3.46	3.7	3.6	3.5
Percentage eligible elective day case surgery	68.3	62.3	61	64.2	69.6	72	72	72
Financial								
Return on net funds employed [Return on equity (YTD)]	0.8%	-0.8%	1.4%	0.1%	0.02%	0.06%	0.13%	0.13%
Operating margins to revenue	1.8%	-1.8%	3.1%	0.1%	1.0%	0.0%	(2.0)%	0.0%
Revenue to net funds employed	0.4	0.4	0.5	0.4	0.0%	0.0%	(1.0%)	0.0%
Debt to debt plus equity ratio	0.7	0.7	0.7	0.6	0.6	0.6	0.6	0.6

[12] This excludes Mental Health, DSS and well babies

Report Of The Auditor-General

To The Readers Of The Financial Statements Of Capital & Coast District Health Board For The Year Ended 30 June 2002

We have audited the financial statements on pages 14 to 67. 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 2002. This information is stated in accordance with the accounting policies set out on pages 14 to 16.

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 2002, 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 C R Fabling, 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.

We have performed an assurance related assignment for Capital & Coast District Health Board. Other than this assignment and 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 67:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:
  - Capital & Coast District Health Board's financial position as at 30 June 2002;
  - 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 24 October 2002 and our unqualified opinion is expressed as at that date.

C R Fabling
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Hospital and Health Services

The provider arm of Capital & Coast DHB is known as Capital Coast Health. It is the leading provider of specialist health, disability support and mental health services, inpatient and community delivered, 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 $173.5 million, Capital Coast Health is a major employer in the 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 and secondary (mainstream 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.

The Hospitals

Wellington Hospital

Wellington Hospital is the largest facility operated by Capital Coast Health. It provides a comprehensive range of specialist services.

Wellington Hospital is also the region's main emergency 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 medical students of the University of Otago's Wellington School of Medicine and Health Sciences and for the Malaghan Institute (medical research), both of which are situated on the same campus as the hospital. Post-graduate training for doctors and other clinical professionals is conducted by the Medical School in such areas as surgery, anaesthetics, paediatrics and radiotherapy. Capital Coast Health also has relationships with other tertiary institutions, particularly in nursing training.

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.

Paraparaumu Hospital

This small community hospital provides maternity services and outpatient treatment clinics for the people of Kapiti. Multi-disciplinary assessment and treatment programmes for the community's elderly are also based at the hospital.

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, adult, family 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 Gotleib (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.

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE		
John Cody (Chair)	**External Members**	
Judith Aitken	Stephen Palmer	Hutt Valley DHB (Public Health)
Karl Geiringer	Kiri Parata	Kapiti Healthlinks
Helmut Modlik	Margaret Southwick	Vaiola Trust Board
Tino Pereira	Herani Demuth	Maori Partnership Board
DISABILITY SUPPORT ADVISORY COMMITTEE		
Helene Ritchie (Chair)	**External Members**	
Karl Geiringer	Valerie Bos	
Ruth Gotlieb	David Heather	
Chris Turver	Lautapu Ioane-Cleverly	Vaiola Trust Board
	Grace Moulton	
	Wendi Wicks	
	Liz Mellish	Maori Partnership Board
HOSPITAL ADVISORY COMMITTEE		
Ian Shearer (Chair)	**External Members**	
John Cody	Marion Bruce	Kapiti Healthlinks
Ruth Gotlieb	Lilian Falealuga	Vaiola Trust Board
Tino Pereira	Don Mackie	Hutt Valley DHB (Emergency Dept)
Helene Ritchie	Peetikuia Wainui	Maori Partnership Board (from 2 April 02)
FINANCE AND AUDIT COMMITTEE		
Judith Aitken (Chair)		
Margaret Faulkner		
Helmut Modlik		
Ian Shearer		
REGIONAL HOSPITAL COMMITTEE		
Bob Henare (Chair)		
Chris Turver		
MAORI PARTNERSHIP		
Helmut Modlik (Chair)		
Bob Henare		
HUMAN RELATIONS		
Margaret Faulkner (Chair plus as co-opted from time to time)		

NB: Board Chair and Deputy Chair *ex officio* on all committees