Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

CAPITAL & COAST DISTRICT HEALTH BOARD'S
Annual Report
2004/05

Together, Improve the Health and Independence of the People of the District

Our Mission

Together, improve the health and independence of the people of the district

Our vision:

Better health and independence for people, families, and communities.

Our values:

- Innovation.
- Action.
- A focus on people and patients.
- Living the Treaty.
- Professionalism (leadership, honesty, integrity and collaboration).
- Excellence (effectiveness and efficiency).

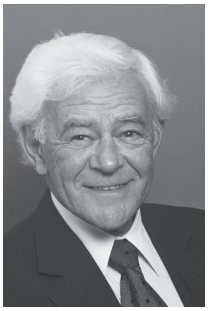
Our health goals:

- Reducing disparity (reducing differences in the health of people across the district).
- Reducing the incidence and impact of chronic disease (reducing the amount of ongoing illness and the impact it has on peoples' lives).

Our strategies to achieve these goals:

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

Chairman's Foreword



2004/05 was a year of considerable progress for Capital & Coast District Health Board. It was a year in which we built on our understanding of the diverse range of health needs in this district, built stronger relationships with the community, and built new facilities to provide new models of health care.

Since the introduction of the DHB model we have been learning how to work with the range of health services in our district so that we are more able to meet the real health needs of the population we serve. Over the past two years we have set up some of the structures that will strengthen services in the community, such as Primary Health Organisations. We have also established strong relationships with the other agencies that serve the health needs of this population. Our focus now is on improving the way that health care and disability support services are provided.

Working with the public is key to this improvement, and in 2004/05 we carried out four major public consultation processes – on After Hours Services, on a new integrated approach to providing care in the home and other community settings, on our draft mental health service plan (The Journey Forward), and on our District Strategic Plan. Each of these consultations has been a valuable learning exercise, which helped reshape our initial plans to develop the different services required.

Some of the key highlights of working with the community in 2004/05 have been:

- Completing our new Health Needs Assessment, which gives a more up-to-date picture of health needs across the district. The Assessment identifies the key health needs of the population we serve, and also highlights where the need is greatest. This up-to-date assessment will help us to arrange our services that will address the key health needs of the district.
- Establishing a sixth Primary Health Organisation (Karori PHO) which will work alongside existing PHOs to help to improve health and reduce disparities.
- The launch in 2005 of 'The Journey Forward', a review of mental health services in the district that will lead to a strategic plan for these services over the next five years. The project has involved extensive public consultation and working closely with providers, the community and client groups.
- The Meningococcal B vaccination programme which was rolled out in our district in 2005. The programme has achieved a high profile and encouraging levels of uptake by children and young people.
- Establishing new Maori primary care services in Wellington. This means we now have Maori primary care services contracted in Kapiti, Porirua and Wellington.

Significant changes have also been taking place in the Hospital & Health Services that we provide:

- Our hospitals and health services are now fully accredited by Quality Health New Zealand and certified by the Ministry of Health. This shows that we are providing quality services to the people of the district.
- Wellington Hospital has become the first Baby Friendly Tertiary Hospital in New Zealand. All three of our maternity hospitals now have this status, which was established by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF).
- Two new facilities at Wellington Hospital have been completed. The Wellington Blood & Cancer Centre and the new Short Stay Unit were opened in September 2005.
- The new Accident & Medical Clinic, Child Health area and front entrance were completed at Kenepuru Community Hospital and opened in August 2005.
- Haumietiketike, a national secure unit for intellectually disabled persons requiring specialist treatment, opened on our Porirua campus in October 2004.
- The Maori Health Development Group provided bi-cultural training for staff and completed the first phase of whanau care services for Maori in-patients in Wellington Hospital.
- We replaced the Linear Accelerator at Wellington Hospital. This major purchase of new equipment will mean we can provide more effective and efficient radiation therapy treatment for patients.
- We have reduced our Did Not Attend appointment rates to under 10% by setting up a central contact centre for outpatient and ambulatory services. As a result these services will be more efficient and able to increase the amount of doctors' appointments available for patients.

I'd like to thank my Board, the Chief Executive and her staff for all their hard work this year, and for their continued commitment to improving the health and wellbeing of the people who live in our district.

Bob Henare
Chairman

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Foreword

The 2004/05 financial year builds on substantial progress already made by Capital & Coast DHB over recent years.

In this foreword we highlight the achievements we have made in the areas we have identified as priorities for this DHB. Good progress has been made across the DHB and our Board and our staff are strongly committed to ensuring we provide the best array of health and disability services for the people of this district.

In July 2004, we set out to achieve six things:

1. Reducing disparities
2. Achieving integrated care
3. Sustaining financial performance
4. Improving quality
5. Progressing new regional hospital
6. Workforce

In June 2005, we can report that we have made substantial progress against each of these priorities.

1. Reducing Disparities

We have built effective relationships with communities and other organisations by:

- C&C DHB and Regional Public Health have formed a joint Youth Health Advisory Group to ensure a continued focus on youth, and enable the DHB to better meet the needs of youth.
- Additional funding has been provided for Kapiti Youth Support (KYS) to extend its services to meet increased demand from youth. KYS has reported an increase in new clients and utilisation of services.
- The Porirua Health Information and Communication System was launched along with a 24 hour free-phone number as part of the Porirua Improving Access project.
- Several groups received funding to help extend the 'reach' of health services and improve health outcomes.
- Three Outreach Immunisation Services have been funded in Porirua. All three services are working with providers and immunisation coordinators to improve coverage in Porirua.
- C&C DHB is supporting the development of links between primary care and whanau with diabetes in Wellington South to ensure optimisation of service provision.
- In conjunction with Wellington City Council, we funded a recreational outreach programme targeting high need whanau/youth in Wellington and Wellington South.

1.1 Maori Health

We gave priorities to children, whanau and diabetes treatment. We have made substantial progress in each of these:

Integrated Well Child/Primary Care/Whanau Ora

- There has been an improvement in breastfeeding rates compared to national rates and against previous rates in our DHB. This improvement may reflect initiatives such as the Baby Friendly Hospitals initiative and offering more concentrated support in the district for Maori, Pacific and low income women.
- In line with whanau models of care, the whanau ora approach has been built in to Maori-specific contracts for diabetes education and management in Kapiti, Porirua and Wellington.
- Two new Maori primary care services were established in Wellington. Hora Te Pai PHO in Kapiti continues to develop and grow its services. Maori primary care services are now contracted in all three districts.
- The Porirua-based heart failure project has contributed to a reduction in hospitalisation across three disease categories – ischemic heart disease,

acute myocardial infarction and stroke. The medication management programmes through PHOs will also have helped reduce hospitalisation.

Whanau Care Services

- The Whanau Care Services approach targets high user, high risk and high need. This strengths-based approach that provides support, care and advocacy and places whanau at the centre of care, from entry through to their exit from the hospital.
- Increased staff numbers and an improved skill base have supported developments in this service.

Diabetes treatment for Maori

- GP services have been developed and Kaupapa Maori Diabetes education and management services have been established within Maori providers in Kapiti and Wellington.
- A community worker supporting peer-led chronic care management with Maori and their whanau living with diabetes in Wellington south, has been very successful. The group is using information from the UK 'expert patient' website and adapting it for their context.

1.2 Pacific Health

We set out to provide a better framework for the health of Pacific youth and established strong relationships with pacific community. We also encourage a focus on each of the different Pacific Island community.

Youth fono

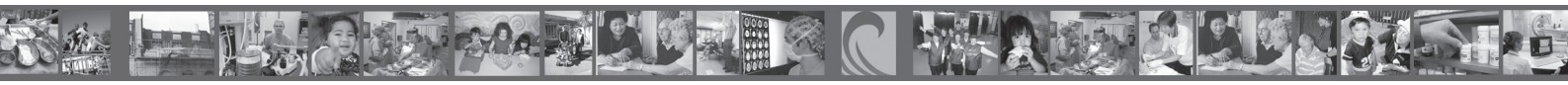
- We held a Pacific youth fono during the year and about 200 youth attended this event and discussed issues regarding health, workforce, barriers and what our DHB can do to better meet the needs of Pacific youth.
- The outcome from the fono was a draft report that was launched at a 'Crossing oceans - Chasing dreams' concert, which was attended by over 1,000 Pacific youth and their families attended the concert. The draft report has been distributed widely for feedback and the final report was produced in March 2005.
- Our DHB approved funding for a Pacific youth comedy project with Regional Public Health. The secondary school based programme, delivered by Samoan comedians, focuses on health promotion around nutrition/physical activity, injury prevention, mental health, sexual health, oral health, alcohol, drugs and tobacco.

Memorandum of Understanding with Tokelau

- C&C DHB received its first patients under the Memorandum of Understanding with Tokelau. When the Tokelauan Premier visited Wellington he commented that his government was very pleased with how the Memorandum of Understanding is operating.

Church-based exercise project

- C&C DHB supported a church-based cardiovascular pilot programme in Porirua for Pacific men aged over 35 years. The programme provided exercise and nutrition classes and cardiovascular screening for both males and females. Those identified as being at risk of cardiovascular disease were referred to PHOs involved in the 'One Heart Many Lives' early intervention project.



Ethnic specific health days

- We have supported and funded ethnic specific community health days for each of the Pacific Community groups. Each community held workshops for health promotion, health education and health checks. Funding has been provided for continuation of these community initiatives. We have funded three ethnic-specific elderly groups to continue their weekly exercise classes. These groups have been linked up with student trainees from the New Zealand Institute of Sport.

Pacific support service improved access to secondary and tertiary service

- The Pacific Support Service (PSS) continues to provide culturally appropriate services to Pacific people and their families.

1.3 Primary Health Care

PHOs

Our six PHOs serve more than 90% of the population of this district. All PHOs have developed health improvement plans for their enrolled population and have also developed Maori Health Plan.

- All six PHOs submitted proposals to the Ministry of Health to provide primary mental health services, and five of these were successful. These primary mental health contracts are designed to give care and support to people experiencing mild to moderate mental illness. A stocktake of local primary mental health initiatives has been completed. Three have been in an establishment phase from 1 April to 30 June 2005 and have subsequently begun service delivery. The other two PHOs have begun establishment and delivery.
- Care Plus PHOs provide a free first assessment and six month follow-up visits for eligible patients, and reduced charge for another two visits (includes nurse/GP etc).and was implemented in all six PHOs.
- Access to primary care has been improved through additional funding for PHOs under Care Plus and over 65s initiatives, and through lower part charges for pharmaceuticals.

Immunisation

Meningococcal B Vaccination programme (MeNZB™)

- The vaccination programme for Meningococcal B for the C&C DHB district started on 9 May 2005. All children and youth aged six weeks to 19 years are being offered three doses of the vaccine (MeNZB™). Vaccinations with MeNZB™ are expected to be largely completed by the end of 2005.
- The aim is achieve 90% coverage in the priority group of young people under 20. Early results are encouraging, particularly the achievement of high coverage for Dose One in several PHOs in the children aged 6 weeks - 1 year.

National Immunisation Register (NIR)

- The project to establish a National Immunisation Register (NIR) has been under development for several years and went live in May 2005. An important reason for the development of the NIR has been the absence of accurate, nationally consistent and readily available immunisation information data. This has impacted on the ability of primary care and public health to deliver optimal immunisation services and achieve national immunisation targets. NIR now records the immunisation details of all children and youth who were vaccinated against Meningococcal B.

Outreach Immunisation in Porirua

- Three Outreach Immunisation Services have been funded in Porirua. All three services are working with providers and immunisation coordinators to improve coverage in Porirua.

Community Clinical Dietician, Wellington

- This initiative arose from the planning process undertaken with the Local Diabetes Team, including a large hui of all stakeholders (clinicians, consumer groups and our DHB) in 2003/04.
- A priority for 2004/05 was increased access to community-based dietetics for people with diabetes. One FTE clinical dietician was funded and is currently being shared by two part time dieticians. Given the demand, it was decided (with input from hospital and RPH dieticians) to limit the scope to one area of the District. Wellington South was identified as an area with high unmet need, and the clinical dietician position was placed with Regional Public Health in Cuba Street to provide an outreach service. The position within RPH ensures collegial support from public health dieticians and good links across PHOs, other providers, and the hospital-based dietetic team.

2. Sustaining Financial Performance

The Board and all the staff has worked very hard to remain within the financial limit set by the Government. There has been a vigorous internal audit programme and managers and staff have also responded very positively to recommendations for improvement to efficiency and effectiveness of our spending priorities. Financial out-turn is well within acceptable range (and our expectations) considering the much demanding year.

3. Improving Quality

Central focus of organisation providing human services is quality. The Board has initiated and approved wide range of development aimed to ensure that individual and families receive high quality services. In addition, we have worked to improve quality of our own system and organisation such as hospital, where people receive care.

3.1 Accreditation and credentialling

- Our DHB is now accredited with Quality Health New Zealand.
- In addition, a number of Hospital and Health Services have achieved more specific specialist or industry standards in their area. These include radiology, medical surgical services, women's health services, laboratory services, child health services.
- Wellington Women's Hospital, Kenepuru maternity Unit and Paraparaumu maternity Unit have all earned accreditation as Baby Friendly Hospitals. Baby Friendly Hospitals are a worldwide initiative launched by the World Health Organization and UNICEF that recognise hospitals which support and promote exclusive breast feeding from birth.
- Medical staff working in a range of services achieved their professional credentials. Those who achieved credentials include Senior Medical Officers working in radiology, medical surgical services, and the women's health service.
- The Hospital Pharmacy developed new computer software to monitor the medicines prescribed against those in-stock, developed a safety programme, and also became a lead pharmacy in the use of information systems for other hospitals in New Zealand

3.2 Practices and procedures to improve quality

- A survey of nurses working in the community has been carried out by Nursing and Midwifery Services to improve communication and determine the nurses professional needs. The Service has also completed a project that will improve the way nurses give medication, and completed a survey to assess safety in this area.
- A consumer reference group has been set up to advise staff of the Capital Support Service.
- Clinical Support Services have changed their focus to provide more acute services and specialised community nursing, with a move to offering more ambulatory care in community. The Service has developed new models of care which have been trialled and introduced, and has also placed all of their policies on intranet for easy access to staff.
- Women's Health now monitor and report on adverse outcomes.
- New Therapeutic Guidelines have been introduced in clinical areas providing medical staff with an information package for point of care use.
- Child Health staff have developed a successful process to manage the NICU Gentamicin Resistant Staphylococcus Aureus (GRSA) Infection. Child Health staff have carried out an audit of the Health Specialty code for babies in NICU, found and corrected errors and developed a new process in this area.

4. Progressing the New Regional Hospital

Development of hospital services at three separate locations in the District – Kapiti, Kenepuru, and Wellington city while also continuing to provide safe and professional community, secondary and tertiary services have been considerable demand. The construction market has been challenging. The Board are pleased with the successful way in which managers and project staff (coordinators) have dealt with scare resources of time, people and money. Kapiti is complete, Kenepuru nearly complete and Wellington well within our planning framework.

4.1 Kenepuru Community Hospital

Accident & Medical Clinic

- The Kenepuru Accident and Medical Clinic commenced building during 2004/05, ready for opening on 25 July 2005. It will be open 24 hours a day, seven days a week, with a doctor and nurse on duty at all times. The previous emergency clinic at Kenepuru had only been open during business hours on weekdays.
- The new clinic improves coordination between health services in both the hospital and the community and will reduce costs to patients for after-hours medical attention. This is a major achievement for C&C DHB and for the PHOs involved in the development of this service.
- New services such as observation beds are available at the A&M, as well as the full range of services provided by the previous emergency clinic – blood tests, x-rays and plastering. Hospital level services remain free of charge and after hour GP services are less costly than current after hours services in and around Porirua.

4.2 Newtown Hospital

Short Stay Unit

- A new short stay unit has been opened in the Emergency Department to care for people needing monitoring and treatment that will not require them to stay in the hospital for more than 24 hours.

Wellington Blood and Cancer Centre

- This new Centre was completed and opened in September 2005.

Child Health

- An extensive review of the Neonatal Intensive Care Unit (NICU) was carried out by the unit. The review was used to plan the move to the New Regional Hospital and to introduce a new model of care. The review covered patient and family, staffing, training, functions and service delivery, equipment and technology and space. The review resulted in an upgrade of the NICU facilities and redesign of the space.

5. Achieving Integrated Care

The Board aimed to ensure that every person who requires healthcare at every level from their own home to a hospital and back to the community experiences the integrated seamless process. During 2004/05 the following steps towards that goal were taken.

5.1 Integrated Home & Community Care

- A new Care Coordination Centre (CCC) is being developed, for launch in September 2005. The CCC receives and screens referrals, provides assessment and care planning for clients, and coordinates home and community services. A key feature of the CCC is being a single point of entry for all home services, to make it easier to pull together packages of care based on need. The service is operated by Nurse Maude Association and is located in Porirua.
- New positions called Care Managers were introduced in March 2005. Care Managers are able to discuss with clients and family/whanau carers their goals, needs and risks, and develop a plan of care based on a holistic assessment of the client. Targeted recruitment (including Maori and Pacific) is underway to ensure the service has this cultural competency.
- We are developing one assessment process for every patient, based on the InterRAI suite of evidence -based assessment tools.
- Care Managers, working with the CCC, will develop care packages for each patient. The packages will be based on the goals, needs and risks of clients and their caregivers/family/whanau and will cover a range of clinical, supportive and rehabilitation services. They will be delivered to people in their homes or in their community and are designed to increase pro-active intervention to prevent or delay deterioration which results in increasing levels of care, acute admissions and premature or inappropriate residential care admissions. These home and community care packages focus on flexible, responsive, integrated service delivery to people who need care and support with a restorative focus, both short term or long term, in order to be able remain living in their own home and participate in their community.
- Collectively the new services identified above are expected to greatly improve coordination of care for adults over 16 years of age with chronic illnesses, older people (including people in the 50-64 age group with early onset of age-related conditions) and other people with a short-term need for home based care.
- We are developing specialist multi-disciplinary services for older people and people who have had a stroke.

5.2 Mental Health

As with every New Zealand community growth in demand for mental health services at every level from the private homes in a community and in the hospital and has grown and has become more complex. During 2004/05, the Board stepped back, reviewed all existing services and launched a new five year plan to provide good services for all who need them.

The Journey Forward

- We commenced a review of mental health and addiction services and the development of a five year action plan – The Journey Forward. Terms of reference and the governance structure for The Journey Forward have been completed and agreed. The background document for The Journey Forward has been completed and reviewed by both the Local Advisory Group and the Steering Group. Public consultation was launched to gain insight from community agencies and individuals which will help shape the draft document. The mental health system will be developed to allow integrated service delivery involving leadership from DHB, primary care and community agencies. Consumers will benefit from a more flexible, responsive and recovery focussed service system.

5.3 Child & Youth

Youth Health Advisory Group

- C&C DHB and Regional Public Health (RPH) have formed a joint Youth Health Advisory Group to ensure a continued focus on youth. This will enable the DHB to better meet the needs of youth in future initiatives. The group is made up of representatives from various Wellington and Kapiti Coast youth organisations, and other individuals with an interest in health.

Skin Project

- C&C DHB & Hutt Valley DHB, in conjunction with Regional Public Health, are reducing the number of children admitted to hospital with serious skin infections.
- The 'Clean, Cut and Cover' project initially targeted 13 schools across the region. School public nurses are working closely with the school community to promote this project. The project emphasises cleanliness and preventing infection and schools are improving their bathrooms and providing paper towels.
- This work has prompted the wider health sector to prepare best practice guidelines for the prevention and treatment of skin infections.

5.4 Palliative Care

- We have employed a palliative physician to the Hospital and Health Service to improve care of patients in medical and surgical settings.
- The chronically medically ill (CMI) programme has been reviewed and improvements made to access criteria and assessment processes to better reflect our District Strategic Plan priorities.

6. Workforce

The health sector faces an international shortage of doctors, nurses and other health workers. Our key priority during 2004/2005 was to develop new roles and enhance existing roles.

6.1 Maori Workforce

- The primary care graduate nurse programme is progressing well, and provider development work continues with Maori and Pacific provid-

ers. C&C DHB is leading the Central Region Maori Workforce Profile project, on behalf of five DHBs.

Kaiawhina training

- We have provided this training opportunity for Kaiawhina (a term that includes Health Care Assistants and community support workers) for the second time. The programme reinforces to Maori workers their value in the health workforce. It supports them to reconnect with traditional Maori strengths-based models, and an environment of inclusiveness and equal status. Although targeted specifically to this group, this has not excluded non-Maori and/or qualified health professionals from registering interest and attending the course.

6.2 Nursing

Nurse Scholarships

- Nurse graduates are able to undertake two six-month rotations in different clinical areas in their first year post registration. These rotations offer graduates the opportunity to learn new skills while deciding which area they want to specialise in. A rotation has been developed in primary health care, which allows the nurses to work in a PHO.
- New primary health care nurse scholarships worth $1,000 each have been set up. These scholarships were given out to five nurses in 2005. They recognise and reward professionalism and commitment and the money contributes to their on-going education.
- A Maori primary care nursing scholarship has also been introduced.

Nurse Practitioners

- Two Nurse Practitioner candidate roles have been created at C&C DHB to help nurse clinicians in their transition to nurse practitioner status in a supported and structured way.
- Collaboration with the Primary Health Department of Nursing is helping to develop a Nurse Clinician (Nurse Practitioner Candidacy Role) for the Accident & Medical Clinic.

New positions

- A range of new nursing roles have been introduced. These include Nurse/Midwife Advisors who deal with professional issues as they arise, a new Nurse Advisor and a Wound Management Specialist in Medical Surgical Services.

6.3 Doctors

Pacific Doctors Pathway (PDP)

- The lack of Pacific doctors is a recognised gap in our workforce, nationally as well as locally. The Pacific Doctor Pathway is an action identified in the Draft Pacific Workforce Plan (Future Hope - Future Gain). The PDP has started with two non New Zealand registered Pacific doctors in observer roles within our DHB, with the aim of registration next year. The rationale for the PDP is to provide culturally appropriate services for our Pacific population and offer choice to Pacific people. It is part of the strategy towards a Pacific Primary Care led service in our district.

7. Inter-sectoral

The Board is extremely committed to the view that we must work with other agencies and communities and voluntary groups to achieve health outcomes, we want for our District. During 2004/05, we moved in that direction as follows:

Providing Access to Health Solutions (PATHS)

- The PATHS service is an inter-sectoral initiative between the Ministry of Social Development, Work & Income and our DHB. PATHS provides health and employment support for people on sickness and invalid benefits who wish to work. The project is going well with about 50 referrals moving on from interviews and assessment to health and wellness plans/actions. A GP and Mental Health coordinator have joined the team.

Housing and Health

- We are supporting a housing renewal project in Porirua aimed at improving people's health by improving their housing and community facilities.

Porirua Health Cluster

- The Porirua Health Cluster (PHC) identified some potential projects for 2005/06 as a result of work undertaken by the Defeat Diabetes sub-group. The environmental scanning process involved working with ten people/providers to evaluate environment, needs, knowledge and skills, and behaviours. Other topics include prevention of obesity and workforce.
- The PHC also organised a hui to reconnect with their broader community and to update and inform them about their work.

Refugee Strategy

- Our DHB has joined an interagency group to work on a refugee health strategy and action plan. The other agencies include (amongst others): Regional Public Health, the Ministry of Social Development, Hutt Valley DHB, South East City PHO, Refugee and Migrant Service and Union Health Services. A summit is planned for late 2005. A young graduate from a refugee background, employed by Regional Public Health, has started work on this strategy.

Homelessness Prevention Strategy

- The DHB has contributed to a taskforce on homelessness hosted by Wellington City Council. Our DHB participates in and provides the venue for these meetings. Early indications are that there are strategies applied in other urban settings that could be useful to Wellington.

8. Public Health

Healthy Eating Healthy Action (HEHA)

- A HEHA mapping meeting was held in June. The information gathered from this meeting highlighted the scope of initiatives currently underway, as well as gaps in services. Outcomes from this process will guide the development of our DHB's Nutrition and Physical Activity Policy. A stock take of HEHA across the district has been completed.
- Regional Public Health, PHOs and our DHB have implemented the HEHA strategy.

Joint Planning with Regional Public Health (RPH)

- There has been excellent cooperation across several areas, including healthy eating, healthy action, particularly with the Porirua Cluster and with all the PHOs, where RPH has been involved and offered great support.
- The RPH Social Environments Team has also led or assisted projects such as the skin infection project, prevention of homelessness, housing and health and income and health work.

Pandemic planning

- We established an outbreak management process and participated in national pandemic planning.

Smoking cessation – 'Smokefree'

- A Smokefree Action Group was formed to work collaboratively on Smokefree issues in the Wellington region.
- A number of events were held for World Smokefree Day on 31 May 2005 including street ball in Newtown and the Southside event.
- Our DHB hosted two smoking cessation workshops for hospital staff, midwives and primary care staff and facilitated a quit coach training programme.
- The Smokefree Schools project is developing smokefree programmes that will assist students to quit smoking and discourage the uptake of smoking. In Porirua College, Regional Public Health has assisted the student counsellor and the public health nurse to undertake a Heart Foundation cessation course and they are working towards establishing a strong infrastructure to support the programme.
- The Porirua Community Project aims to reduce smoking prevalence amongst all groups, particularly among Maori and Pacific people where rates are high.
- Smoking cessation service with a focus on Maori (Aukati Kaipaipa) based in Porirua was contracted through the Ministry of Health with DHB input.

9. Improving services for patients and staff

During 2004/05, we initiated a number of improvements to services for patients.

Food Services

To improve the quality of food available to patients we have introduced a range of initiatives.

- We developed and implemented a 'Catering to You' initiative. Food Services staff now deal direct with dieticians and ward staff. Ward based staff (Catering Associates) allow an improved understanding of the nutritional needs of the patient and create more direct interaction with dieticians.
- To support these improvements we have employed a full time on-site dietician to assess the nutritional requirements of the patients' meals, together with a dedicated Food Services Manager at our Kenepuru site.
- We introduced new and upgraded food trays for Wellington and Kenepuru hospitals, and have established a Food Management system to provide recipes and nutritional analysis that support the menu.

Together with our improvements to the food available to patients, we have also focused on providing healthy foods within the cafeterias in line with 'Nutrition Policy for Patients' and the 'Healthy Food for Cafeterias and Catering Policy'. This has involved the removal of high fat and sugar dense foods and introducing an extended range of salad options. These policies also include ensuring that the drink vending machines become 100 percent compliant with this policy.

Transport and accessability

- We've employed a Travel Plan Co-ordinator to develop a travel plan which assesses people's travel habits to and from the hospital, with a view to reduce car use. C&CDHB will be the first DHB to complete a Travel Plan.
- Our Wellington/Kenepuru patient, staff and visitor shuttle is a well-used service, transporting 2,000 passengers per month.
- We continue our initiatives to centralise vehicles

on Wellington, Kenepuru and Kapiti Sites, and at various community bases.

Improving Support services

- The migration of seven additional services to the Contact Centre has resulted in reduced number of Did Not Attends (people who do not attend out patient appointments) and has increased efficiencies in each area.
- We met our August deadline to code 100% of records which resulted in improved revenue for this year.

Hazard Management

- Hazard Management Plans have been developed and managed effectively to ensure safe work practice is maintained and hazards are identified and eliminated or controlled.
- We have introduced weekly Team Meetings in which workplace hazards are discussed and recorded in minutes.

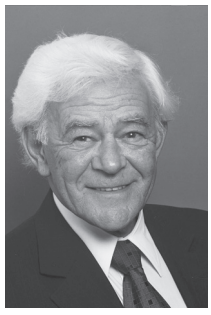
Building on experience

- At the corporate level, the organisation is careful to use all feedback we receive from Board, staff and public at large to identify what still has to be done in coming years. This emphasis on review and evaluation has been a major achievement for corporate management during 2004/05 year.

Statement of responsibility
for the year ended 30 June 2005

1. The Board and Management of Capital and Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.
2. The Board and Management of Capital and Coast District Health Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.
3. In the opinion of the Board and Management of Capital & Coast District Health Board, the annual Financial Statements for the year ended 30 June 2005, fairly reflect the financial position and operations of Capital and Coast District Health Board.

Bob Henare
Chairperson



Margot Mains
Chief Executive

Calum Laurie
Director of Finance

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Statement of accounting policies
for the year ended 30 June 2005

Reporting Entity

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

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

Measurement base

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

Accounting policies

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

Joint Venture Company

Capital and Coast District Health Board holds a 16.7% shareholding in Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial and financial policy decisions. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region.

CRTAS has a total share capital of $600 of which Capital & Coast DHB's share is $100. At balance date all share capital remains uncalled. The results of the joint venture company have not been included in the financial statements as they are not considered significant.

Associate Company

Associate companies are entities in which Capital & Coast DHB has significant influence, but not control, over their operating and financial policy decisions. Capital & Coast DHB and Taranaki DHB have an interest in the equity of HIQ Limited which was incorporated on 18 October 2004. The interest in HIQ Limited has been reflected in the financial statements on an equity accounting basis, which shows the share of surplus/deficits in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

Budget Figures

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

Goods and Services Tax

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

Taxation

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

Donation, Bequest and Trust Funds

Donations and bequests are recognised as revenue at the point when they are formally acknowledged. Funds received, to which conditions are attached, are acknowledged as revenue, unless the conditions cannot be fulfilled in which case the funds are lodged as DHB's Trust Funds. The use of these funds must comply with the specific terms of the sources from which the funds were derived and are therefore accounted for separately through the DHB's Trust Ledger.

Accounts Receivable

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

Inventories

Inventories are stated at the lower of cost, determined on a *weighted average cost* 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.

Property, Plant and Equipment

Property, plant and buildings other than land and buildings

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

Revaluation of land and buildings

Land and buildings are revalued every five years (unless a material change in asset value is identified during this period) to reflect their fair value as determined by an independent registered valuer by reference to their highest and best use. Fair value is determined using market evidence or depreciated replacement cost where appropriate. Additions between revaluations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation surplus reverses a previously recognised revaluation decrement, the revaluation surplus is recognised as revenue in the Statement of Financial Performance. Where a revaluation of an asset class results in a debit balance in the asset revaluation reserve for that asset class, the debit balance will be expensed in the Statement of Financial Performance.

Buildings were revalued at 30 June 2004. Land was revalued as at 30 June 2003.

Surplus Properties

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

Disposal of Property, Plant and Equipment

When a property, plant and equipment 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 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:

- Building structure – 2 to 60 years
- Building fitouts – 2 to 25 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 depreciated from that date.

Employee Entitlements

Provision is made for the DHB's liability for annual leave, 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

Finance leases

Leases, where the lessee effectively retains substantially all the risks and benefits of ownership of the leased items, are classified as finance leases. Finance lease assets are recorded at the lower of the fair value of the asset or the present value of the minimum lease payments. The leased assets and corresponding lease liabilities are recognised in the Statement of Financial Position. The leased assets are depreciated over the period the DHB is expected to benefit from their use.

Operating Leases

Leases, where the lessor effectively retains substantiality all the risks and benefits of ownership of the leased items, are classified as operating leases. Operating lease expenses are recognised in the Statement of Financial Performance 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 and Coast District Health Board and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

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

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2005, indirect costs accounted for 6.84% of Capital and Coast District Health Board's total costs (2004: 6.18%).

Capitalisation of interest

The DHB has adopted a policy of capitalising interest costs incurred on debt financing in respect of major capital projects. The interest cost of debt financing for the new regional hospital development project (NRH) has been capitalised to the Statement of Financial Position.

The capitalised interest of $2.2m (2004:$0.8m) has resulted in a decrease in the reported net deficit for the period.

Changes in accounting policies

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

Statement of financial performance
for the year ended 30 June 2005*

	Notes	Actual 2005 $000	Budget 2005 $000	Actual 2004 $000
Revenue	1	558,785	537,173	523,132
Expenses	1	555,535	525,219	518,583
Capital charge	16	4,872	4,955	4,538
NET (DEFICIT)/ SURPLUS	**1**	**(1,622)**	**6,999**	**11**

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

Statement of movements in equity
for the year ended 30 June 2005*

	Notes	Actual 2005 $000	Budget 2005 $000	Actual 2004 $000
EQUITY AT BEGINNING OF THE YEAR		129,750	129,668	129,724
Net surplus/(deficit) for the period		(1,622)	6,999	11
Other movements	2(c)	-	-	15
Total recognised revenues and expenses for the year		**(1,622)**	**6,999**	**26**
Contributions from owners	2(a)	-	-	-
EQUITY AT THE END OF THE YEAR		**128,128**	**136,667**	**129,750**

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

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Statement of financial position
for the year ended 30 June 2005*

	Notes	Actual 2005 $000	Budget 2005 $000	Actual 2004 $000
EQUITY				
General funds	2(a)	205,243	205,243	205,243
Retained earnings	2(b)	(94,176)	(85,637)	(92,554)
Revaluation reserves	2(c)	17,061	17,061	17,061
Total equity		**128,128**	**136,667**	**129,750**
REPRESENTED BY:				
ASSETS				
Current Assets				
Cash		13	767	1,612
Receivables and prepayments	3	115,489	113,762	21,632
Inventories	4	4,609	4,430	4,632
Trust funds	12(a) & (b)	4,382	3,615	3,709
Total current assets		124,493	122,574	31,585
Non-Current Assets				
Investment in associate company	17	2,134	-	-
Property, Plant and Equipment	5	220,327	221,142	197,886
Receivables and prepayments	3	-	-	86,000
Total non current assets		222,461	221,142	283,886
Total assets		**346,954**	**343,716**	**315,471**
LIABILITIES				
Current Liabilities				
Bank Overdraft		30,472	-	-
Payables and accruals	6	41,853	34,461	39,312
Employee entitlements	7	26,967	24,636	24,951
Current portion of term loans	8	11,139	20,000	7,615
Total current liabilities		110,431	79,097	71,878
Non-Current liabilities				
Employee entitlements	7	3,941	1,674	3,770
Term loans	8	104,340	126,200	109,979
Restricted and Trust fund liabilities		114	78	94
Total non current liabilities		108,395	127,952	113,843
Total liabilities		**218,826**	**207,049**	**185,721**
NET ASSETS		**128,128**	**136,667**	**129,750**

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

Statement of cash flows

for the year ended 30 June 2005*

	Notes	Actual 2005 $000	Budget 2005 $000	Actual 2004 $000
CASH FLOWS FROM OPERATING ACTIVITIES				
Cash was provided from:				
Receipts from MOH and other crown entities		544,493	522,859	492,789
Other revenue		11,986	13,446	14,628
Interest received		643	227	165
		557,122	536,532	507,582
Cash was disbursed to:				
Payments to employees and suppliers		524,254	506,299	493,354
Capital charge		6,844	4,468	2,634
Interest paid		4,310	6,039	5,841
GST (net)		(20)	611	896
		535,388	517,417	502,725
Net cash inflow/(outflow) from operating activities	**9**	**21,734**	**19,115**	**4,857**
CASH FLOWS FROM INVESTING ACTIVITIES				
Cash was provided from:				
Trust property cash released		-	-	387
Proceeds from sale of property, plant and equipment		-	14,481	9
		-	14,481	396
Cash was applied to:				
Trust property cash received		653	-	-
Purchase of property, plant and equipment		49,258	61,824	32,793
Advances to associate		3,561	-	-
		53,472	61,824	32,793
Net cash inflow/(outflow) from investing activities		**(53,472)**	**(47,343)**	**(32,397)**

	Notes	Actual 2005 $000	Budget 2005 $000	Actual 2004 $000
CASH FLOWS FROM FINANCING ACTIVITIES				
Cash was provided from:				
Proceeds from term loan		6,000	28,200	98,000
		6,000	28,200	98,000
Cash was applied to:				
Repayment of term loan		6,333	-	70,694
Net cash inflow/(outflow) from financing activities		**(333)**	**28,200**	**27,306**
Net increase in cash held		(32,071)	(28)	(234)
Add opening cash		1,612	795	1,846
Closing cash balance		(30,459)	767	1,612
Made up of:				
Cash		13	767	1,612
Bank Overdraft		(30,472)	-	-
Closing cash balance		(30,459)	767	**1,612**

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

Statement of contingent liabilities

for the year ended 30 June 2005

	2005 $000	2004 $000
Legal proceedings	3,310	973
Personal grievances	141	42
Other	63	-

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. In the event of the Courts finding for the plaintiffs, the Board believes that any damages awarded will be met by its insurers.

Statement of commitments

for the year ended 30 June 2005

	2005 $000	2004 $000
Capital Commitments including New Regional Hospital (NRH)		
Less than one year	32,066	28,365
One to two years	834	9,503
Two to five years	-	872
	32,900	**38,740**
Finance Lease commitments		
Less than one year	49	1,477
One to two years	-	349
Two to five years	-	1
	49	**1,827**
Operating lease commitments		
Less than one year	1,796	2,361
One to two years	963	1,676
Two to five years	502	1,106
Over five years	837	590
	4,098	**5,733**
Other non-cancellable service contracts		
Less than one year	22,046	25,613
One to two years	9,926	9,419
Two to five years	6,187	2,142
Later than five years	6	999
	38,165	**38,173**
Total commitments	**75,212**	**84,473**

With the formation of HIQ Limited, a number of Finance and Operating leases and service maintenance contracts previously recognised by C&CDHB, were assigned to the new company.

Note 1: Net (Deficit)/Surplus

	2005 $000	2004 $000
Revenue	**558,785**	**523,132**
After crediting:		
Interest income	643	165
Revaluation of fixed assets	-	11,898
Donations and bequests	1,656	1,408
Less Expenses		
After charging:		
Remuneration of auditor		
Audit fees	108	102
Assurance related services	5	13
Depreciation		
Buildings	10,007	9,314
Plant and equipment	10,364	9,240
Loss on sale of fixed assets	38	345
Board members' fees	340	327
Interest expense	6,955	6,135
Rental and operating lease costs	2,998	5,689
Bad debts written off	110	121
Changes in provision for doubtful debts	213	696
Personnel costs	211,187	204,566
Information technology service fees	4,389	-
Other operating expenses	111,716	112,731
Provider payments	197,105	169,304
	555,535	**518,583**
Capital Charge	4,872	4,538
Net (deficit)/surplus per Statement of Financial Performance	**(1,622)**	**11**

Note 2: *Equity*

(a) General Funds	2005 $000	2004 $000
Opening balance	205,243	205,243
Contribution from owners	-	-
General funds at 30 June	**205,243**	**205,243**

(b) Retained earnings	2005 $000	2004 $000
Retained earnings at 1 July	(92,554)	(92,565)
Operating (deficit)/surplus	(1,622)	11
Retained earnings at 30 June	**(94,176)**	**(92,554)**

(c) Land revaluation reserve	2005 $000	2004 $000
Opening balance	17,061	17,046
Revaluation	-	-
Other movements	-	15
Land revaluation reserve at 30 June	**17,061**	**17,061**

Note 3: Receivables and prepayments

	2005 $000	2004 $000
Associate company debtor	6,445	-
Trade debtors	16,079	19,413
Provision for doubtful debts	(1,327)	(1,114)
Accrued income	7,824	2,488
Prepayments	468	845
Crown equity due[1]	86,000	-
	115,489	**21,632**

Note 4: Inventories

	2005 $000	2004 $000
Pharmaceuticals	1,244	1,094
Surgical and medical supplies	3,260	3,433
Other supplies	105	105
Total Inventory	**4,609**	**4,632**

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.

[1] 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 5: Property, plant and equipment

	2005 $000	2004 $000
Land		
Land at valuation	21,722	21,722
Transfers from Surplus Properties	295	-
Total land	**22,017**	**21,722**
Buildings		
Buildings at cost	13,904	5,257
Buildings at valuation	88,878	88,878
Accumulated depreciation	(11,525)	(882)
Total buildings	**91,257**	**93,253**
Plant and Equipment		
At cost	100,405	112,933
Accumulated depreciation	(61,937)	(67,358)
Total plant and equipment	**38,468**	**45,575**
Plant and Equipment finance leases		
At cost	1,091	1,827
Accumulated depreciation	(1,042)	-
Total plant and equipment finance leases	**49**	**1,827**
Surplus Properties		
At cost	10,847	12,602
Accumulated depreciation	(3,288)	(3,929)
Total surplus properties	**7,559**	**8,673**
Capital Work in Progress		
Buildings	54,967	20,155
Plant and Equipment	6,010	6,681
Total capital work in progress	**60,977**	**26,836**
Total property, plant and equipment		
At cost and valuation	298,119	270,055
Accumulated depreciation	(77,792)	(72,169)
Total carrying amount	**220,327**	**197,886**

Restrictions

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

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

Valuation

Buildings are stated at fair value determined by reference to depreciated replacement cost by M J Bevin, MPA, SNZPI (Registered Valuer) of DTZ Darroch as at 30 June 2004.

Land was revalued at fair value determined by reference to market value and other special circumstances by M J Bevin, MPA, SNZPI (Registered Valuer) of DTZ Darroch as at 30 June 2003.

Surplus properties were revalued at fair value determined by reference to market value and other special circumstances by EF Gordon, FNZIV (Registered Valuer) as at 30 June 2005.

Note 6: Payables and accruals

	2005 $000	2004 $000
Trade creditors and accruals	36,648	31,478
Capital charge due to the Crown	470	2,441
Accrued expenses	4,415	4,981
Revenue in advance	320	412
Total payables and accruals	**41,853**	**39,312**

Note 7: Employee entitlements

	2005 $000	2004 $000
Accrued pay	5,828	4,830
Annual leave	18,217	16,799
Retirement and long service leave	4,648	4,983
Other	2,215	2,109
	30,908	**28,721**
Made up of:		
Current	26,967	24,951
Non-current	3,941	3,770
	30,908	**28,721**

Note 8: Term loans

	2005 $000	2004 $000
Crown Health Financing Agency (CHFA)	104,000	98,000
Bank revolving credit	-	6,000
Capital & Coast notes	11,000	11,000
Finance leases	44	1,827
Other loans	435	767
Total	**115,479**	**117,594**
Less current portion	11,139	7,615
Non current portion	**104,340**	**109,979**
Interest Rates Summary:		
CHFA	5.86%pa	5.88%pa
Revolving credit	6.89%pa	6.02%pa
Capital & Coast notes (weighted coupon)	7.90%pa	7.90%pa
Leases	6.00%pa	6.00%pa
Repayable as follows:		
One to two years	53,267	11,368
Two to five years	51,073	98,611
	104,340	**109,979**

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

a) Security interest: Create any security interest over its assets except in certain defined circumstances; or

b) Loans and guarantees: Lend money to another person (except in the ordinary course of business and then only on commercial terms), or give a guarantee; or

c) Change of business: Make a substantial change in the nature or scope of its business as presently conducted; or

d) Disposals: Dispose of any of its assets except disposals made in the ordinary course of its business or disposals for full value; or

e) Provided services: provide services to or accept services from a person other than for proper value and on reasonable commercial terms.

The Finance leases are secured over leased assets disclosed in note 5.

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

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

	2005 $000	2004 $000
Net surplus/ (deficit)	(1,622)	11
Add/(less) non-cash items:		
Depreciation/assets written down	20,371	18,554
Asset revaluation	-	(11,898)
Total non-cash items	**20,371**	**6,656**
Add/(less) item classified as investment activity:		
Net loss/ (gain) on sale of fixed assets	38	345
Total investing activity items	38	345
Add/(less) movements in working capital items:		
(Increase)/decrease in receivables and prepayments	(1,737)	(3,691)
Increase in inventories	23	(435)
Increase/ (decrease) in payables and accruals	2,465	94
(Decrease)/Increase in provisions	2,196	1,877
Working capital movement – net	2,947	(2,155)
Net cash inflow from operating activities	**21,734**	**4,857**

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

Note 10: Related parties transactions

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

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

Related party transactions and balances

(a) Funding

Total Crown revenue received in the year ended 30 June 2005 was $559m, $530m (95%) was received directly from the Ministry of Health. The amount outstanding to CCDHB as at 30 June 2005 was $5.3m (2004: $9.1m).

(b) Joint venture company

Capital & Coast District Health Board purchased services from Central Regional Technical Advisory Services Ltd of $383,868 during the year ended 30 June 2005 (2004: $541,797).

(c) Associate company

Capital & Coast District Health Board purchased services from HIQ Limited of $4.3m for a period of 8 months to 30 June 2005 (2004: Nil). The balance owing to Capital and Coast DHB at year end was $6.4m (2004: Nil).

(d) Key management and Board members

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

Note 11: Financial instruments

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

The Board has a series of policies providing risk management 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 borrowings are disclosed in note 8. There were no interest rate instruments in place at 30 June 2005.

Credit facilities

As at 30 June 2005, Capital and Coast District Health Board had committed to an overdraft facility of $30m expiring on 4 October 2007. $27.2m was drawn against this facility at 30 June 2005 leaving $2.8m available (2004: $29m was available against a $35m short term borrowing facility).

The bank overdraft is secured by a negative pledge deed entered into between the DHB and the bank.

Currency risk

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

Capital and Coast District Health Board undertakes transactions denominated in foreign currencies from time to time and exposures in foreign currency arise from these activities. It is the DHB's policy to hedge any such risks using forward and spot foreign exchange contracts to manage these exposures. There were no foreign currency 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, causing the DHB 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 95% 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: Trust funds

Capital and Coast District Health Board administers certain funds and donations 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 2005 are not recognised in the Statements of Financial Performance, Financial Position or Cash Flows of Capital and Coast District Health Board.

(a) Patient funds	**2005 $000**	**2004 $000**
Opening balance	82	82
Monies received	222	166
Interest earned	3	2
Payments made	(204)	(168)
Closing balance	**103**	**82**

(b) Donated funds	**2005 $000**	**2004 $000**
Opening balance	3,627	3,655
Monies received	1,422	972
Interest earned	254	188
Payments made	(1,024)	(1,188)
Closing balance	**4,279**	**3,627**
Total	**4,382**	**3,709**

Note 13: Board Members' remuneration

The Board of Capital and Coast District Health Board as at 30 June 2005, and those who ceased to hold office during the year ended on that date, are set out below together with details of their remuneration (excluding expense reimbursement), received or receivable, for that period:

	2005 $000	2004 $000
Bob Henare (Chair)	54	55
Margaret Faulkner (Chair – DSAC)	36	37
John Cody (appointed, term ended Dec 2004)	13	27
Ruth Gotlieb	27	26
Helene Ritchie	26	26
Karl Geiringer (elected, term ended Dec 2004)	11	25
Judith Aitken (Chair – FRAC)	32	26
Ian Shearer (elected, term ended Dec 2004)	13	27
Tino Pereira (appointed, term ended Dec 2004)	13	26
Chris Turver (elected, term ended Dec 2004)	12	26
Helmut Modlik (appointed, term ended Dec 2004)	14	26
Brendon Bowkett (elected, Dec 2004)	14	-
Ruth Bradwell (elected, Dec 2004)	15	-
Peter Dady (elected, Dec 2004)	15	-
Ken Douglas (Chair – HAC) (elected, Dec 2004)	15	-
Kiri Parata (appointed, Dec 2004)	15	-
Fuimaono Karl Pulotu-Endemann (Chair – CPHAC) (appointed, Dec 2004)	15	-
	340	**327**

Legend:

DSAC – Disability Support Advisory Committee

HAC – Hospital Advisory Committee

CPHAC – Community and Public Health Advisory Committee

FRAC – Finance and Risk Assurance Committee

Note 14: Employee remuneration

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

Total remuneration and other benefits $(000)	Number of employees 2005	Number of employees 2004
100 - 110	48	41
110 - 120	43	24
120 - 130	24	22
130 - 140	21	20
140 - 150	22	12
150 - 160	8	21
160 – 170	18	14
170 - 180	16	11
180 - 190	14	12
190 - 200	5	6
200 - 210	7	9
210 - 220	8	4
220 - 230	4	4
230 - 240	2	1
240 - 250	1	1
250 – 260	3	2
260 – 270	1	1
270 – 280	2	-
280 – 290	1	1
290 – 300	-	1
300 – 310	-	2
310 – 320	2	1
320 – 330	1	-
330 – 340	1	-
350 – 360	1	-
360 – 370	-	1
380 – 390	1	-
390 – 400	2	-
	256	**211**

The Chief Executive's remuneration and other benefits are in the $390,000 to $400,000 bracket (2004: $360,000 to 370,000).

Of the 256 employees shown above, 220 are or were medical or dental employees and 36 are or were neither medical nor dental employees. This represents an increase of 45 staff in total over the previous year. Of these 42 are or were medical and dental employees and 3 are or were neither medical nor dental employees. The increase reflects salary rate changes in national Collective Agreements for medical and dental staff.

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 369, compared with the actual total number of 256.

Note 15: Termination payments

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

Number of employees	Amount Paid
1	500.00
1	2,000.00
1	2,089.34
1	2,179.30
1	2,987.58
1	3,000.00
1	3,560.09
1	3,625.17
1	4,000.00
1	4,613.99
1	4,732.42
1	4,846.16
1	5,368.11
1	5,726.18
1	6,503.50
1	6,750.00
1	7,458.66
1	8,500.00
1	9,200.00
1	9,692.32
1	10,762.50
1	13,000.00
1	13,325.00
1	17,000.00
1	18,000.00
1	20,719.44
1	22,998.00
1	23,000.00
1	26,153.46
1	38,250.00
1	64,228.03
31	**364,769.25**

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 2005 was 11.0% (2004: 11%).

Note 17: Associates

Capital & Coast DHB has a significant interest in the following associate:

Associate	Interest 2005	Interest 2004	Nature of business
HIQ Limited	50%	-	Owns and manages information systems

HIQ Limited was jointly created with Taranaki DHB on 16 October 2004 and has a balance date of 30 June. C&C DHB and TDHB share information services through HIQ Limited. The board of HIQ Limited has equal representation from both DHBs. C&C DHB and TDHB own class A and class B shares in the company.

	C&CDHB	TDHB	Shares on issue
Class A shares	1	1	2
Class B shares	2,140,260	2,624,571	4,764,831

The class A shares represent voting rights and are split evenly between the two DHBs. The class B shares confer the level of contributions and ownership benefits of each DHB. The company is considered to be jointly controlled because of the equal sharing of voting rights conferred through class A shares and is therefore an associate of both C&C DHB and TDHB in accordance with *FRS-38: Accounting for Investments in Associates*. Each DHB will account for their respective ownership interest as determined by the appropriate value of class A and class B shares held. C&C DHB ownership in HIQ Limited as 30 June 2005 is 44.92%.

Investment in associates

Investment in associate	**2005 $000**	**2004 $000**
Opening balance	-	-
Equity earnings of associate	-	-
Equity capital contribution	2,134	-
Closing balance investment in HIQ Limited	**2,134**	**-**

The C&C DHB's share of the results of HIQ Limited is as follows:

Share of associate's surplus	2005 $000	2004 $000
Share of net surplus before tax	-	-
Tax expense	-	-
Share of associate's surplus	-	-

During the year the DHB has entered into several transactions with its associate. The nature of these intra-group transactions and the outstanding balance at the yearend are as follows:

Inter company transactions and balances	2005 $000	2004 $000
Expenditure incurred by C&C DHB to fund the operations	4,389	-
Equity issued to C&C DHB	2,134	-
Current receivables owing to C&C DHB	6,445	-

Note 18: Major budget variations

Statement of Financial Performance

The DHB recorded an operating deficit of $1.6m compared with the budget of $7m with both revenue and expenditure higher than budgeted, primarily due to additional revenue allocated by the Crown for various services after the budget estimates were completed. The net variance is due to non-completion of a land disposal with an estimated profit of $7m and the non-receipt of $1.7m Crown funding to meet FRS 3 requirements.

Statement of Financial Position

The variance of $6m in the term loans is due to additional CHFA borrowing during the year.

Statement of Cash Flows

Cash provided from proceeds from sale of property, plant and equipment was lower than budget by $14.5m due to the non-completion of a land disposal planned during the year.

The favourable variance of $12.5m in the cash applied to purchase property, plant and equipments is attributed to delays with the new regional hospital spending in the current year.

Cash provided from term loans was lower than the amount budget by $22.2m. It was no longer necessary to obtain a term loan as an overdraft facility of $30m was arranged with the ASB bank.

Cash applied to the repayment of term loan was $6.3m higher than the budget due to repayment of outstanding debt with the use of $6m CHFA loan.

Summary of revenues and expenses by output class:

Statement of objectives and service performance

for the year ended 30 June 2005

	Funding $000	Governance and funding administration $000	DHB Hospital Provider $000	Elimination* $000	Total DHB $000
Revenue					
Crown	513,310	5,296	335,089	(313,562)	540,133
Other	-	-	18,652		18,652
Total Revenue	**513,310**	**5,296**	**353,741**	**(313,562)**	**558,785**
Expenditure					
Personnel	-	2,255	208,932	-	211,187
Depreciation	-	13	20,358	-	20,371
Capital charge	-	-	4,872	-	4,872
Other	510,642	3,970	122,927	(313,562)	323,977
Total expenditure	**510,642**	**6,238**	**357,089**	**(313,562)**	**560,407**
Net surplus/(deficit)	**2,668**	**(942)**	**(3,348)**	**-**	**(1,622)**

Reconciliation to retained earnings:

	Funding	Governance and funding administration	DHB Hospital Provider	Elimination	Total DHB
Opening retained earnings	(88)	(2,249)	(90,217)	-	(92,554)
Less deficit for the year	2,668	(942)	(3,348)	-	(1,622)
Closing retained earnings	**2,580**	**(3,191)**	**(93,565)**	**-**	**(94,176)**

Good Employer Policies

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

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

The Board acknowledges and supports the right to equal opportunities, privacy, fairness and equity in the management of the employment relationship, and recognises cultural differences and diversity and the needs of ethnic and minority groups. Regular internal and external audits are undertaken to ensure legislative and policy requirements are met.

* DHBs are required to differentiate their funding broadly into hospital and non hospital activities. To recognise and give effect to CCDHB as a funder of both hospital and non hospital activities two sets of books (ledgers) are maintained which require intra-DHB revenues and costs to be 'eliminated'.

Statement of Service Performance

C&C DHB is required by the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989 to report on its service performance. The performance report below is for the performance areas and targets identified in C&C DHB's Statement of Intent for 2004/05 – 2006/07.

The Statement of Intent was designed to demonstrate how the DHB's activities will impact on the DHB's primary objectives, which are:

1) To improve, promote and protect the health of people and communities.
2) To promote integration of health services, especially primary and secondary health services.

The measures included in C&C DHB's Statement of Intent for 2004/05 – 2006/07 focussed on activities in the priority areas identified in C&C DHB's Draft District Strategic Plan.

This Statement of Service Performance considers what progress has been achieved towards the goals and activities set out in the Statement of Intent 2004/05 – 2006/07.

In the following tables, C&C DHB's actual performance for the year ended 30 June 2005 is measured against the strategic objectives detailed in the Statement of Intent 2004/05 – 2006/07.

C&C DHB continues to develop ways to measure performance that is appropriate to the needs of our stakeholders, both within Parliament and in the community. These measures and associated performance targets will continue to be reflected in future Statements of Intent and reported on in subsequent Statements of Service Performance.

The Audit Office has audited this performance report for accuracy and reasonableness.

Strategic objectives

C&C DHB's strategic objectives (as outlined in C&C DHB's Draft District Strategic Plan) are based on Government expectations, local health requirements (as identified in our Health Needs Assessment), and C&C DHB's knowledge of making services effective.

These objectives and priorities have a focus on the areas of health and disability that C&C DHB believes have the greatest potential for gains in health and wellbeing.

DHB priority: Reducing disparities

Outcome

Improved access to primary care, immunisation, and disability support services for Maori, Pacific and people from low income communities. Improving immunisation, access to primary care and providing health days for Pacific communities will help people better manage their illnesses in their own community and reduce admissions to hospital for diseases that are preventable.

Invest additional funding on various services for Maori including primary care, midwifery / Tamariki Ora (wellness of the child), and Well Child framework during 2004/05.

Invest additional funding of $120,000 in Maori primary care services in Wellington and Kapiti. Timeliness: June 2005	**Achieved** We have established a new Kaupapa Maori primary care service in Wellington and increased funding to Maori providers (primary care) in Porirua, Wellington and Kapiti. New GP Services in Wellington: Funding was approved in June 2004 and services were contracted in July 2005. 'Ora Toa Poneke' opened on 2 May 2005 in Hall Street, Newtown. In May 2005 a GP clinic/service was established at Te Ngawari Hauora base in Newtown, Wellington. The service was initiated and funded by Capital PHO in a bid to improve access for high need and high risk whanau. Funding was approved to support the establishment and the provider was contracted in June 2005.
Implement Maori integrated maternity / Tamariki Ora/whanau ora project. Timeliness: April 2005	**Partially Achieved** We have invested additional funding into three Tamariki Ora service providers to support the Well Child Framework. We moved three providers from Tamariki Ora contracts to the Well Child Framework. This meant funding was increased towards meeting the current delivery and the investment totalled $218,000. Funding was approved and providers contracted in June 2005. The three current Tamariki Ora service providers now deliver to the full Well Child Schedule. Growing Well Child services within a Maori midwifery service was an initiative considered in early 2004. This approach attempted to support the continuum of care and transition between Lead Maternity Carers and Tamariki Ora / Well Child services. Although the completed feasibility study supported the development, the Maori/Pacific Midwifery service in Wellington opted not to grow Well Child services within current operations. Therefore the scope was changed from integrated maternity / Tamariki Ora / whanau ora to transitioning Tamariki Ora providers to the Well Child framework (as above). Project scope was changed from integrated maternity / Tamariki Ora / whanau ora to transitioning Tamariki Ora providers to Well Child framework. Funding was approved and providers were contracted in June 2005. We will continue to view/evaluate the effectiveness of Well Child services and fund in-line with the Well Child funding formula.

DHB priority: Reducing disparities [cont.]

Outcome

Improved access to primary care, immunisation, and disability support services for Maori, Pacific and people from low income communities. Improving immunisation, access to primary care and providing health days for Pacific communities will help people better manage their illnesses in their own community and reduce admissions to hospital for diseases that are preventable.

Improve responsiveness of Hospital & Health Services to Maori.	
Develop & implement responsiveness framework to support Hospital & Health Services. Timeliness: June 2005	**Partially Achieved** The responsiveness framework for Hospital and Health services to Maori was developed during the year. The implementation of a responsiveness framework is a continuous quality improvement process and implementation is planned over the next 2-3 years. Service development, education and monitoring were the key improvement areas targeted in 2004/05. The Maori Health service HHS was reconfigured to navigate whanau/families through the often complex maze of services, treatment interventions and multiple relationships. Increased staff numbers and an improved skill base have supported developments. Bicultural Education was reviewed and the following areas for improvement were identified: • Supported access to Treaty education. • Access to advanced learning material. • Appropriate methods that address diverse learning styles. Strategies to implement the changes will occur in 2005/06. The Board along with the Maori Partnership Board have agreed to the mutual monitoring of the DHB's response to Maori Health. The development of Maori Health indicators is under way and implementation is planned for 2005/06. In June 2005 funding of $75,000 was agreed to establish Cardiovascular Disease (Heart) Advocacy and Facilitation support in the HHS. This will be established from October to December 2005.
Promote Pacific healthy lifestyle and wellbeing.	
Each of the six Pacific Island groups will have held at least one ethnic specific health day. The health day programme to include immunisation, health of elderly health checks in conjunction with the Regional Public Health. Timeliness: June 2005	**Achieved** We have supported and funded ethnic specific community health days for each of the Pacific Community groups. Each community has held workshops for health promotion/health education and health checks. Funding has been provided for continuation of these community initiatives. We have funded three ethnic-specific elderly groups to continue their weekly exercise classes and we have linked them with student trainees from the New Zealand Institute of Sport.

Promote participation of disabled Pacific peoples.	
Develop a work programme with the HHS for Disability support targeting Pacific. Timeliness: January 2005	**Partially Achieved** A Needs Assessment and Service Coordinator for Pacific people facing disability started providing services one day a week in January 2005 in the Pacific Support Service of the Hospital and Health Services.
First disability graduates complete disability competence programme. Timeliness: April 2005	**Not Achieved** An audit of disability access across the five Pacific Providers has been deferred from 2004/05 to the first half of 2005/06, due to the lack of a disability auditor. Once it has been audited disability competence training will be developed.

DHB priority: Achieving Integrated Care

Outcome

Patients and consumers of health services receive services that focus on patients' needs and ensure resources like staff and funding are appropriately utilised. By improving the way mental health, disability support services and services for children are delivered, we can better address the needs of people, rather than delivering services in a way that suit the provider. We want to develop services like reducing smoking and the uptake of exercise that are easy for young people to use to prevent future heart and other diseases.

Develop integrated care for mental health patients to improve access.	
Fund a whanau model of community based mental health care for people with severe mental illness and alcohol and drug addiction. Timeliness: October 2004	**Achieved** A service to support at risk whanau/family with mental health issues/illness was established in Newtown. Funding was approved and the service (Menenga Pai Trust) contracted in 2004. Menenga Pai Trust is contracted to provide a whanau model of community based mental health care for people with severe mental health illness and drug addiction. The service provides a unique model of care to tangata whai ora (people who seek assistance) with high needs and challenging behaviour based in community with services of high intensity Kaupapa Maori approach. Menenga Pai Trust presented their model of care (community based) at the 2005/06 THEMHS (Australia/New Zealand Mental Health Services) conference in Adelaide, August 2005. A process to evaluate effectiveness and impact of this service is planned in the 2005/06 year.

DHB priority: Achieving Integrated Care [cont.]

Outcome

Patients and consumers of health services receive services that focus on patients' needs and ensure resources like staff and funding are appropriately utilised. By improving the way mental health, disability support services and services for children are delivered, we can better address the needs of people, rather than delivering services in a way that suit the provider. We want to develop services like reducing smoking and the uptake of exercise that are easy for young people to use to prevent future heart and other diseases.

Develop integrated care for mental health patients to improve access.	
Develop implementation plan for the establishment of community based alternative to acute hospital care. Timeliness: December 2004	**Partially Achieved** We completed a literature review for community based service and shared our findings with mental health providers and consumers. We held a workshop with consumer groups, community providers, Hospital & Health Services and others with a special interest in mental health to get their input into developing a of model of care, which can be used as alternative to acute hospital care. It was agreed the development of this service should become part of the wider review of mental health and addiction services (the strategic plan, 'The Journey Forward'). The wider mental health sector was consulted about this decision and was supportive of this approach. While we are developing the strategic plan for mental health, we are working with the community providers to improve the process for looking after people who are acutely unwell. We consulted with communities during June and July 2005 for their input towards finalising the strategic plan, including alternatives to acute hospital care.
Improving immunisation coverage in the District.	
National immunisation register implementation action plan finalised. Timeliness: December 2004	**Achieved** The National Immunisation Register action plan was finalised in December 2004. It has been approved by the Ministry of Health and implementation is in progress.
Invest additional funding for developing capacity of Maori providers to support the implementation of the Well Child framework. Timeliness: March 2005	**Achieved (Delayed)** Additional funding ($218,000) was provided for immunisation coordination and to support three Tamariki Ora providers to implement the Well Child Framework during June 2005. The delay was due to work required to achieve alignment with the Well Child framework. This supported the planned transition towards a Well Child contract, meaning funding was increased and in-line with the Well Child funding formula.

Reduce the impact and incidence of cardiovascular diseases by working with Regional Public Health, PHOs and joint planning with the Hospital and Health Services.	
Establish smoking-stopping services within the District with a special focus on Maori population. Timeliness: December 2004	**Achieved (Delayed)** Smoking cessation service with a focus on Maori (Aukati Kaipaipa) based in Porirua was contracted through the Ministry of Health with DHB input. The service was delayed due to the Ministry's contracting process. It was funded in June 2005 and the service begins in the first quarter of 2005/06. Regional Public Health, PHOs and the DHB have worked to implement the 'Healthy Eating, Healthy Action' strategy, increased smoking cessation skills (workshops) and services (additional contract through Ministry of Health). We are also supporting projects such as Cardiovascular (heart) risk assessment to reduce the incidence and impact of heart disease.
Implement Rangatahi project to promote physical activity and smokefree lifestyle in Wellington South. Timeliness: March 2005	**Achieved** We have contributed to a joint 'Push Play' initiative with Wellington City Council and Regional Sport Wellington. This joint initiative focuses on increasing physical activity in schools and encouraging affordable/accessible recreation to communities where there are a high proportion of Maori, Pacific and children from low income families. One-off funding was approved in June 2005 and awarded to Consultancy Advocacy Research Trust to work with high risk and hard to reach youth in Wellington. This project aims to influence 'Healthy Eating and Healthy Action' through increasing physical activity and improving the uptake of healthy food as a lifestyle choice. We also put in place several initiatives to promote physical activity and a smokefree lifestyle, including: • smokefree streetball in Newtown • Push Play initiative with Wellington City Council.
Implement recommendations of resource allocation working group and joint service planning with the Hospital and Health Services. Timeliness: June 2005	**Partially Achieved** A Cardiovascular Working Party is being established to guide the implementation of the New Zealand Guidelines Group's Cardiovascular (Heart) Disease Risk Modification Guidelines during 2005/06. Funding has been agreed to establish a Cardiovascular Advocacy and Facilitation Service in the Hospital and Health Services of the DHB. Public Health Intelligence is assisting with determining equitable access targets for hospital services for Maori and Pacific Peoples. A service development team has been formed and a business case is being developed to support the strategic expansion of the cardiology service.

DHB priority: Achieving Integrated Care [cont.]

Outcome

Patients and consumers of health services receive services that focus on patients' needs and ensure resources like staff and funding are appropriately utilised. By improving the way mental health, disability support services and services for children are delivered, we can better address the needs of people, rather than delivering services in a way that suit the provider. We want to develop services like reducing smoking and the uptake of exercise that are easy for young people to use to prevent future heart and other diseases.

Reduce the impact and incidence of cardiovascular diseases by working with regional public health, PHOs and joint planning with the Hospital and Health Services.

Implementation of one point entry system for therapies, community health services, assessment, treatment & rehabilitation services and needs assessment & service coordination for elder people and adults with chronic illness. Timeliness: December 2004	**Partially Achieved** The scope of this initiative has been broadened beyond one point entry system to include screening of clients, coordination of services, budget management and care coordination. Specifications for the new service (Care Coordination Centre) were released in October 2004 and a Request for Expressions of Interest in providing the service was issued in November 2004. The Care Coordination Centre, which includes this one point entry process, will be in place by September 2005.

Implement an integrated specialised community based service to improve access to various services for older people and adults with chronic illness.

Establish an assessment process and care planning for older person's services. Timeliness: June 2005	**Achieved** A Care Management service (for assessment process and care planning for older persons) has been in operation since February 2005. The service involves Care Managers using the InterRAI (software developed specifically to assess support needs) assessment and care planning system to identify client goals and community services/ interventions which will achieve those goals.

DHB priority: Improving Quality

Outcome

We expect the quality of service to improve by reducing number of medication mistakes. We are now accredited by Quality Health New Zealand (QHNZ[1]) and certified by the Ministry of Health (required under the Health and Disability Services (Safety) Act 2001), which improves confidence of people who work in and use our hospitals.

Achieve Quality Health New Zealand (QHNZ) Accreditation.	
The DHB will implement action plans as agreed with QHNZ. Timeliness: June 2005	**Achieved** We achieved three year accreditation by Quality Health New Zealand in December 2004. We have developed and implemented action plans for the areas that Quality Health New Zealand identified as needing improvement.
Achieve Ministry of Health certification	
HHS will implement action plans as agreed with QHNZ. Timeliness: June 2005	**Achieved** We are certified by the Ministry of Health to provide health care services, which is a new requirement for DHBs as a result of the Health and Disability Sector Standards. The certification notice took effect from 30 September 2004. All areas of Hospital and Health Services have corrective action plans to address issues identified by the Quality Health New Zealand (as the agent of the Ministry of Health). We have provided progress report (at the end of three and six months post certification) to the Ministry of Health. The 12 months progress report was provided to the Ministry of Health in July 2005. A further compliance audit for Mental Health and surveillance visit for other services occurred between 30 August 2005 to 2 September 2005.

[1] QHNZ is a nationally recognised provider of accreditation for health service providers and facility.

DHB priority: Improving Quality [cont.]

Outcome

We expect the quality of service to improve by reducing number of medication mistakes. We are now accredited by Quality Health New Zealand (QHNZ[1]) and certified by the Ministry of Health (required under the Health and Disability Services (Safety) Act 2001), which improves confidence of people who work in and use our hospitals.

Implement strategies to improve patient outcomes and improve safety of drug use.	
Major trends and issues in drug utilisation errors identified. This will form the basis of HHS-wide improvement projects. Timeliness: June 2005	**Achieved** Medication incidents have been regularly reviewed by the Medicines Review Committee. The Safe Use of Medicines Pharmacist has been involved in implementation of the 5 rights. In April 2005 the pharmacy department began the '5 Rights' medication safety campaign to remind us of the principles of safe medicine use. The campaign involved posters being placed above most patients' beds, in treatment areas and stickers placed on medicine charts. This is one of the first projects aimed at medication safety and complements the work of Karen McBride-Henry (Research Nurse from Victoria University of Wellington). The aim is to help reduce the potential for medication errors at the time of administration and for the '5 Rights' principles to be incorporated into daily medication administration and prescribing practice. This has been a multi disciplinary approach which includes education in the implementation plan. Patients and staff have been surveyed. This project is ongoing. A nurse led Medication Administration project has commenced. The project aims to reduce medication administration errors. The first phase will identify systems issues that contribute to medications administration errors, raise awareness of how errors occur and assess how intervention programmes impact on nurse and midwives' perception of organisational safety. Our participation in the national Safety and Quality of medicines group helps to maintain consistency of approach for medication alerts and improvement projects.
Clinical audit activities will provide the basis for reflection of clinical practices and improvements.	
All services will identify and implement clinical audit activities including identifying clinical indicators. Timeliness: December 2004	**Partially Achieved** Clinical audit activities are included in all service quality plans for 2004/05. Some of these audits were completed before December 2004 (as per service audit plans). Some services identify quality /clinical indicators in their service plans. Some services also complete certain Australian Council on Health Care Standards (ACHS) indicators. (These are identified and completed six monthly). Stocktake of clinical audit processes in place for Medical – Surgical Services was completed. This initiative was led by the Quality Improvement Unit registrar. The audit picked up on processes recommended by Professional Colleges and/or Ministry of Health. Quarterly reporting of HHS audit activities continues to be collated and reported six monthly to the Ministry of Health.

DHB priority: Progressing the New Regional Hospital

Outcome

The physical development of a new infrastructure is an opportunity to develop new models of care. During 2004/05, we nearly completed development of new buildings for maternity services and Accident and Medical services at Kenepuru and acute assessment unit and cancer building at Newtown. The project will continue in out years.

Complete facility planning and tender and award the main contract for Newtown Hospital.	
Front block demolished. Timeliness: September 2004	**Achieved** The demolition of the Front Block was successfully completed in November 2004. The Triple Arches and Steps from the Front Block were retained and have been re-erected in a planned courtyard.
Main contract awarded. Timeliness: March 2005	**Partially Achieved** Due to difficulty in finding building contractors during a building boom in Wellington, the contracting method has been changed. A process to select the main contractor commenced in October 2004 but was cancelled without result in March 2005. An alternative process has commenced with early works under a separate contractor.
Acute assessment unit and cancer building complete. Timeliness: June 2005	**Partially Achieved** Acute Assessment Unit (Short Stay Unit) The contract to build this was let four weeks later than planned and due to unexpectedly poor ground conditions a total of six weeks has been lost. The building was completed in August 2005 with commissioning expected to take one month. Blood and Cancer Building Because of poor ground conditions, progress on the piling for the new Cancer building was delayed. The building was handed over in July, but commissioning of equipment commenced with the relocation of the simulator which was moved to its new location on 30 June. The first linear accelerator was relocated on 28 July and the remainder of the service will move during September. Commissioning of the equipment will continue through to October although both levels of the building were fully operational in early September.

DHB priority: Progressing the New Regional Hospital [cont.]

Outcome

The physical development of a new infrastructure is an opportunity to develop new models of care. During 2004/05, we nearly completed development of new buildings for maternity services and Accident and Medical services at Kenepuru and acute assessment unit and cancer building at Newtown. The project will continue in out years.

Commit construction for new works and refurbishment to Kenepuru clinical service block.	
Commission Accident and Medical Centre facility. Timeliness: April 2005	**Achieved (Delayed)** Although the construction schedule could have allowed for early completion of the A&M centre, the continuing construction in surrounding areas would have adversely affected the operation of the service. It was decided that the best operational solution was to complete A&M, Child Health and the new main entrance and commission and occupy all of these areas at one time. Due to excellent co-ordination by the Contractor (Mainzeal Construction), the Design Team and the Project Manager, the new main entrance, Child Health area and the A&M were opened on 25 July 2005. This three month delay allowed the team to get staffing and other arrangements ready before opening.
Complete main entrance and education building at Kenepuru. Timeliness: April 2005	**Partially Achieved** Following the appointment of the contractor, a revised construction timetable was prepared which included the main entrance opening at the end of July and the Education Centre and new Outpatients building opening late in 2005. The new Therapies zone opened in early June 2005.
Occupy new maternity facility. Timeliness: June 2005	**Achieved** Following a review of the budget it was decided to move the existing maternity building closer to the main Kenepuru Hospital. This was successfully completed in September 2004. Additional capacity of two beds is planned to be built during early 2006.

DHB priority: Workforce

Outcome

Improved capacity in primary care, home based care and care provided by Maori and Pacific providers will improve these providers' ability to respond to the health needs in the community. Improved roles and training for primary care nursing workforce and Health Care Assistants will improve the quality of workforce and reduce the turnover of people.

Improve workforce capacity and capability in all providers including community (including Maori and Pacific providers), primary care and hospital.

Develop the Pacific workforce development plan. Assist PHOs to set up new nursing graduate recruitment and development programme. Timeliness: September 2004	**Achieved (Delayed)** Pacific workforce development plan, Future hope, Future gain, was developed in October 2004 and includes the Pacific workforce both within the Hospital and in the community based providers. Action points related to Pacific Nurses in Primary Care working for Pacific Providers have been supported in further study. Currently two general practitioners with overseas qualifications are supported through a preparation programme for New Zealand registration. New nursing graduate programme A pilot graduate nursing programme was finalised in November 2004 for new graduates starting training and employment in primary care during 2005. The programme consists of four placements during 2005. There were two placements during the first half of 2005 and two more for the second half of 2005. Two Maori nurses have been selected for the programme and they will be in a practice setting in the area they live. The placement is in the PHO environment and includes experience with Maori service providers. The ongoing programme will contribute towards developing workforce at primary care level.

DHB priority: Workforce [cont.]

Outcome

Improved capacity in primary care, home based care and care provided by Maori and Pacific providers will improve these providers' ability to respond to the health needs in the community. Improved roles and training for primary care nursing workforce and Health Care Assistants will improve the quality of workforce and reduce the turnover of people.

Improve workforce capacity and capability in all providers including community (including Maori and Pacific providers), primary care and hospital.

Implement Maori workforce plan. Timeliness: March 2005	**Achieved** We have started to implement the Maori workforce plan and we have focused on: ● Raising awareness of health as a career option to a Maori audience. ● New graduate placements – resulting in two Maori nurses in joint HHS/Primary Care roles. ● A Career exposure seminar to secondary students. We have also planned development for a career progression framework for Maori staff within the Hospital & Health Services and implementation will begin during 2005/06. We have funded a Primary Care Nursing Scholarship for Maori. We have developed a training programme for Maori health support workers, health care assistants and Kaiawhina and implementation will begin during 2005/06. We are leading the Central Region Maori Workforce Profile project on behalf of five district health boards. This project aims to capture the makeup and skill mix of the Maori workforce within the Central Region and use this information to better identify the areas for workforce utilisation and growth.
Explore career pathways for Health Care Assistants to progress to other health roles. Timeliness: March 2005	**Achieved** We have explored the career pathway for Health Care Assistants (HCAs) to progress to other health roles including nursing. We provide support to HCAs with the application process to the Bachelor of Nursing programmes and help access funding for Maori and Pacific HCAs. We currently conduct a two day in-house core training programme for HCAs (on demand), which includes role and scope of practice, principles of communication, policies for chaperoning, infection control, delegation and supervision, manual handling, patient emergencies and environmental management. All our HCAs have been through this training programme before March 2005. We are currently developing a policy document based on the recently released criteria from the New Zealand Nursing Organisation and DHB working party, which will be used by team leaders.

DHB priority: Sustaining financial performance

Outcome
Appropriate utilisation of resources including blood products and pharmaceuticals.

Appropriate utilisation of resources including blood and pharmaceuticals.

Working with New Zealand Blood services to provide education and training for use of blood products and blood. Timeliness: Ongoing	**Achieved** The transfusion committee Terms of Reference and members have been reviewed. The focus for 2005 is: ● Monthly monitoring and review of blood product utilisation ● Data quality ● Monitoring and audit of blood reactions/incidents ● Participation in national audits in conjunction with the New Zealand Blood Service ● Educational programmes – identified from the outcome of audit activity ● Priority areas: Cryoprecipitate, Intragram and Platelets, FFP, Factor 7A The Blood Transfusion committee has continued to meet to focus on the above priorities. Monthly utilisation reports are monitored and exceptions are followed up. We continue to work with the New Zealand Blood Service to improve the data quality and presentation of reports. The outcome of the Cryoprecipitate audit has been discussed with no specific actions required. The Intragram P Audit has just been circulated. Meetings have been held with key services within the DHB to implement strategies to control utilisation which include: ● Establishing guidelines for use. ● Introducing a standard form. ● Establishing an internal review process. ● Establishing a joint review team with Auckland and Canterbury DHBs for requests made outside the guidelines.

DHB priority: Sustaining financial performance [cont.]

Outcome
Appropriate utilisation of resources including blood products and pharmaceuticals.

Appropriate utilisation of resources including blood and pharmaceuticals.

Establish a process for approval of usage of new drugs. Timeliness: September 2004	**Achieved** The process for approval of new medicine usage has been enhanced (approved by the Medicine Review Committee of the DHB) for appropriate usage, to reflect our new role as DHB and includes: ● Medicines Information Unit in Pharmacy provides the Medicines Review Committee (MRC) with an evaluation of the medicines and this is assessed by the Committee members. ● The Chair of the MRC advises the Funding Management Committee (FMC) about new medicines including additional costing information (provided by Pharmacy). FMC makes the final decision in regards to funding. ● One-off approvals (urgent after hours requests) are provided without MRC involvement and is documented. ● One-off approvals may be provided by the Chair/Vice-Chair of MRC in an urgent situation. The applicant must forward the application forms and advise the outcome of the treatment at the following MRC meeting. In the last 12 months Medicines Information has prepared eight evaluations for the Medicines Review Committee, which feeds into the approval of usage of new drugs. The Chair of the MRC has written to the FMC to advise of the MRC's decisions on new medicines, and approval for funding sought on behalf of the applicants. There have been 12 one-off approvals in the last 12 months for new medicines. These were urgent one-off requests which will be monitored by the Drug Utilisation Evaluation pharmacist. All Clinicians are requested to report the outcome of the one-off treatment to the Medicines Review Committee.

Progressing the implementation of the New Zealand Disability Strategy

Outcome

Implementing the framework for the New Zealand Disability Strategy was identified as one of the priorities for implementation. Raised awareness and improved competency amongst staff and Board members regarding disability issues will help us look after people with disabilities better and make our buildings easier for people with disabilities to use.

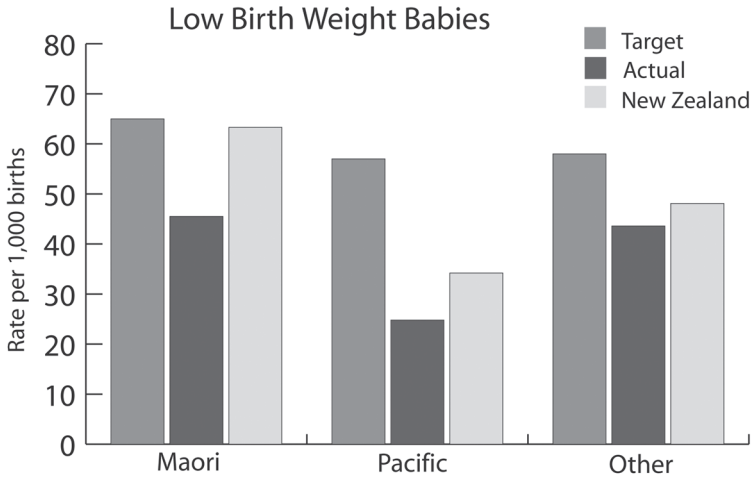
Implement the key actions of the NZDS as they relate to our responsibilities and activities.

Disability issues training component included in staff orientation programmes and Board training processes. Timeliness: September 2004	**Not Achieved** The disability issues training has been approved by the Chairman and Chief Executive Officer. A training session for the Board and Executive Management Team (EMT) members was held on 20 July 2005. The training session will be followed up at an EMT meeting to identify specific actions to further progress the aims of Promoting Participation, the Framework to implement the New Zealand Disability Strategy. This includes the roll-out of disability equity training to services we fund.
Initial access audits including use of appropriate signage are carried out on all public buildings housing the DHB funded services (surviving the NRH Project). Timeliness: June 2005	**Achieved** We carried out access audits, including signage, of the Emergency Department and the Fracture Clinic during 2004 as these two buildings will continue to be used after completion of the new regional hospital project. During 2004 the Technical Advisory Service[1] (an organisation jointly owned by six central region DHBs) surveyed providers funded by us that provide health and disability support services, to see how accessible their premises were. We are currently analysing the results of this survey to determine priorities and the risks involved in supporting providers to improve access to their services for disabled people.

[1] Technical Advisory Service is jointly owned by six central region DHBs: Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawke's Bay.

Indicators of DHB performance

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Description	Final Result
Low Birth Weight Babies: Rate per 1,000 births in public hospital with low birth weight.[1] Targets: Discharge Rate per 1,000 Maori 65 Pacific 57 Other 58	**Achieved** We are happy to have exceeded our targets for Low Birth Weight Babies. Results reflect a strong focus on maternity and child health, Maori and Pacific-specific services and a reducing inequalities focus on mainstream midwifery, primary care, Well Child and Tamariki Ora providers. Smoking cessation services, additional training in smoking cessation for midwives and attention to support for whanau and families, have also contributed. The second highest rates of Low Birth Weight are in the 'Other' ethnicity population. It is difficult to comment on the relative contribution of assisted reproductive technologies versus low income and refugee populations without better sub-analysis. We will continue to support initiatives to reduce Low Birth Weights and reduce disparities, with focus on Maori in particular. 

[1] Babies weighing less than 2,500 grams.

Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Oral Health:

Percentage of children caries free at age five years.

Targets:

Maori: 45%

Pacific: 35%

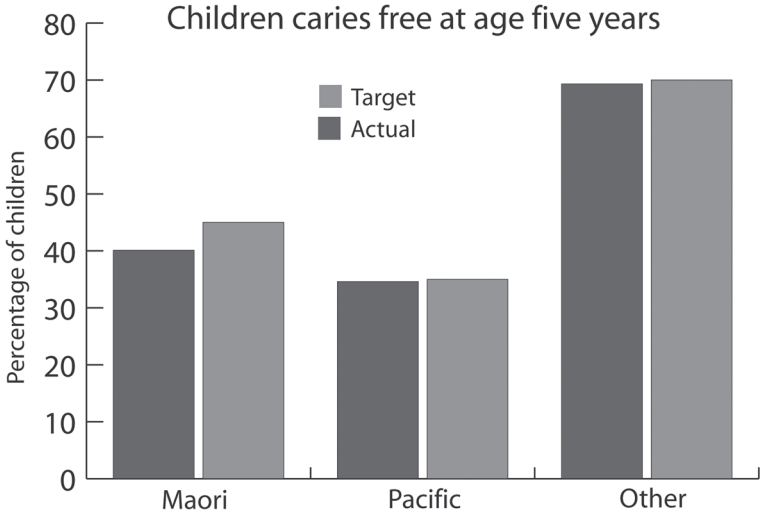
Other: 70%

Partially Achieved

Although targets have not been met, the percentage of Pacific and Other children caries free has improved from 2003. The percentage of Maori children caries free has declined slightly. Enrolment with the School Dental Services (SDS) is encouraged from age 2.5 years and earlier for the at risk groups (Maori, Pacific, low income). However most children do not enroll until age five.

Strategies to improve oral health at age five include:

- Trying to improve enrolment rates with the SDS by advocating earlier enrolment (age 2.5 years). The SDS are going to pre-school groups and providers to provide education and obtain enrolments.
- Engaging with Maori Health providers to improve enrolment.
- Educating care givers and other health providers on oral health matters for preschoolers and working collaboratively with regional Public health on developing further approaches and resources to address the problem.



Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Oral Health:

Mean Decayed, Missing and Filled Teeth (DMFT) score at Year 8 (Form 2).

Targets:

Maori: 1.1

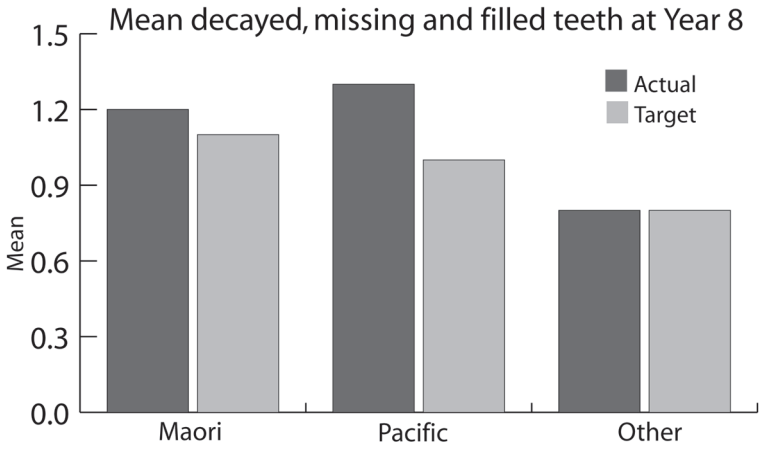
Pacific: 1.0

Other: 0.8

Partially Achieved

A comprehensive review of the School Dental Service was completed during 2004 and has proposed a move to a community based clinic model, with improved promotion, recognising the need to address high needs groups and communities. Other strategies to improve oral health are:

- Targeting of the dental service to highest risk children and providing higher levels of recall and preventive activity for children at highest risk.
- Engaging with Maori Health providers to improve general health.



Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Youth Health

Teenage Pregnancy:

The number of babies born live (discharge rate per 1,000) in a public hospital to mothers aged 13 to 17 inclusive.

Targets: Teenage Pregnancy

Maori 18

Pacific 9

Other 1.8

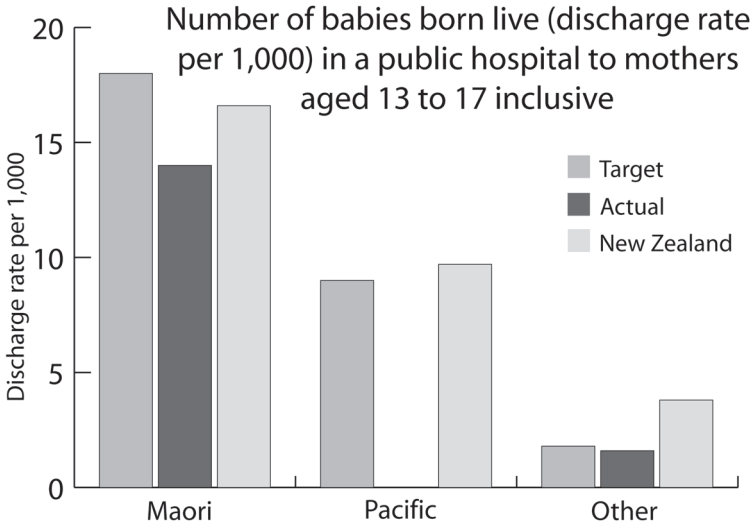
Achieved

We have achieved the targets and our focus is on reducing further the number of teenage pregnancies. However, we will continue to focus on good access to information and services, including contraception that supports young people in their sexual health.

We are currently reviewing sexual health services for young people and will focus on a range of free and youth friendly service settings as well as integrated health promotion and a youth development approach.

The national campaign of use of contraception may also have contributed to these outcomes.

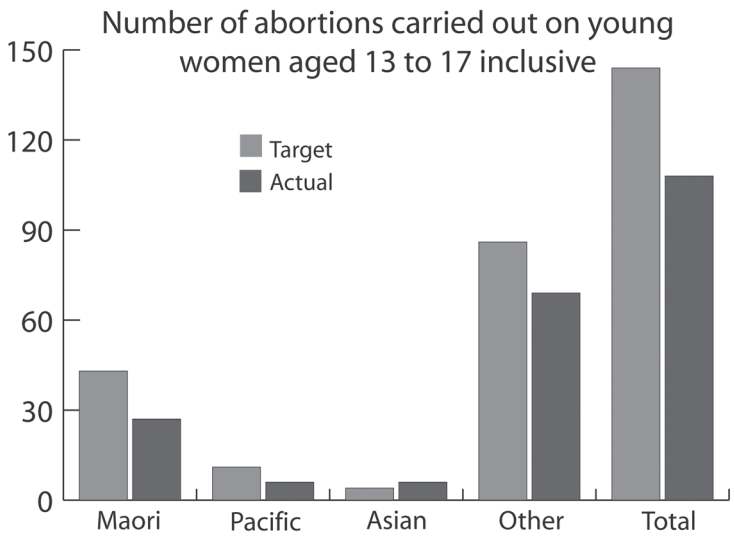
Pacific sexual and reproductive health promotion is contracted through Regional Public Health. We are working with RPH to jointly plan this year's programme.



Note: Data for Pacific teenage pregnancy in the District was not provided by the Ministry of Health.

Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Teenage Abortion: The number of abortions carried out on young women 13 to 17 inclusive: Teenage Abortion: Targets Maori 43 Pacific 11 Asian 4 Other 86 Total 144	**Partially achieved**  We achieved targets, except for Asian women, and our focus is on further reducing the number of teenage abortions. Specific attention will be given to the information needs of international students. We currently have a Chinese Social Worker on staff working with the Asian community to help support them through our services, with a goal of decreasing repeat terminations and increasing the use of safe and effective contraceptive choices. Sexual health services for young people have been the subject of review and additional investment as noted above in the teenage pregnancy section. As part of the commitment to our High Risk Youth programme, we have Social Work / Counselling staff specifically skilled in working with young people. We feel that it is important to note that only three of the patients in the graph above were 14 years of age and that there were no patients 13 years of age or less seen in the District.
Heart Services: Risk- adjusted standardised 30-day mortality rate following heart attack[2]. Target: 1	**Could not be measured** C&C DHB could not measure this performance target as the Ministry of Health could not provide information. Information regarding past performance is not available as this is a new performance measure.

[2] The Risk-Adjusted Mortality Index (RAMI) provides a means of comparing 30-day post-admission mortality by adjusting for patient risk on admission. The RAMI is simply the ratio of the actual to expected mortality rate for a DHB. The expected mortality rate, the anticipated rate for the DHB based on its mix of cases, was calculated using logistic regression.

Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Diabetes:

Case detection and follow-up rate. Estimated (by the Ministry of Health) diabetics on Diabetes Register.

Targets:

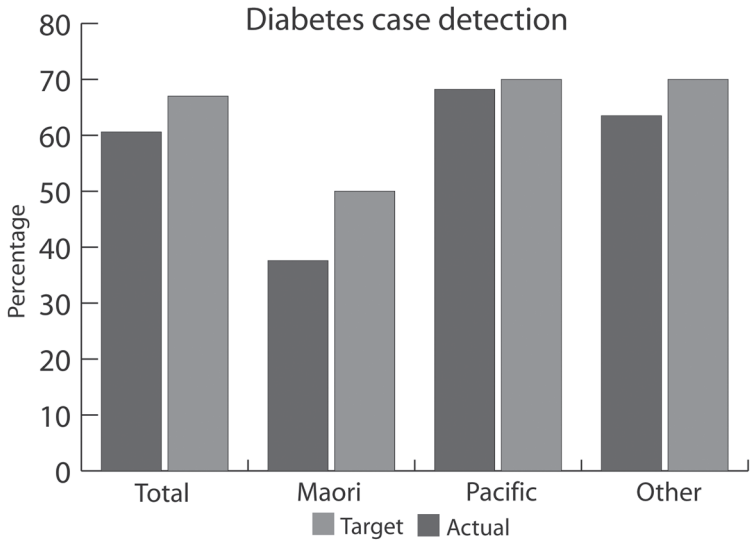
Total population: 67%

Maori: 50%

Pacific: 70%

Other: 70%

Not Achieved



While the overall volume of case detection increased, we set high percentage targets last year and did not meet them. We have seen some improvement but Maori 'case detection' (based on an Annual Check) remains unacceptably low.

An overall increase in primary care, an increase in diabetes-specific resource in primary care and specific Maori provider support all occurred in 2003/04. Rather than adjust the target, the DHB will re-emphasise this area as a priority for PHOs, primary care providers and the DHB.

Diabetes:

Case management. Number of people on Diabetes Register have better blood sugar control (HBA[1c] level below 8%).

Targets:

Total population: 24%

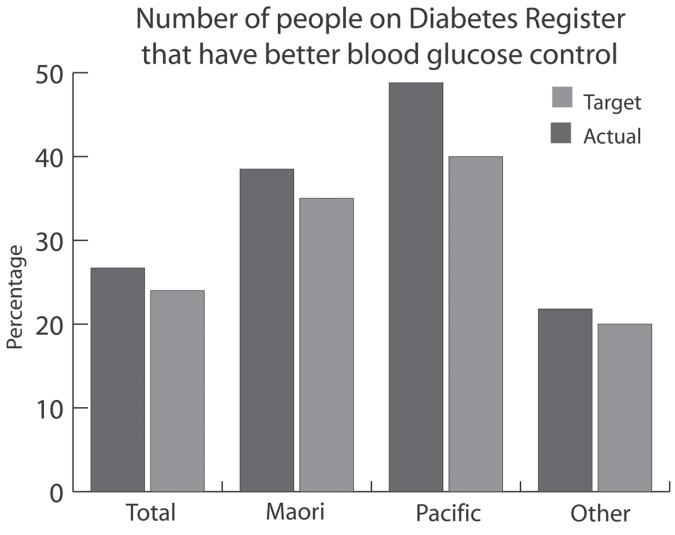
Maori: 35%

Pacific: 40%

Other: 20%

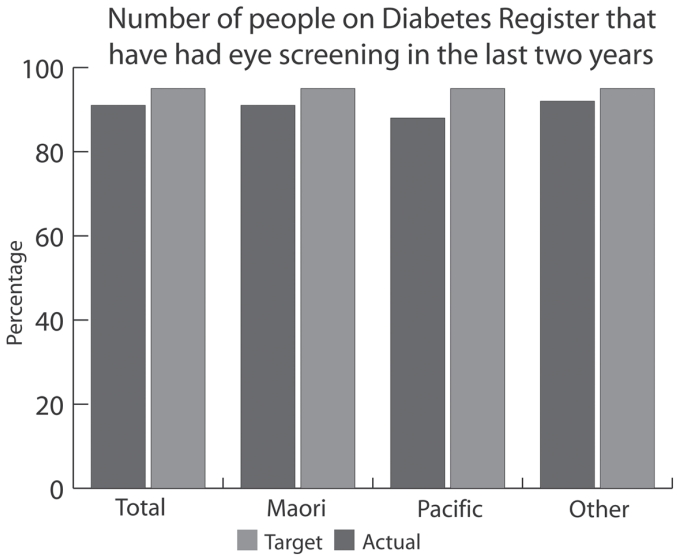
Achieved

It is encouraging that those attending primary care for Annual Checks show an improvement in blood sugar control. Disparities remain however.



Indicators of DHB performance [cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Diabetes: Eye screening. Number of people on Diabetes Register that have had eye (retinal) screening in the last two years. Targets: Total population: 95% Maori: 95% Pacific: 95% Other: 95%	**Not Achieved** In 2003, we exceeded our targets and set ambitious targets for 2004. The last 10% is hardest to achieve and we will continue to work to achieve these targets in 2005. Outreach clinics were held to improve coverage in 2004 and collaborative arrangements between providers to achieve outreach retinal screening in high need communities continues in 2005. 

Indicators of DHB performance[cont.]

The Ministry of Health has established a set of DHB performance indicators to focus DHBs on priority health and disability support objectives, identified in various Government strategies. Results of these indicators, which reflect improvement in service access and improvement are listed below:

Improving the health status of people with severe mental illness:

The average number of people domiciled in the DHB region, seen each month for the three months being reported.

Target:

child & youth aged 0-19

Maori 1.05%

Others 0.65%

Total 0.72%

adults aged 20-64

Maori 1.99%

Others 0.89%

Total 1.1%

older people aged 65+

Maori 0.95%

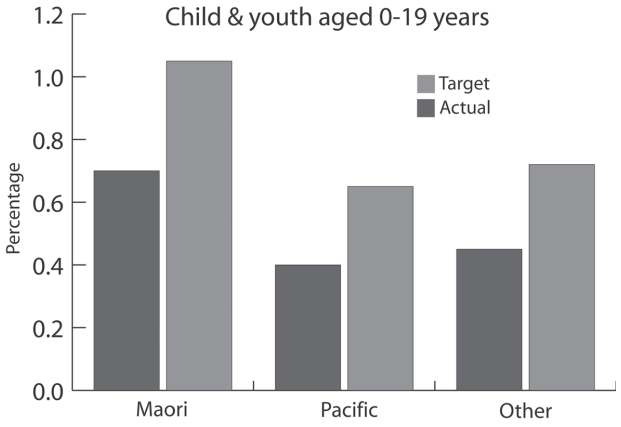
Others 0.26%

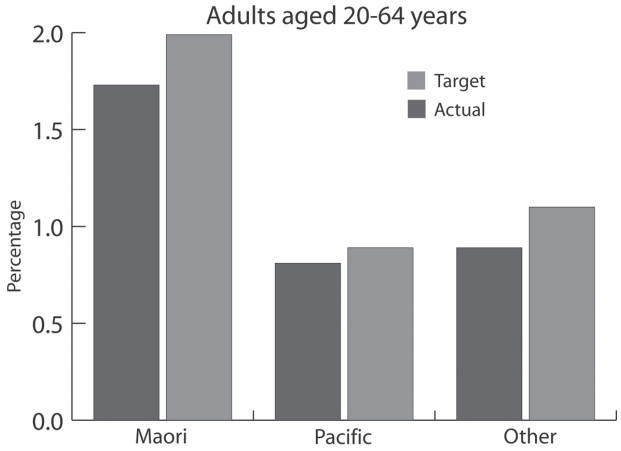
Total 0.28%

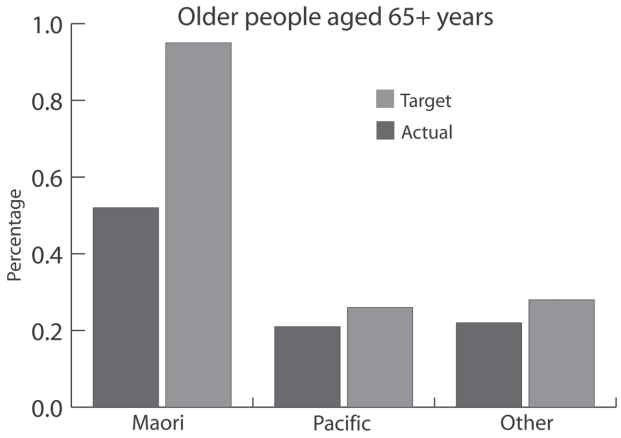
Not achieved

Overall there appears to have been a slight decrease in access compared to the prior period. We are also developing a strategic plan for mental health to address the issues of decreased access to services, including a couple of proposed pathways to improve the availability of community services and improve the recruitment and retention of mental health staff.

While we acknowledge non achievement of target, the integrity of the information is questionable. We are currently addressing the question of the integrity of the information and we have employed another staff member for the mental health data team.







Indicators of DHB's operations

Key performance indicators and achievements identified below are used to measure service access, efficiency and patients' satisfaction within our Hospital and Health Services (Provider arm of the DHB).

Description	Final Result
Waiting times This indicator is designed to measure the number of people who wait more than six months for their first specialist assessment and the number of patients with certainty waiting longer than six months for elective surgery and measures progress made on the Elective Services key strategic goal. It ensures that the health services are delivered in accordance with the Government's service priority for reducing waiting times for public hospital elective services.	**Not Achieved** We have signed off the Elective Services Performance Indicators (ESPI) recovery plan with the MoH that we will achieve ESPI compliance by June 2006. This will mean that 2% or less of the total volume of patients waiting for a First Specialist Assessment (FSA) will wait longer than six months. 5% of the total volume of patients waiting for Elective Surgical treatment will wait longer than six months. Although we have not achieved the targets set for this year, a lot of time has been focused on the Elective Services area. This included: ● activating and reviewing the Terms of Reference/membership of the Internal Elective Services Steering group ● reviewing the membership and Terms of Reference of the external steering group to reflect the changes over the past three years and ensure representation from the six PHOs. The focus has been on putting sustainable policies and processes into place with buy in from the services involved. We are working with Primary Care General Practitioners (GPs) and the Ministry of Health to improve the coordination between GPs and the Hospital and this initiative includes: ● The reassessment and re-referral by GPs of all patients who have been waiting longer than six months for their first assessment by a specialist in the areas of ophthalmology, otolaryngology and dermatology. ● The development of guidelines for GPs when referring patients to ophthalmology and otolaryngology services. ● The development of a brochure for patients to be included with their appointment letters. ● Improved communication between the DHB, GPs and patients when a referral is received by a hospital.

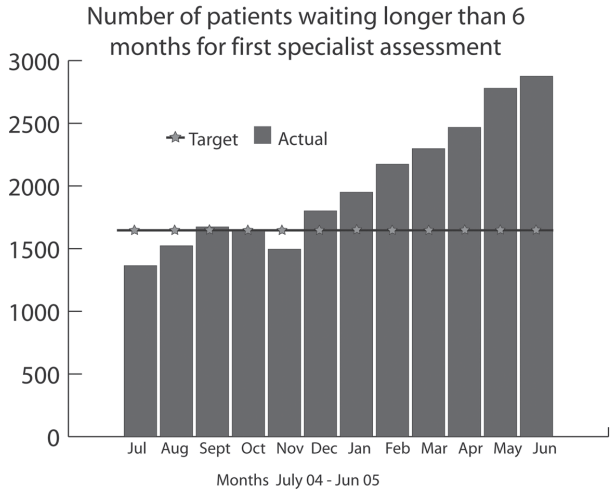
Indicators of DHB's operations [cont.]

Key performance indicators and achievements identified below are used to measure service access, efficiency and patients' satisfaction within our Hospital and Health Services (Provider arm of the DHB).

Target:

Number of patients waiting longer than six months for First Specialist Assessment 1,600

First Specialist Assessment (FSA)



Gains have been made in the acknowledgement of referral letters with 10 day time frame that includes expected wait times. All services have been reviewing their access criteria for FSA. This has included auditing the referrals with the Clinical leaders and GP Liaison and establishing what could be managed for longer by the GP and developing management guidelines.

In addition, nurse led clinics that have been established for a number of specialities will start to impact on the FSA numbers. An example of this is the Orthopaedic nurse led joint follow up clinic. With a trained nurse seeing one and two year joint follow-ups, the consultants will have more time available to see FSAs.

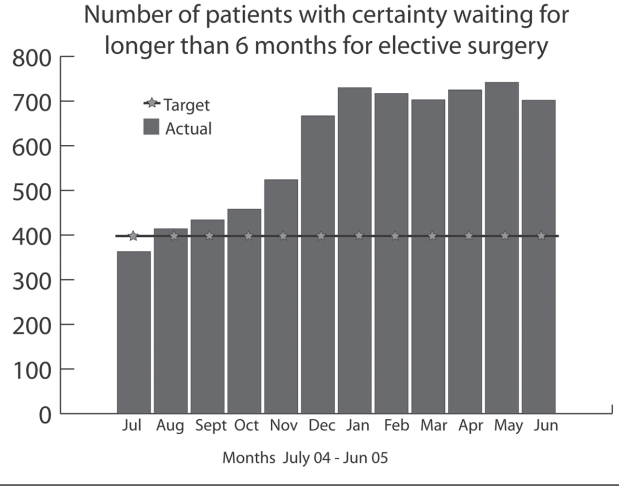
In addition, to clear the back log of patients who have waited longer than six months, additional clinics are being set up for Eye, Vascular and Ear, Nose and Throat (ENT).

Target:

Number of patients with certainty waiting for longer than six months for elective surgery 400

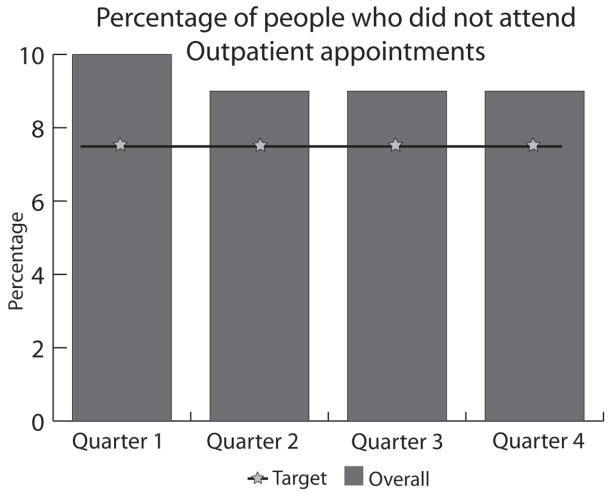
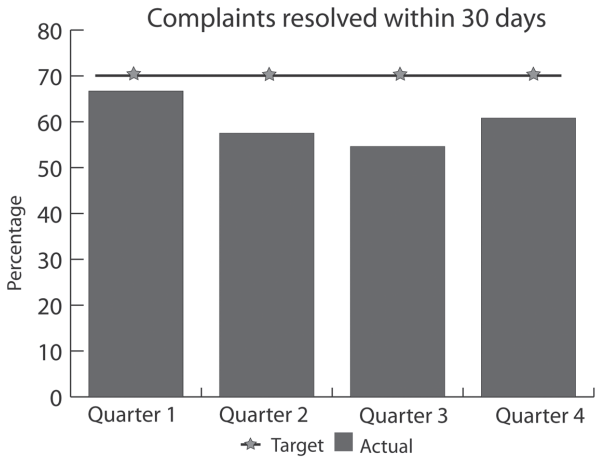
Treatment

A lot of work has taken place with each service on ensuring patients are placed in the correct treatment category and that we are not giving patients certainty until they are ready to have surgery. A new theatre will be operational in October 2005 which will increase the throughput of patients and reduce cancellations due to lack of theatre access. The theatre review has been completed and efficiencies identified in this review are currently being implemented.



Indicators of DHB's operations [cont.]

Key performance indicators and achievements identified below are used to measure service access, efficiency and patients' satisfaction within our Hospital and Health Services (Provider arm of the DHB).

Did not attends (DNAs) Every year a number of patients do not attend their out patient attendances. When a patient does not attend the appointment, the clinical time is not used and access to service reduces as we have fix number of outpatient clinics per year. Target 7.5%	**Not achieved** We have a 9% rate for DNAs for over two years now, the second lowest rate of all DHBs. We have put strategies in place to reduce the rates further. Moving to a centralised contact centre environment for First Specialist Assessments has increased our ability to improve contact with patients and remind patients of their out-patient appointments. We expect DNAs to reduce further as this initiative is implemented to all departments. A reduction of 1% in DNAs equates to 2,200 appointments per year. 
Complaints resolved This indicator measures the responsiveness to resolving consumer (patient) concerns that are expressed as formal complaints to the HHS. It also assists with monitoring compliance with legislative requirements regarding timely response to complaints. Target 70%	**Not Achieved** 

Indicators of DHB's operations [cont.]

Key performance indicators and achievements identified below are used to measure service access, efficiency and patients' satisfaction within our Hospital and Health Services (Provider arm of the DHB).

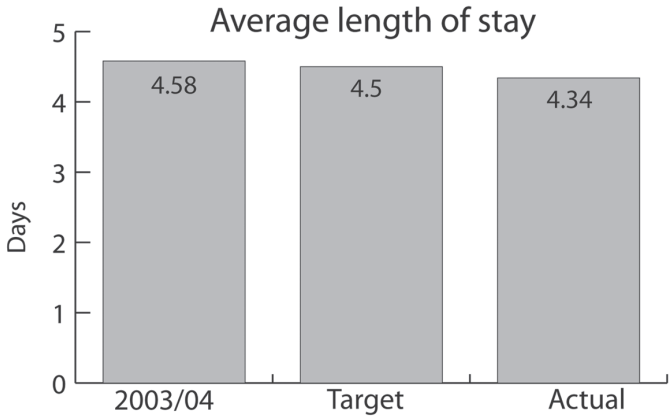
Average Length of Stay

One of the ways of measuring the efficiency of our HHS is measuring the average amount of time spent by a patient in hospital.

Target

4.50 days

Achieved



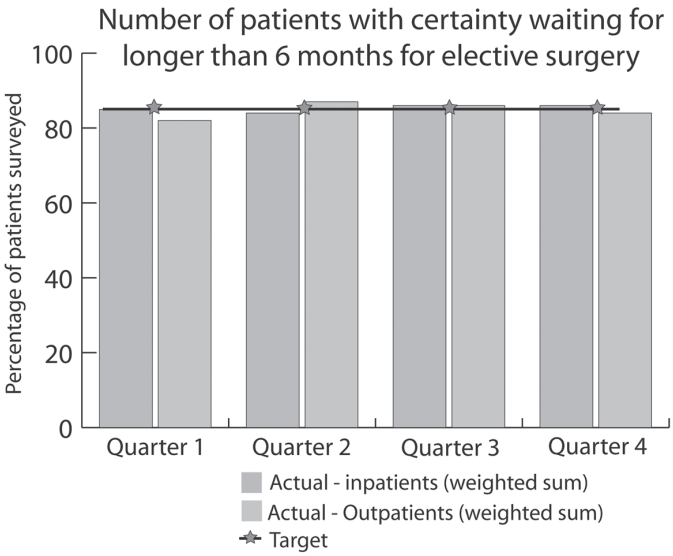
Patient satisfaction

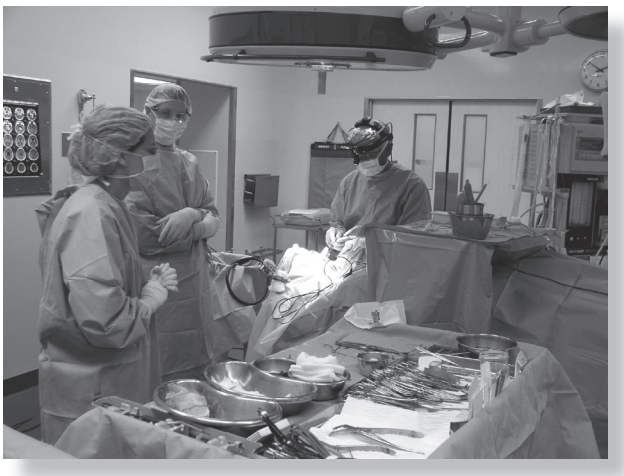
We regularly measure whether our patients are satisfied with the service they receive during their stay in hospital. The surveys also help to identify areas for improvement.

Target

85%

Achieved





Audit New Zealand

AUDIT REPORT

TO THE READERS OF CAPITAL AND COAST DISTRICT HEALTH BOARD'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

The Auditor-General is the auditor of the Capital and Coast District Health Board (the Health Board). The Auditor-General has appointed me, Rudie Tomlinson, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements of the Health Board, on his behalf, for the year ended 30 June 2005.

Unqualified opinion

In our opinion the financial statements of the Health Board on pages 19 to 73:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect:

  the Health Board's financial position as at 30 June 2005;

  the results of its operations and cash flows for the year ended on that date; and

  its service performance achievements measured against the performance targets adopted for the year ended on that date.

The audit was completed on 12 October 2005, and is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

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

Audit procedures generally include:

- determining whether significant financial and management controls are working and can be relied on to produce complete and accurate data;
- verifying samples of transactions and account balances;
- performing analyses to identify anomalies in the reported data;
- reviewing significant estimates and judgements made by the Board;
- confirming year-end balances;
- determining whether accounting policies are appropriate and consistently applied; and
- determining whether all financial statement disclosures are adequate.

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

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

Responsibilities of the Board and the Auditor

The Board is responsible for preparing financial statements in accordance with generally accepted accounting practice in New Zealand. Those financial statements must fairly reflect the financial position of the Health Board as at 30 June 2005. They must also fairly reflect the results of its operations and cash flows and service performance achievements for the year ended on that date. The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you. This responsibility arises from 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.

Independence

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

In addition to the audit we have carried out an assignment reviewing the non-financial performance measures in the draft statement of intent, which is compatible with those independence requirements.

Other than the audit and this assignment, we have no relationship with or interests in the Health Board.

R L Tomlinson
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

About C&C DHB

Directorate of Service Planning & Funding

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

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

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

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

Hospital & Health Services

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

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

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

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

Specialist tertiary-level care is provided to patients from the wider region, serving a population base of around 900,000. These services include cardiology and cardiothoracic surgery, neurology, neurosurgery, vascular surgery, renal medicine and transplants, genetics, oncology, paediatric surgery, neonatal intensive care, obstetrics, endocrinology, gynaecology, orthopaedics, urology, and specialist forensic services.

Wellington Hospital

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

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

Kenepuru Hospital

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

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

Kapiti Health Centre

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

Community Services

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

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

Board and Committees:

The following members were elected in October 2004 and currently hold office: Judith Aitken, Brendon Bowkett, Ruth Bradwell, Peter Dady, Ken Douglas, Ruth Gotlieb and Helene Ritchie.

Members appointed by the Minister of Health in December 2004: Bob Henare (Chair), Margaret Faulkner, Kiri Parata and Fuimaono Karl Pulotu-Endemann.

BOARD COMMITTEES

1 July 2004 – 30 June 2005

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE	
Committee for the period 1 July 2004 – December 2004	
John Cody (Chair) Tino Pereira Karl Geiringer Bob Henare (ex officio) or Margaret Faulkner (ex officio)	External Members Stephen Palmer Kiri Parata (Appointed Board member December 2004) Herani Demuth Sandra Jensen (term ended February 2005)
Committee for the period December 2004 – 30 June 2005	
Fuimaono Karl Pulotu-Endemann (Chair) Kiri Parata Brendon Bowkett Bob Henare or Judith Aitken –ex officio alternate	External Members Stephen Palmer Herani Demuth Ida Faiumu-Isaako (commenced 3 March 2005)

DISABILITY SUPPORT ADVISORY COMMITTEE	
Committee for the period 1 July 2004 – December 2004	
Margaret Faulkner (Chair) Helene Ritchie Bob Henare (ex officio) Chris Turver	External Members Valerie Bos John Forman Tupu Ioane-Clever-ley Grace Moulton Wendi Wicks Liz Mellish
Committee for the period December 2004 – 30 June 2005	
Margaret Faulkner (Chair) Ruth Bradwell Helene Ritchie Bob Henare or Judith Aitken – ex officio alternate	External Members Valerie Bos John Forman Tupu Ioane-Cleverley GraceMoulton Wendi Wicks Liz Mellish

HOSPITAL ADVISORY COMMITTEE	
Committee for the period 1 July 2004 – December 2004	
Ian Shearer (Chair) Ruth Gotlieb Helmut Modlik Bob Henare (ex officio) **or** Margaret Faulkner (ex officio)	External Members
	Marion Bruce Hilda Broadhurst Don Mackie *(resigned December 2004)*
Committee for the period December 2004 – 30 June 2005	
Ken Douglas (Chair) Ruth Gotlieb Peter Dady Bob Henare – Judith Aitken – ex officio alternate	External Members
	Marion Bruce Hilda Broadhurst Lani Wills *(commenced 3 March 2005)*

FINANCE, RISK AND AUDIT COMMITTEE	
Committee for the period 1 July 2004 – December 2004	
Judith Aitken (Chair) Bob Henare Helmut Modlik	External Member
	Neil Stiles
	External Attendees
	KPMG Audit New Zealand
Committee for the period December 2004 – 30 June 2005	
Judith Aitken (Chair) Bob Henare Margaret Faulkner	External Member
	Neil Stiles
	External Attendees
	KPMG Audit New Zealand

STRATEGIC COMMUNICATIONS COMMITTEE
Committee for the period 1 July 2004 – December 2004 (then discontinued)
Bob Henare Tino Pereira Chris Turver

BOARD REPRESENTATIVES TO MAORI PARTNERSHIP BOARD
For the period 1 July 2004 – December 2004
Bob Henare Helmut Modlik
For the period December 2004 – 30 June 2005
Bob Henare (Chair) Judith Aitken Kiri Parata Fuimaono Karl Pulotu-Endemann

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