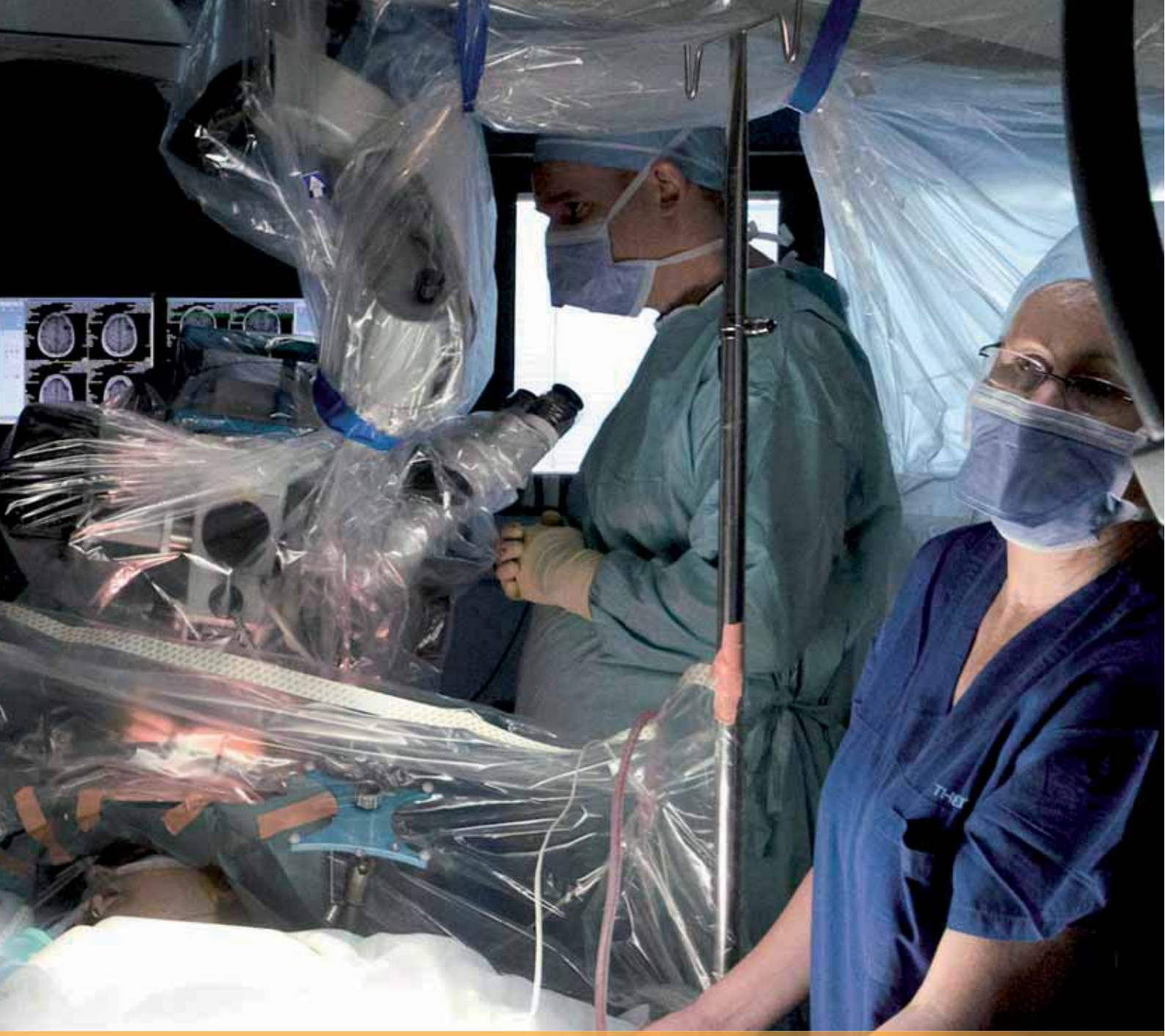

ANNUAL REPORT

2010/2011

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

TABLE OF CONTENTS

The C&C DHB Annual Report 2011 is published online at **www.ccdhb.org.nz / about us**

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Phone (04) 385 5999

Cover photo of awake craniotomy, at Wellington Regional Hospital.

Photo taken by Louise Goossens, Otago Medical team.

ABOUT OUR ANNUAL REPORT

A DAY IN THE LIFE:

- Over 150 patients are admitted to our hospitals. About 50 of these are 'day patients' receiving treatment or surgery which is not expected to require an overnight stay
- Around 3226 patients are seen by a GP or a primary health care nurse
- About 55 patients undergo surgery
- 1400 outpatients are seen
- About 300 patients are examined in radiology
- 240 clients are seen by our mental health community teams
- About 1100 laboratory tests are performed in the hospital laboraties
- 5400 prescriptions are filled by community pharmacies
- 75 people have their vision checked
- About 135 people are assessed at Wellington Regional Hospital Emergency Department, and more than 95 are assessed at Kenepuru Community Hospital's Accident & Medical Clinic
- 2 patients are admitted to the Intensive Care Unit at Wellington Regional Hospital
- Around 3800 tests are performed by the community laboratory
- 7 patients are flown to, or from, Wellington Regional Hospital
- 11 babies are born
- 35 infants are cared for in Wellington Regional Hospital's neonatal unit
- More than 675 medical records are processed
- 8000 phone calls are answered by telephonists
- 5000 letters are processed in the mailroom
- 1350 people are cared for in subsidised aged residential care
- 1300 clean sheets are sent out from the hospital's own laundry
- 1900 meals are prepared and distributed (1150 at Wellington Regional Hospital, and 750 at Kenepuru Community Hospital).

2011 ANNUAL REPORT

This report presents Capital and Coast District Health Board's (C&C DHB) performance for the year 1 July 2010 to 30 June 2011. It provides an overview of what the DHB committed to deliver in that year and how it met that commitment.

The Annual Report outlines progress against our Statement of Intent (SOI) 2010/11, and provides a detailed account of how the health funding received by C&C DHB has been managed. The SOI is an annual statutory document which determines our course of activities for the financial year including milestones and measures. It includes long-term goals and annual accountability objectives and is the formal accountability document between the Government and C&C DHB.

MESSAGE FROM THE CHAIR

Dr Virginia Hope

Following the October 2010 Health Board Elections, a number of cross-Board appointments were made to District Health Boards in the interests of closer collaboration between neighbouring District Health Boards. I was appointed by Health Minister Tony Ryall as joint Chair for both Capital & Coast and Hutt Valley District Health Boards. Capital & Coast Deputy Chair Peter Glensor is also an elected member on the Hutt Valley Board and Committee Chairs Keith Hindle and Peter Douglas and Crown Monitor Debbie Chin have also been appointed to both Capital & Coast and Hutt Valley District Health Boards.

While Hutt Valley and Capital & Coast have always had a close working relationship, these cross-board appointments signalled a further emphasis on greater sub-regional collaboration in the planning and delivery of health services for the wider Wellington region.

C&C DHB delivers around 31% of Hutt Valley's elective surgery each year and Hutt delivers around 12% of C&C DHB's elective services. Our populations often live in one DHB catchment, work in the other, and use health services in both so a collaborative approach has the potential to improve health services for the populations of both District Health Boards. A common Chair and members, governance structures and joint strategic processes provide opportunities to achieve this whilst enabling the two District Health Boards to continue to focus on their own populations for local services and retain their own strengths and community links.

C&C DHB delivers around 31% of Hutt Valley's elective surgery each year and Hutt delivers around 12% of C&C DHB's elective services.

As Chair I see significant opportunities to leverage off the strengths of each DHB and improve outcomes for both our populations. I am very encouraged by the opportunities that exist to improve health services, and operational efficiency through much greater collaboration between local, sub-regional (Capital & Coast, Hutt, and Wairarapa) and central regional (sub-regional DHBs along with Mid-Central, Hawke's Bay, and Whanganui) DHBs.

As DHBs continue to work together to improve the way we deliver services, Capital & Coast will continue to unlock financial savings that will contribute to our organisation's financial sustainability, and allow us to continue to invest in improved population health.

One example of this is the building of stronger relationships with Primary Care and other NGO sector partners. The DHB has made substantial progress in

our plans to reconfigure primary care organisations and integrate hospital services into community settings in 2010/11. In the past year, we have crystallised the focus of the DHB on patient outcomes. We are realigning our structure to support greater local decision-making and community engagement.

We have also created strategic clinical networks for specific areas of patient care, such as cardiac, mental health, cancer, and others, which allow our doctors, nurses, therapists and other health care professionals to collaboratively share best practice, face new challenges and create new and innovative approaches to patient care locally and regionally.

Arriving at our present position has required a focussed approach to the management of costs while maximising our revenue opportunities.

In the 2010/11 year, our budget and priorities were more closely aligned than ever before. We continue to streamline administration, eliminate duplication and collaborate with our sub-regional partners across a wide range of clinical and non-clinical areas. This resulted in us meeting the planned year end result.

While we have made good inroads into making sustainable savings, we continue to implement and refine the recovery plan developed some years ago. The Board remains focussed on meeting the health needs of our population, ensuring optimal service coverage and reducing disparities amongst vulnerable populations. Service reconfiguration and provider consolidation remain important mechanisms in delivering against the recovery plan over the coming years, as does ongoing work with national initiatives such as the procurement programme and the National Health Information Technology Board.

On behalf of the Board, I would like to pay tribute to former Board Chair Sir John Anderson for his commitment to Capital and Coast District Health Board and his wisdom, guidance and steady hand over the past triennium.

It is with sadness that we heard of the passing of our colleague Dr Donald Urquhart-Hay in August 2011. Dr Urqhuart-Hay was a urologist especially well-known in Wellington and Kapiti. He brought a knowledge of local medical history, clinical pragmatism and a sense of humour to the board table which will be missed.

I would also like to thank the executive team for their focus and determination over the past year. Former Chief Executive Ken Whelan, Acting Chief Executives Shaun Drummond and Stephen McKernan, and now our new Chief Executive, Mary Bonner collectively provided the leadership to bring us through a challenging year. Along with senior managers and clinicians they helped us develop a strong sense of purpose and direction in our community and with our neighbours.

Finally, I would like to thank the Board and all the staff at Capital & Coast for their support and commitment to the people of this region. We will continue to move forward, putting our patients and their families first.

Dr Virginia Hope

Chair

MESSAGE FROM THE CEO

Mary Bonner

It is never easy coming into an organisation part way through a financial year when the priorities have been set and work already well underway. Capital & Coast has a reputation for great leadership, strong clinical governance and staff who are dedicated and skilled. That is exactly what I found when I arrived in March. I am proud to lead an organisation where the commitment of staff is so focussed on making our patients and clients transition back to full health as smooth as possible. While the 2010/11 year saw an extraordinary amount of change in the Chief Executives office, I'd like to acknowledge the smooth transition between Ken Whelan, Shaun Drummond and Stephen McKernan before my arrival. That the transition process went so well is due to the hard work, clear change processes and welcoming manner of all staff.

As a DHB, our collective challenge is to continue to find savings while maintaining our commitment to patients.

Alongside all of that Capital & Coast managed to deliver solid results against aggressive deficit targets while carrying on with business as usual. Our achievements in meeting the six health targets, as identified by the Ministry of Health, all show good gains, especially around short waiting times for oncology services, better access to diabetes and cardiovascular services as well as providing help for smokers to quit. Our elective surgery targets were exceeded by 239 surgical discharges.

Immunisation rates for 2 year olds are also a key government priority, and C&C DHB has achieved target and is well placed for the increase to a 95% target by 30 June 2012. Immunisation rates for Māori and Pacific two year olds remain consistently high with one Primary Health Organisation achieving 100% for their Māori and Pacific two year old cohort. This demonstrates C&C DHB's success in reducing inequalities in immunisation rates.

While we still have some way to go in meeting the Emergency Department target, we are starting to see gains in this area. The opening of the new Minor Care Zone in ED, in April 2011, is one initiative designed to help us in this area. Developed with the patient in mind, this predominately nurse-led area, will assist to manage patient flow much more efficiently and support the patient's journey as they are assessed, triaged, educated and discharged.

There were several major projects undertaken in the past financial year that have had a positive impact on the way we work as well as the way we deliver services. Information Communication Technology department successfully migrated the old data server into a new Data Centre during April and May 2011. This was a huge undertaking and combined with the 2010 roll out of the second stage of the

Electronic Health Record has meant a more user-friendly and more reliable information system that will help clinicians to improve the quality of healthcare.

In March this year patients in Wellington's Te Whare O Matairangi (TWOM) were relocated to the Kenepuru campus so that a 14 month redevelopment project of the mental health building, including earthquake strengthening, could begin. There has been a huge amount of work done by mental health staff, who have been looking at work practices and models of care to ensure that the new physical environment supports the model of care. We are all looking forward to opening this modern purpose built facility in early 2012.

The opening of the new Research Office and Clinical Trials Unit in April this year confirmed the DHBs commitment to research. This allows us to be at the forefront of planning and developing research and being involved in collaborative studies with our partners Victoria University, Otago University and MRINZ. The integration of Clinical Research in tertiary hospitals is an important part of their development and this initiative will help fully establish Wellington Regional Hospital as a research hospital.

Regional and sub-regional work continues to be a major focus, with areas such as diabetes, Health of Older People and Ear, Nose and Throat initiatives showing positive outcomes. A haematology chemotherapy outreach pilot at Kenepuru Hospital is proving an innovative way to expand Blood & Cancer service delivery to the community. A specialist wound care clinic in Cannons Creek has set an international benchmark for healing rates, which are 13% higher than the national figure of 55% and has resulted in a dramatic reduction in the need for patients to be admitted to hospital for skin ulcers.

With family in Christchurch I was impressed to hear of Capital & Coast's response to support its fellow DHB after the devastation of the February earthquake. It was a timely reminder to us all of the importance of having robust emergency management processes in place and of the important role Primary Care staff

Pōwhiri for Mary Bonner
February 2011

have in a mass casualty situation. My goal going forward is to review and enhance our approach in light of the lessons all DHBs learnt from the Christchurch experience.

As a DHB, our collective challenge is to continue to find savings while maintaining our commitment to providing the best possible service to patients. We also need to simultaneously adhere to the Ministry of Health's quarterly targets, and meet the many daily challenges that a busy tertiary hospital offers. C&C DHB has some integrated care service development occurring under the umbrella of the Primary Secondary Clinical Governance Group and the Clinical Pathways Collaborative process. The DHB has already devolved significant services to Primary Care as part of the Better, Soon, More Convenient policy and we will continue to work together on areas where integrated care is the best option for our community.

The coming financial year is going to present many challenges for us all. Since my arrival at C&C DHB I have found a great sense of focus and teamwork evident throughout the hospital and I'm sure that through thinking smarter and changing simple everyday habits we can all make a difference.

Mary Bonner
Chief Executive

ABOUT C&C DHB

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

Currently almost 298,000 people live within the Capital & Coast district, with two thirds of the population in Wellington City, 18% in Porirua and 14% on the Kapiti Coast.

C&C DHB assesses the health status of the population and determines what funds should be directed to preventing illness and early intervention of illness (via primary health and public health services), while continuing to provide and improve existing hospital and other specialist services.

C&C DHB is the leading provider of specialist tertiary services for the upper South and lower North Islands, which includes a population of about 900,000.

In all, the DHB offers hospital services across a wide range of specialist areas including; cardiology and cardiothoracic surgery, neurosurgery, vascular surgery, renal medicine and transplants, genetics, cancer services, paediatric surgery, neonatal intensive care, obstetrics, endocrinology, orthopaedics, urology, and specialised forensic services.

Community-based services provided include both 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, alcohol and addiction services.

C&C DHB operates two hospitals; Wellington and Kenepuru, supported by the Kapiti Health Centre, a large Mental Health campus at Kenepuru and other community based services. It is a major employer in the Wellington region with about 3,500 full-time equivalent staff with an additional number working on a part-time or casual basis; in total over 5000 staff.

The health of our population

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

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

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

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

We have fewer than average Māori (10%) and a higher than average Pacific (7%) and Asian (9%) populations. The Māori and Pacific populations are younger than other groups in the district, and comprise more children and fewer elderly people.

Overall our district is relatively advantaged in terms of socioeconomic deprivation, with nearly a quarter of the population living in the least deprived areas (NZDep2006 decile 1). However, there are pockets

of deprivation in Porirua and south east Wellington and those communities experiencing poorer health outcomes. Māori and Pacific people are more likely to live in a deprived neighbourhood and have significantly higher rates of avoidable morbidity and mortality than other ethnic groups.

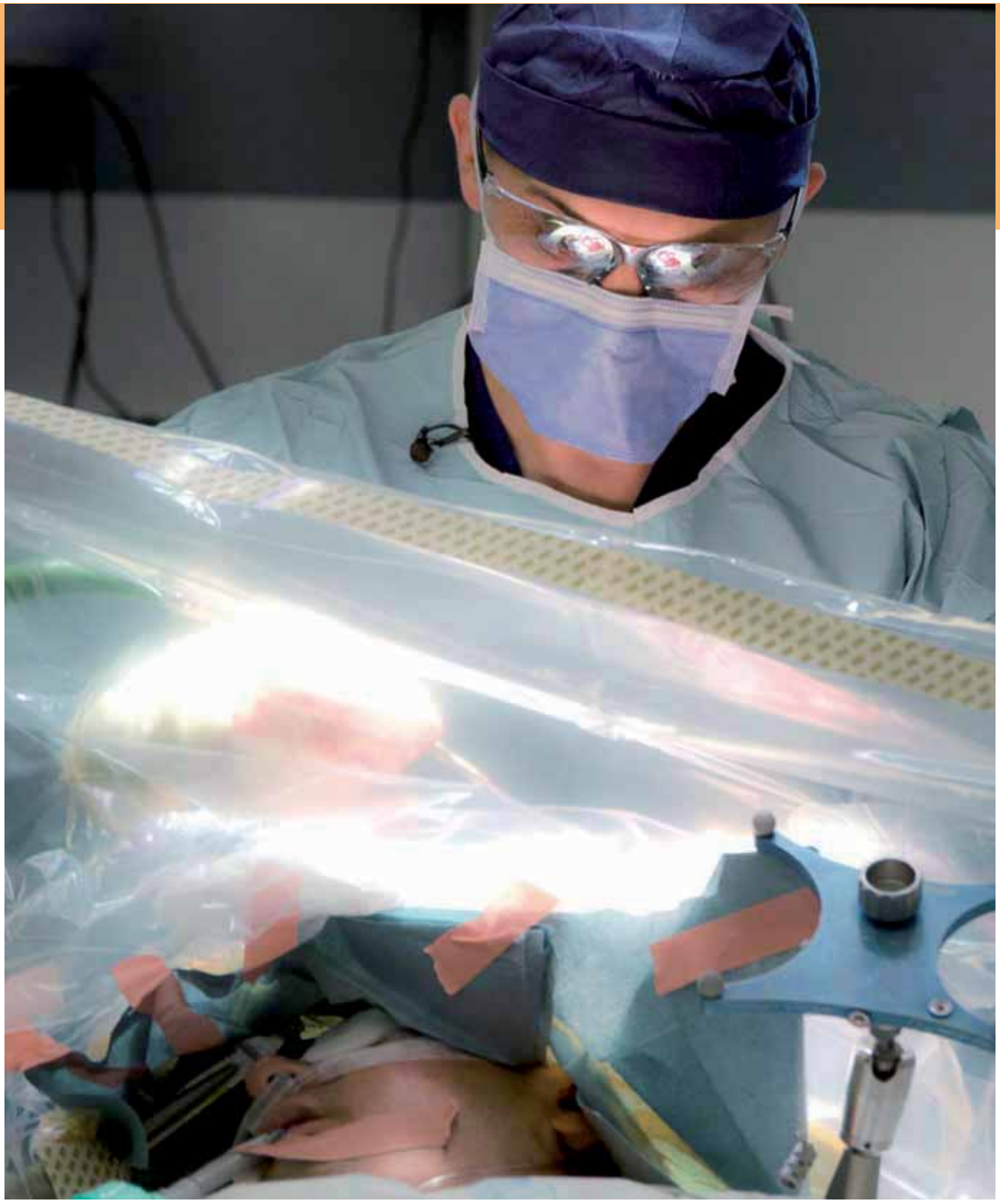
The district population is predicted to increase 15% by 2026 with the highest growth in Wellington and Kapiti. The proportion of Māori and Pacific will increase. Like the country as a whole, the population will age over the next 20 years with the number aged over 65 years to grow by 78% and an expected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

Key health issues for this DHB include:

Reducing the incidence of long term conditions (such as cardiovascular disease, diabetes and respiratory conditions) and minimising the impact on people's daily lives. Māori and Pacific tend to have earlier onset of long term conditions than other groups.

- The burden of cancer and reducing disparities in survival
- Experience of mental illness and its unequal impact on younger, disadvantaged population groups
- Addressing issues for children and youth, including oral health, respiratory, skin infections and injuries, mental health and youth suicide, as well as sexual health
- Health of older people, including management of long term conditions, cancer, musculoskeletal disease (for example, arthritis, osteoporosis), injury from falls, the impact of dementia, and home and community support needs
- Responding to the needs of 15% of the district population estimated to have a disability.

For more detail on the health needs of our population see the 2010 – 2011 Annual Plan.



STRATEGIC DIRECTION

OUR VISION

Better health and independence for people, families and communities. We understand that we must work with our communities to help reduce disparities in health status and reduce the incidence of chronic conditions amongst our population while increasing the independence of the people in our district.

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

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

OUR VALUES

As a healthcare provider, we work according to core values:

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

STRATEGIC GOALS

We aim to meet the Government's service objectives as well as the needs of our population through:

- Reducing health disparities within our population
- Further developing the infrastructure that supports integrated delivery of services
- Maintaining financial and clinical sustainability of services
- A culture that embraces collaboration with C&C DHBs local and regional provider partners.

CHIEF MEDICAL OFFICER

Dr Geoffrey Robinson

There has been a continuing emphasis from the Minister of Health for clinical leadership, and I believe C&C DHB has taken this up with alacrity and success. Clinicians – including Clinical Directors, the Director of Allied Health and the Director of Nursing & Midwifery and myself - are on the DHB Executive Management Committee.

Many senior doctors are in clinical leadership roles as Directors or Clinical Leaders (Heads of Departments), or on sub-committees of the Clinical Governance frameworks, which includes the important Primary/ Secondary Governance Committee. The latter is the formal interface with Primary and Community Services and develops interface issues including referral processes, discharge planning, IT systems, medication management and clinical pathways.

The introduction of a National Medicines Prescription Chart has made a considerable advance regarding medicines safety.

It was particularly gratifying that Capital & Coast DHB came second in the Association of Salaried Medical Specialists survey on clinical governance and leadership in 2011. This was a significant improvement on previous years.

It is notable that over the past year, the DHB has fewer major adverse clinical events and adverse media exposure arising from the Health and Disability Commissioner or Coronial findings.

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

The introduction of a National Medicines Prescription Chart has made a considerable advance regarding medicines safety.

The long awaited new electronic patient clinical record system, Concerto, has been welcomed by hospital clinicians. This encompasses clinical discharge summaries and investigations – all readily accessible; and is a considerable advance from old electronic records. Clinicians are looking forward to new easy linking to Wairarapa and Hutt Valley via an icon for each of these DHBs.

Capital & Coast continues its successful tradition of providing a strong commitment to undergraduate and post-graduate medical education, in partnership with the University of Otago Wellington School of Medicine, the New Zealand Medical Council and Medical Colleges. The DHB is also supporting General Practice Training in conjunction with Health Workforce New Zealand initiatives.

Wellington Regional Hospital's new educational facilities have been well used this past year for local, national and international conferences. Together with the Research Office and Clinical Trials Unit, and the simulation skills facility, our reputation as a tertiary hospital that fosters teaching and ongoing staff development will continue to attract high calibre academic senior medical staff and clinicians to our region.

A great deal of time and effort from senior clinicians continues to be directed towards regional DHB integration, both in the lower North Island and sub-regionally with Hutt Valley and Wairarapa DHBs. Plans have been developed for joint clinical governance, joint appointments, regional leadership and service planning. The current DHB planning and funding models, Human Resources and Occupational Health frameworks are being revised to accommodate Regional Clinical Services planning.

There will soon be a Regional Clinical Governance Committee set up over six lower North Island DHB's which will oversee endeavours of the regional training hub, regional credentialing and policy alignment with health and safety ideals.

A pleasing trend during the past year has seen a more meaningful engagement with local Primary Care/Community and hospital clinicians with current work streams on Acute Demand/After Hours, Long Term Conditions, and Health of Older People aligned with the Ministry's "Better, Sooner, More Convenient" principles.

DIRECTOR OF NURSING & MIDWIFERY

DIRECTOR OF NURSING
PRIMARY HEALTH & INTEGRATED CARE

Kerrie Hayes, Director of Nursing and Midwifery, and Vicky Noble, Director of Nursing, Primary Health and Integrated Care

The Directors of Nursing for the Hospital and Health Service (HHS) and Primary Health Care & Integrated Care have worked closely together to achieve the best possible outcomes for the population of the C&C DHB region. Our focus has been on further integrating primary and secondary health care services to ensure a smooth transition for people and their families/whanau, not only between services but also across DHBs.

Our Nursing and Midwifery teams across the DHB continue their commitment to provide person/family centred care using current evidence to assist people to achieve their optimum health.

This year's priority actions to achieve this have focussed on:

- Safe care, including Releasing Time to Care and sub-regional collaborative activities with Hutt and Wairarapa DHBs (e.g. a shared preceptorship programme for all nurses)
- Enabling better teamwork
- Growing and supporting our Nursing and Midwifery Workforce
- The Releasing Time to Care module which has been introduced to Wards 6 and 7. In Ward 7 North direct patient time has been lifted from 35% to 45%, medication errors are down from 10 a month to one a month and patient complaints have dropped from 20 a year to just 4.

We have seen a wide range of initiatives and activities to develop the capability of our workforce designed to improve health care provision. Highlights include:

Enrolled Nurses transitioning to new scope of practice

Enrolled Nurses (ENs) now have an expanded scope of practice which allows them to be more involved in nursing assessment and treatment. The DHB designed a transition process for all ENs across the DHB. This process was especially welcomed by ENs in the aged care and other primary health care settings. So far, of the 44 ENs in aged residential and primary health care settings, 72% have completed the transition process. Within the hospital services, 80% of ENs have completed the process with one nurse assistant working within conditions specified (due to imminent retirement) and four working towards their full scope of EN practice.

Nurse Practitioner workforce development

The development of our nursing and midwifery workforce is key to future-proofing our health service delivery and increasing the safety and effectiveness of care in our communities. This last year has seen the realisation of recent work focused on the development of a nurse practitioner pathway and the expanded scope of practice for registered nurses.

- In May 2011 one Nurse Practitioner successfully completed an application to Nursing Council in the area of Mental Health (with prescribing)
- Five Nurse Practitioner Candidate positions have been established in the following areas: child health, primary health care (general practice), older adult health, palliative care, and diabetes and long term conditions. These nurses will progress to applications to Nursing Council in the second half of 2011
- Two Nurse Practitioner Candidate positions are currently being explored within the Emergency Department with a further two primary health care positions in the scoping stage.

Expanded scope of practice for Registered Nurses

This project has formalised the process for credentialing expanded registered nursing roles. The first credentialed role for C&C DHB is a Surgical Assistant in Women's Theatres.

Professional Development and Recognition Programme

A growing number of primary health care nurses, including aged residential care and hospice nurses are accessing C&C DHB's Professional Development and Recognition Programme (PDRP).

The 2010 revised programme has made entry to the PDRP more streamlined and accessible. It is now a requirement for all nurses and midwives accessing professional development funding to participate in either the PDRP (for nurses) or the Quality Leadership Programme (for midwives).

Nurse Entry to Practice Programme

In 2011, 58 graduate nurses were supported through their first year of practice while simultaneously undertaking a post graduate Certificate paper in Nursing. A principle focus of this paper is on strengthening skills, knowledge and expertise in health assessment (including mental health and cultural assessment). Growing our workforce has included targeting areas of shortage for the future.

- 20 Mental Health Nurses with more expected to come
- Three Pacific new graduate nurses supported into primary health care practices and all have succeeded in the Nursing Entry to Practice programme. It is pleasing to note that all three have now been employed by their supporting practices
- Scholarships awarded to two hospital based health care assistants to undertake undergraduate nursing (BN) studies.

Porirua Kids Action Project

Primary health care nurses have been actively engaged in this programme which aims to address rheumatic fever in Porirua East. This programme includes the development of standing orders for registered nurses to provide assessment and treatment for children presenting with sore throats.

DIRECTOR OF ALLIED HEALTH, TECHNICAL & SCIENTIFIC

Sally Taylor

"One voice – many different professions"

The past year has reminded me how well healthcare workers care for and support each other. As Canterbury dealt with the realities of a major earthquake and many aftershocks, our staff supported in whatever way they could. Some went and worked there and many sent down care packages with the flight team with helpful provisions and things to help them smile in challenging times.

In 2010/11 we have seen a concentrated effort on supporting our staff to orientate to our organisation and to be an employer of choice. It has been a pleasure to attend our orientation day and be a part of the welcoming powhiri. We are certainly a multicultural workforce. It is heartening to know that over 90% of our Allied Health, Technical and Scientific staff feel well supported and oriented to our organisation and the team that they work within.

The past year has seen a number of Allied Health Technical and Scientific Developments such as:

- A change in the prescribing legislation allows dietitians to prescribe nutritional supplements. The majority of our dietetic staff have completed the training and have had this scope of practice endorsed by the Dietitian's Board
- We have developed and endorsed a framework for designated positions for Allied Health. This has then led to the implementation of a Psychotherapy Professional Leader function
- A psychological first aid module has been developed as part of the regional welfare advisory group, a sub committee of the regional emergency management structure
- We had the pleasure of hosting a number of national events within the recently redeveloped education centre including: the National Allied Health Summit, the National DHB Physiotherapy Leaders group meeting, National Dietetics Leaders meeting and the National Assistants Conference. For the first time the National Assistants Conference was an

interprofessional assistant's conference and had dental, nursing and allied health assistants attending.

There are a number of examples of collaboration between C&C DHB and HVDHB. These are:

- A joint Allied Health educator position
- Enhanced and formalised paediatric inpatient speech language therapy memorandum for cover arrangements during periods of leave
- Collaboration between the Respiratory Physiology services to enhance training and service access.

As a workforce, the Allied Health, Technical and Scientific professions continue to develop their quality systems in order to serve our community and their health needs in the best way possible. Only a few projects have been mentioned and there are many more - all are to be congratulated on their commitment to the provision of health services for our community.

ALLIED HEALTH

WHERE THE MONEY WENT

2010/2011 SPENDING ($M)
(FIGURES SHOWN ARE FOR FUNDER ARM ONLY)

183.04

Hospital - Medicine, Cancer & Community

70.52

Hospital - Mental Health Services

215.59

Hospital - Surgical, Theatre, Anaesthesia & ICU, Women's & Children **

1.15

Hospital - Clinical and Corporate Support

8.73

Other Hospital Services

29.23

Home-Based and other Elderly & Disability Support Services

15.78

Community Laboratories

(Paid to Hutt DHB)

28.20

Mental Health Services

(Including inter-district)

51.11

Primary Health Organisations & GP Services

60.72

Community Pharmaceuticals

44.82

Inter-District Outflows

2010/2011 REVENUE ($M)

40.26

Other Services

49.23

Aged Residential Care

*** Surgical/Theatres/ICU & Womens/Children's combined mid 09/10 financial year*

628.91

Ministry of Health

164.29

Other DHBs

1.35

Other Revenue

SURGERY, WOMEN'S & CHILDREN'S DIRECTORATE

SURGICAL SERVICES

Cardiothoracic

This year saw the successful implementation of the National Cardiac Surgery Prioritisation urgency scoring system for valve and coronary artery bypass surgery. This system is designed to give greater accuracy around patient prioritisation for both elective and acute procedures.

A total of 530 patients received cardiothoracic surgery this year. The Ministry of Health set the maximum number waiting for surgery at 60 patients. This number was exceeded four times in the year. The maximum number of patients waiting for surgery at any one time was 62. Only one patient waited over six months for surgery and that was by patient choice, not waiting list issues.

General Surgery

The department has been involved in the Clinical Pathway Collaborative (CPC) for dermatology and minor skin surgery. The aim of this CPC was for relevant secondary and primary clinicians and service leaders to work together to explore the issues and causative factors and recommend options to address the dermatology wait list issue. This included looking at the minor skin surgery referral pathway and the potential for some work to be managed in primary care. This work is in progress.

C&C DHB was successful in submitting a proposal to be the regional provider of bariatric surgery. At the moment the DHB are in the planning and implementation phase of the new service. The DHB expect to commence the provision of surgical bariatric services at Wellington Regional Hospital early in 2012.

Ophthalmology

The Ophthalmology Service moved from the Riddiford Building to a fully refurbished permanent location on level 9 Grace Neill Block. This move has resulted in significant quality improvements for patients attending the area and for staff working in ophthalmology. The service is extremely busy and this year there were 23,425 patient appointments. The service took the opportunity of the move to make changes in clinic patient flow processes with the establishment of nurse assessments and triage.

There has been marked improvement in the waiting times for surgery, particularly for patients waiting for cataract surgery. The service delivered an additional 239 cataracts over required contract volumes for local and Hutt Valley DHB populations. The additional cataract volumes helped C&C DHB and HVDHB achieve the health target discharge volumes.

DHB	Planned	Actual	Variance
C&C DHB	698	846	+148
Hutt Valley DHB	378	469	+91

Orthopaedics

Last year saw the retirement of Professor Geoffrey Horne in November 2010, after 30 years working at C&C DHB. Professor Horne has continued to provide regular locum work pending the commencement of his replacement later in 2011.

The orthopaedic service has also demonstrated a reduction in the number of long wait patients. This has been assisted by the employment of a 12 month locum with a special interest in spinal surgery, which is an area where historically there has been long waits for surgery.

NEWBORN HEARING FIRST BIRTHDAY

Orthopaedic clinicians have been involved with a Primary Secondary Governance Group looking at:

- Clear guidelines for referral from primary to secondary care for orthopaedic surgery
- Drafting referral guidelines for total knee and total hip replacement
- Reviewing the process of radiology ordering and orthopaedic referrals.

This work is ongoing.

Vascular

A vascular laboratory was planned as part of the Wellington Regional Hospital design and built within the Clinical Measure Unit (CMU). After much planning, and the appointment of a Specialist Vascular Sonographer, the vascular laboratory will be officially opened in September 2011. Having the Vascular Laboratory on site will make a big difference to patients who previously had to go to Wakefield for the procedures.

Ear, Nose and Throat

The number of patients waiting for First Specialist Assessment for 2010/2011 is less than 300, a significant reduction compared to 600 in previous years. This has been achieved by running additional clinics, which has been helped by the appointment of a 12 month locum. The locum has also been able to service the local need for advanced sinus surgery, which has historically been referred to Auckland.

The Ear, Nose and Throat service at Wellington is

also part of a sub regional working group which includes Hutt Valley and Wairarapa DHBs looking at how to work collaboratively to meet the needs of the patients from the region. While not finalised some of the key objectives the group are discussing include:

- Establish as one service for the sub-region
- Establish a Clinical Governance Group
- Improve access to and quality of ENT medical service
- Strengthen and develop the ENT workforce
- Improve ENT service infrastructure
- Implement a sub-regional Audiology service
- Develop and strengthen the Speech Language Therapy Service
- Improve ear health in Primary Care

Urology

The waiting list for Urology surgery has reduced from over 500 to 300, and now the service consistently meets all the Ministry of Health patient flow indicators.

Audiology

Audiology received 71 referrals from the Newborn Hearing Screening Service for further investigations for possible hearing loss. Of that, 15 had a confirmed diagnosis of hearing loss (see Table 1) and 15 referrals were made to intervention services (see Table 2).

Identifying hearing loss at an early age ensures early intervention and improves a child's ability to develop language and speech and to develop social skills.

TABLE 1 - NEWBORN HEARING SCREENING SERVICE DIAGNOSES OF HEARING LOSS			
Referred for Audiology Assessment			71
	Bilateral	Unilateral	
Confirmed Sensorineural Loss (Total)	2	4	
Confirmed Conductive Loss (Total)	5	2	
Confirmed Mixed Loss (Total)	1	0	
Confirmed Auditory Neuropathy (Total)	0	1	

TABLE 2 - NEWBORN HEARING SCREENING SERVICE INTERVENTIONS	
Referred to a Ear, Nose, Throat Specialist (Otolaryngologist)	7
Referred to Ministry of Education for Early Intervention Services	2
Referred for Hearing Aids	4
Referred for Cochlear Implants	2

Main Outpatients

The drive continues for more clinics to be held at Kenepuru. This year the number of clinics has been expanded to include pain clinics, two additional orthopaedic clinics and radiation oncology.

ELECTIVE SERVICES

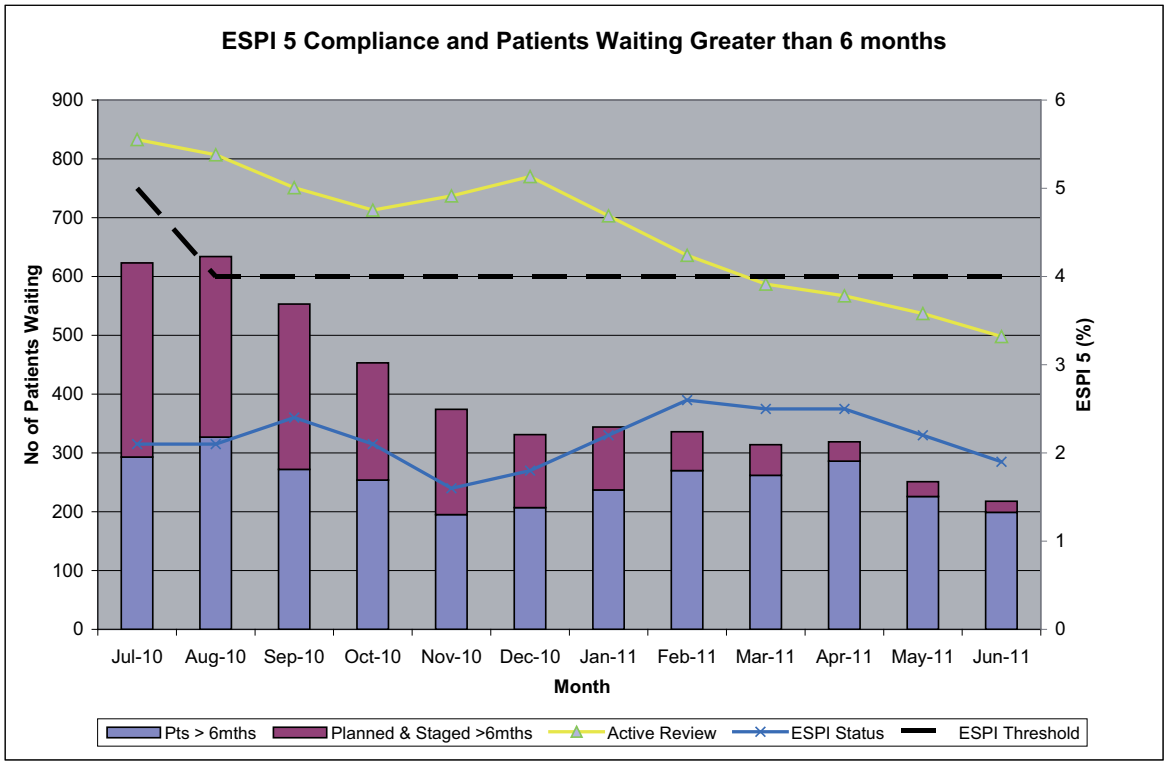
Improved Access to Elective Surgery

Over the past year we have significantly improved access to elective services.

First Specialist Assessment (FSA) volumes were met and significant improvements were made in reducing the numbers of patients waiting for a FSA. In July 2010 there were 544 patients who had been waiting longer than six months for a FSA. In June 2011 this number had reduced to just 55 patients waiting greater than six months. Improvements have been made across all services; however, this is most marked in dermatology where there was previously a high number of patients waiting greater than six months for a FSA.

We had a very productive year in terms of our elective surgery and managed to exceed the elective surgery discharges target by 215 discharges. In addition to providing more surgery than planned C&C DHB also achieved significant improvements in our waiting times for surgery. This was particularly evident in the number of patients waiting over six months for surgery who had been assigned a status of planned and staged (see graph below).

C&C DHB has also improved access to elective surgery by reducing the number of patients assigned an active review status. This category is often confusing for patients, raising expectations for surgery that cannot be met. In July 2010 there were 833 patients in this category, compared with 498 patients



in June 2011. The focus on this area will be maintained to further reduce the number of patients assigned in active review status.

Effective Management of Patient Flow Processes

The newly established Elective Services Manager role has been key to monitoring and managing the elective services patient flow processes. This resource has supported the surgical services in achieving their targets and also in the development, implementation and refinement of standards and processes. Subsequent to this role we have noted improvements across the MOH Elective Services Patient Flow Indicators (ESPIs) which support the principles of clarity, timeliness and fairness in relation to accessing elective services.

NATIONAL ELECTIVE SURGERY PERFORMANCE INDICATORS					
	MOH Target	2010 July	2011 June	% Improvement	Targets Met
ESPI 1 DHB services that appropriately acknowledge and process all patient referrals within 10 working days.	>90%	100.0%	100.0%	0.0%	Yes
ESPI 2 Patients waiting longer than six months for their first specialist assessment (FSA).	<1.5%	1.8%	0.1%	**1.7%**	Yes
ESPI 3 Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	<5%	0.6%	0.0%	**0.6%**	Yes
ESPI 4 Clarity of treatment status.	<5%	0.0%	0.0%	0.0%	Yes
ESPI 5 Patients given a commitment to treatment but not treated within six months.	<4%	2.1%	1.8%	**0.3%**	Yes
ESPI 6 Patients in active review who have not recieved a clinical assessment within the last six months.	<15%	9.7%	2.8%	**6.9%**	Yes
ESPI 7 Patients who have not been managed according to their assigned status and who should have recieved treatment.	<5%	1.3%	0.9%	**0.4%**	Yes
ESPI 8 The proportion of patients treated who were prioritised using nationally recognised processes or tools.	>90%	100.0%	100.0%	0.0%	Yes

Capital & Coast envisages further improvements and looks forward to building on the significant gains made in 2010–11.

ICU

Intensive Care Services have had a very busy year. March to June saw record admissions while continuing to support the delivery of elective surgery to the region. Challenges included H1N1 and admissions arising from the Christchurch earthquake. This event demonstrated the strong collegial network across the speciality in New Zealand with the ability to communicate effectively and respond quickly at short notice.

Three senior registrars passed their part two intensive care specialist qualifications. The college have complimented the ICU, at audit, as an excellent site for training in New Zealand. Eleven senior nurses achieved Senior Nurse status on the Professional Development Recognition Programme and eight RNs achieved Expert status.

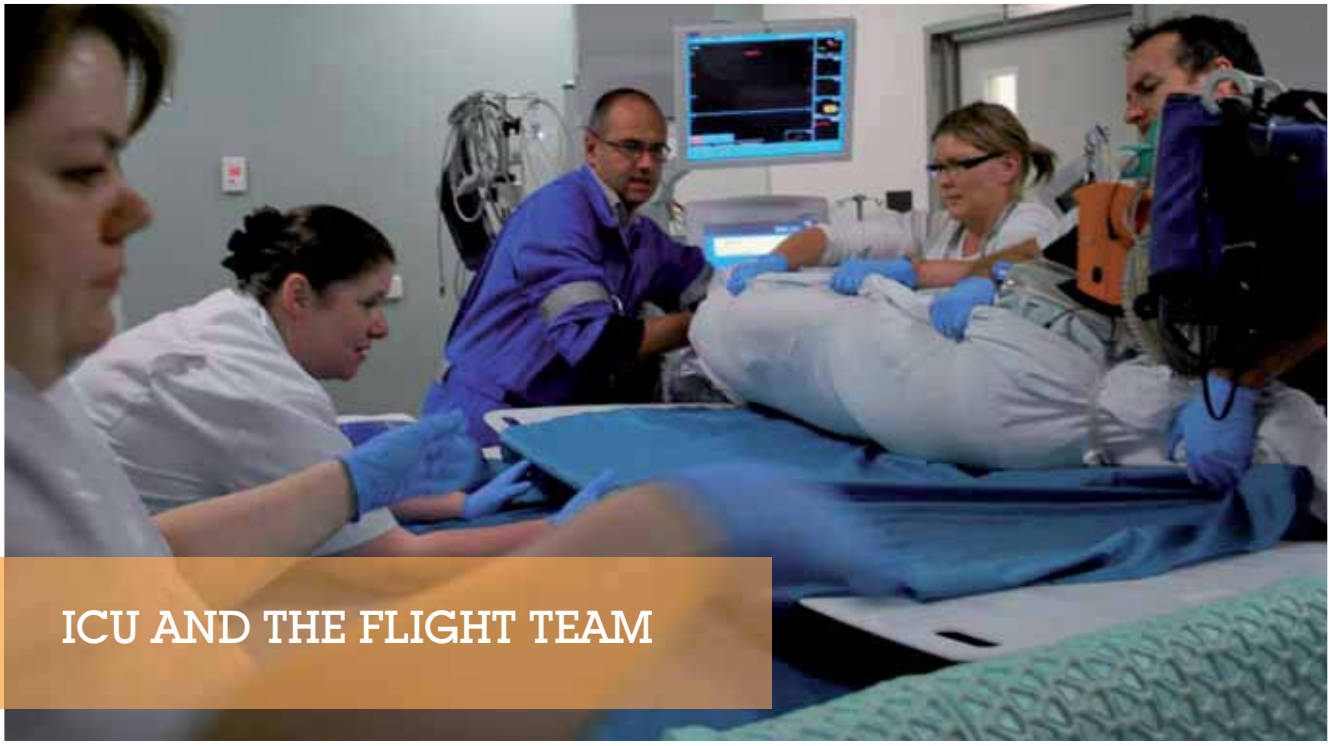
The ICU Research team had a very productive year contributing to clinical trials both nationally and internationally.

PAR Service

In August 2010 the Patient At Risk (PAR) team expanded from being a nurse-led service operating 14 hours a day to a multi-disciplinary group that operate 24-hours-a-day, seven-days-a-week. This also included the ICU medical team formalising their relationship with the PAR service as they attend to deteriorating patients on the ward.

To help the PAR team get an early warning if a patient was deteriorating, a new Adult Vital Signs and Fluid Balance chart was developed by them and designed by the Communications Unit. The goal was to make it visually easier to track a patient's progress through a coloured scoring process which would trigger a compulsory response to the Medical Emergency Team (MET) if a patient's progress deteriorated.

On 7 June 2011, the single vital observation and fluid chart for Wellington and Kenepuru Hospitals was introduced. This replaced over 30 other forms; the



ICU AND THE FLIGHT TEAM

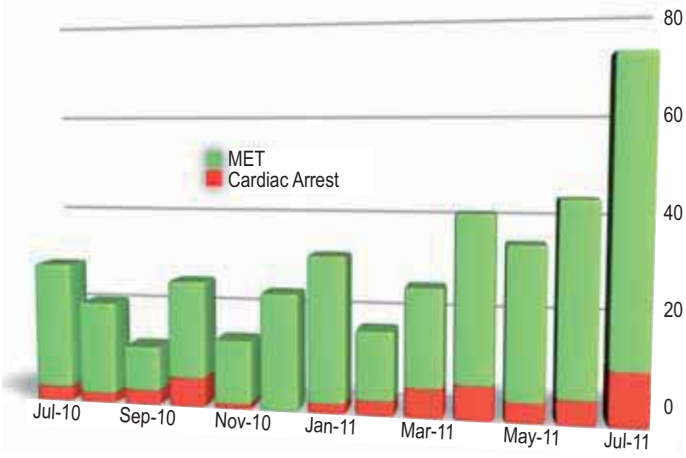
universal format supports the early recognition of clinical deterioration across the DHB.

The MET calls are not always about taking the patient away from the ward so much as preventing an intensive care admission through specialist care knowledge. The MET team's goal is a reduction in cardiac arrest numbers through catching people earlier by recognising the signs that they are deteriorating. The MET can then devise a revised care plan to reverse the problems.

The graph below shows an increase in (MET) calls over the year due to this initiative which also mandated MET calls if a patient's vital signs continued to deteriorate or crossed values deemed as unsafe. International data suggests that earlier intervention on a deteriorating patient through MET calls prevents continued deterioration so cardiac arrest can be avoided.

The system at C&C DHB is still in its infancy and it is expected it may take several years for this cause and effect to be firmly established. We hope to replace the cardiac arrest team as the ambulance at the bottom of the cliff with the MET team and PAR service as the fence at the top.

Monthly '777' calls to switchboard by type



THE NEW VITAL SIGNS AND FLUID BALANCE CHART

Wellington Theatres

Wellington Theatres focus in 2010/11 has been to support the delivery of surgery to both the local and wider population. C&C DHB exceeded the number of elective operations target for 2010/2011, which is a testament to the focus and work of our clinicians and support teams.

Our theatres achieved overall elective utilisation of 82% with acute theatre achieving 69%. This translated into 7572 elective operations, 4677 acute operations and 1366 caesarean deliveries for the year.

Staffing within the theatre continues to be very stable with any vacancies attracting high levels of interest from quality applicants.

In 2010/11 the wider theatre team focused on the costs of consumable items used within the complex. This work identified and realised significant opportunities to reduce the costs of many items without compromising patient care or quality. This work contributed $1.7m annually in savings, which will be sustained through

the introduction of pricing agreements and tendering of contracts for specific items. Reviewing operation packs resulted in savings of over $500,000 alone. This focus will continue into the 2011/12 year with a review of gowns, drapes and disposable instruments.

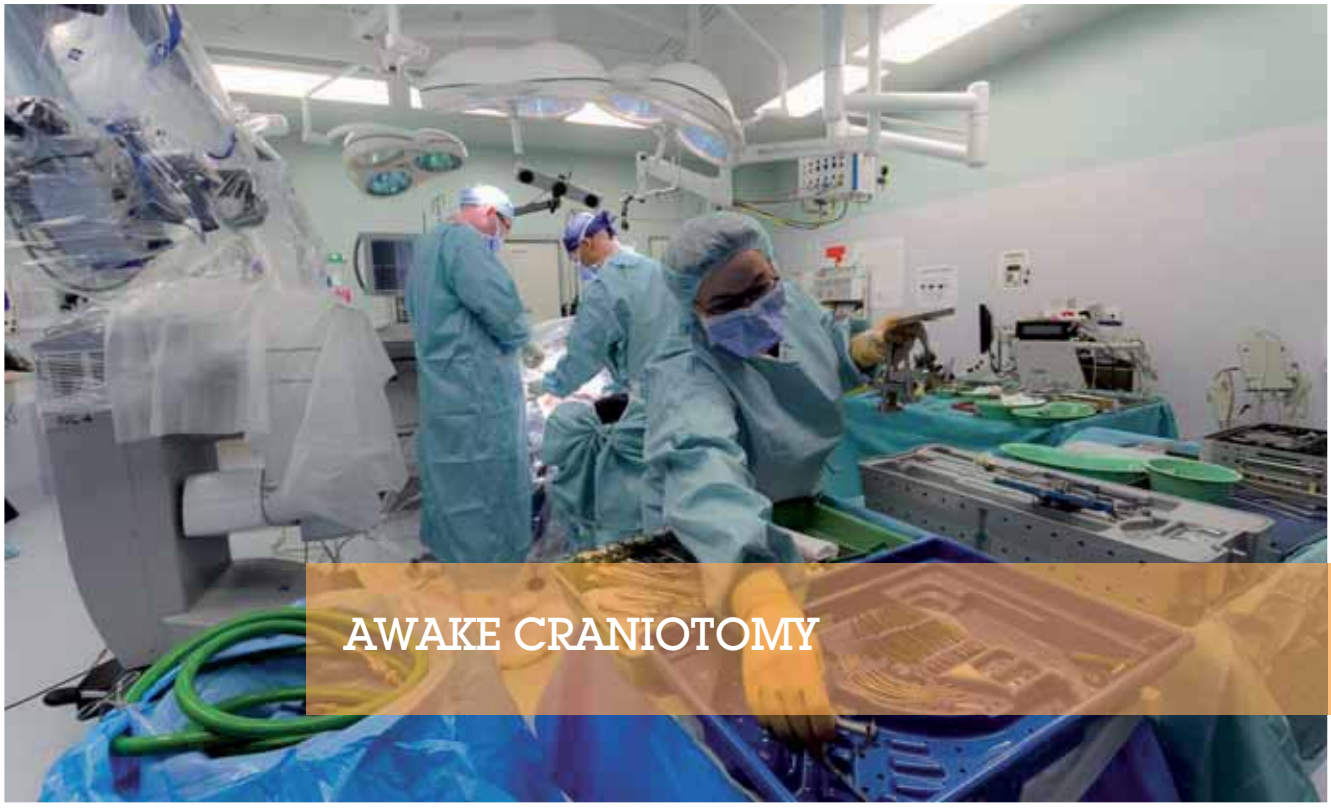
Perioperative Services

The patient journey for those undergoing elective surgery starts in the Pre-Assessment Unit (PAU). Anaesthesia pre-assessment is delivered from a team based in the Wellington Regional Hospital outpatients facility, and is charged with the timely and effective preparation of elective patients undergoing anaesthesia and/or surgery. The pre-assessment area is led by a nursing team who coordinate interdisciplinary specialty appointments and referrals.

On the day of their surgery the patient arrives into the Surgical Admissions Unit (SAU). This unit serves as the front door for all day-of and inpatient patients undergoing surgery, procedural or anaesthesia intervention, inducting patients into one of Wellington Regional Hospital's 14 operating theatres and procedure rooms. Approximately 20 to 30 patients come through this area on the day of their surgery where the SAU nurses meet and prepare them for their surgery. From here the patient is escorted through to the operating theatre.

Following surgery the patient then goes to the Post Anaesthetic Care Unit (PACU). Comprehensive post-anaesthetic care is provided from the purpose-built 24-bay PACU situated in the midst of the operating theatres by a team of dedicated PACU nurses. This team also provides post-anaesthesia care to obstetric, blood and cancer, and interventional radiology services in one of its three smaller satellite units.

Day case caseload is supported through these services by an adjourning Second Stage Recovery Unit, utilising a 23-hour concept to safely discharge



AWAKE CRANIOTOMY

patient's home the same day, or following an overnight stay. This concept means that surgical wards have beds available to those who stay longer than 24 hours and patients do not have to stay in hospital any longer than required. This results in better outcomes for the patient and their family as well as overall cost savings.

Anaesthesia

Anaesthesia and Pain Medicine had an exciting and challenging year. The service has continued to grow and now offers regional support in pain management and a wide range of sub-specialty services. Our cardiothoracic anaesthesia team received a commendation from visiting representatives of the Royal Australasian College of Surgeons (RACS).

Our paediatric anaesthesia surgery was one of the factors that resulted in RACS granting C&C DHB recognition for its ability to train paediatric surgeons.

Nursing staff working in our Post Anaesthesia Care Unit (PACU) have worked with others to develop techniques of vascular access to the point where they now form a key component in an organisational vascular access service. This year has at last seen the recognition of New Zealand's anaesthetic technicians as registered health professionals and this represents an opportunity for our staff to make a greater contribution to the delivery of care in and around the operating rooms.

Anaesthesia and Pain Medicine's educational programs continue to be at the forefront of New Zealand's efforts to maintain a skilled workforce and are an integral part of our service planning and employment policies. In the next year we anticipate the arrival of some highly trained young specialists as a final phase in what has been a three year program to renew and invigorate our workforce.

One of our greatest challenges has been devising ways to provide our patients with high quality care in a cost constrained environment and representatives of our service have made valuable contributions to an organisation wide drive to avoid unnecessary expenditure.

At the centre of all our activities are our patients and it has been very rewarding to see the continued arrival of compliments that reinforce the feedback we receive from satisfaction surveys.

Sterile Services

This year has seen the introduction of computers and label scanning technology into the processing systems for the packing and sterilising process. This has enabled the team to increase their computer skills, have better control of the processing, improve the quality of labelling of trays and pouches, and improve accuracy of load documentation for the sterilising process. It has also enhanced auditing and stock control within the service.

As theatre increases its productivity, the ability of sterile supply to maintain delivery of service has been tested. Ongoing assessment of the impacts of this and the most sustainable longer term solution is currently being assessed.

Patient Transfer Service

The Patient Transfer Service is a multifaceted area covering patient transfers within the hospital, and transfers to and from other hospitals around New Zealand by road or air. The adult/paediatric flight transfer services transported 746 patients for the year to June 2011, a slight increase on previous years. Air transfers are in conjunction with The Life Flight Trust, either by fixed wing or helicopter and road transfers are in conjunction with Wellington Free Ambulance (WFA). 2010/11 saw the introduction of a dedicated WFA staff member on site during working hours which has enhanced the smooth running of the service.

The Christchurch earthquake, while unfortunate, gave us huge insight into how to respond in a disaster

reinforcing many good things and showing areas that can be strengthened.

The Transit Lounge

The Transit Lounge is in its second year of operation and already some areas are often surpassing the 30% target of all ward discharges coming to the lounge, while other areas are making an effort to reach this. Overall, the Transit Lounge has reached heights of almost 20% of all hospital discharges, a figure Capital & Coast hope to improve on next year.

National Travel Assistance

National Travel Assistance (NTA) has also had a bumper year with a total of 756 people registered for travel assistance in the year to June 2011 – an increase of 153 people from the previous year. NTA booked 966 commercial flights for patients to travel to other hospitals in the year to June 2011.

NTA was very busy following the Christchurch earthquake, as it was the main contact for travel and accommodation questions from families of patients transferred to Wellington. NTA also arranged travel for support people so they could return home and start to sort out their housing.

TRANSIT CARE

Transit Care

There has been a general increase of acuity of the patients transferring within C&C DHB keeping Transit Care nurses busy. The addition of the resource nurse after hours has seen an extension of the transit workload by providing support to staff after hours.

Following a pilot study between Transit Care and Radiology, the decision was made to remove the inadequate marquee trolleys from use. These were the preferred trolley to be used when transferring patients with hip replacements, spinal and abdominal injuries. The marquee trolley was hard and uncomfortable for the patient, and didn't reduce the number of bed-trolley-bed transfers. The decision was made to leave the patient in their bed, and transfer them to the radiology bed directly. This has shown to increase comfort for patient and reduce staff injuries due to the ability to attach equipment to the bed.

Other Exciting Activities

One of our ICU flight nurses had the privilege to join forces with other medical teams and work voluntarily in Zambia to provide cardiac surgery to those who otherwise couldn't afford it. This was a satisfying experience for the ICU nurse knowing that this surgery changes lives.

WOMEN'S HEALTH SERVICE

Maternity

It was another busy year for maternity with 3926 women giving birth to 4013 babies. There were a total of 3535 women who birthed at Wellington Hospital, 225 at Kenepuru Birthing Unit and 166 at Paraparaumu Birthing Unit. Both Kenepuru and Paraparaumu had an increase in the number of births compared with 2009/10.

Foetal Loss

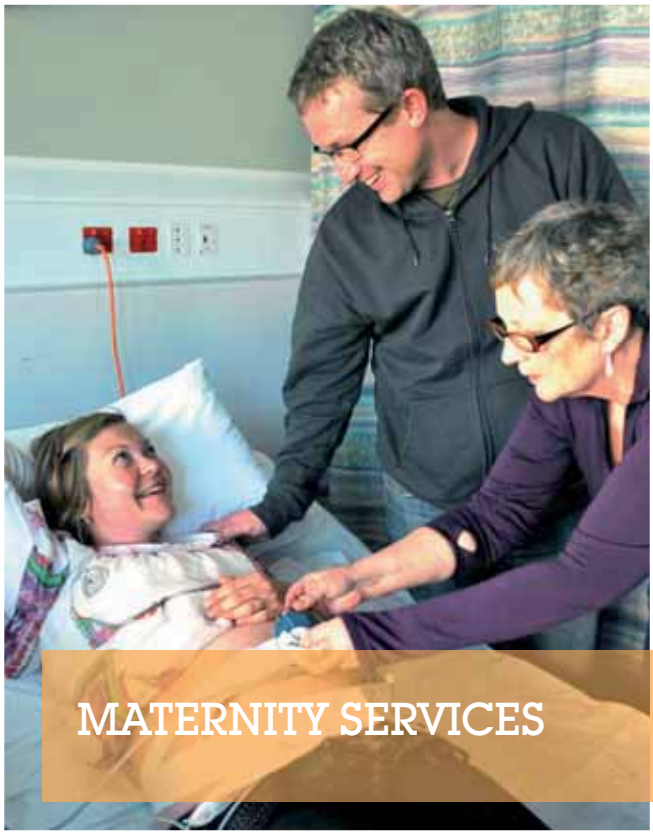
Gail Austin, Registered Midwife who works as an Associate Charge Midwife Manager in the Antenatal and Postnatal Unit, undertook a quality initiative in relation to foetal loss as part of the LAMP Programme. The need for this service improvement was identified by the senior midwifery team. Through Gail's project the team has introduced a staff education programme and a process that allows women to provide feedback which assists in identifying improvements in service delivery. This initiative is supported by the local Stillborn and Newborn Death Support (SANDS) group and will be presented at the SANDS Conference in November 2011.

Quality Leadership Programme (QLP) for Midwives

Since the introduction of the Associate Charge Midwife Manager (ACMM) mentor role, there has been an improvement in the number of midwives obtaining Confident or Leadership on the QLP. Each ACMM has a small team of midwives to provide support and advice in relation to ongoing professional development.

Practical Obstetric Multi-Professional Training (PROMPT)

The PROMPT course was successfully introduced last year and covers the management of a range of obstetric emergency situations. The course consists of multiple interactive drills and workshops within the normal working environment and participants include midwives, obstetricians and anaesthetists.



MATERNITY SERVICES

Gynaecology

Day of surgery admissions (DOSA)

In 2010/11 all gynaecology day surgery admissions for non-cancer surgery were admitted directly to the Surgical Admissions Unit, rather than being admitted directly to the inpatient ward (4 North). This helped with good theatre throughput and allowed inpatient ward staff to focus on the care of their post-operative patients, facilitate beds for acute admissions, facilitate discharges and plan for post-surgery admissions later in the day.

Royal NZ Ballet cast from the Nutcracker visited the children's ward

CHILDREN'S HEALTH SERVICE

This year saw the appointment of several senior nurses to new and vacant positions within Ward 18. Alison Slade was recruited to the Charge Nurse Manager role from a senior nursing position in paediatric oncology, Great Ormond Street Hospital, UK. Christine Smith and Hayley Morum, Associate Charge Nurse Manager and Nurse Educator, were also appointed, further strengthening the Paediatric Oncology senior nursing team.

Dr Andrew Marshall was appointed as Clinical Leader Paediatrics following the resignation of Dr Ross Wilson, who led the Service for 7 years and returned to general paediatrics. Andrew maintains an active clinical interest in developmental paediatrics whilst taking on the role of leading Wellington region's paediatric medicine service. The Ministry of Health's interest in forging closer links between neighbouring DHBs offers our region some exciting challenges and the Wellington region is determined to maintain its contribution to New Zealand's child health services.

A review of Child Health Services for the sub-region (C&C DHB, HVDHB and WDHB) was undertaken in 2011. This initiative between the three DHBs aims to identify ways in which the three services can work more closely together in the future to benefit children across all the communities we serve. Seven work steams were indentified: governance, child development, child protection, data sharing, ambulatory sensitive hospitalisations, systems and workforce. Recommendations from each working group will be presented to DHBs in the form of a sub-regional Child Health Report in September.

Wellington Children's Hospital turned 99 this year and to celebrate His Excellency the Governor-General of New Zealand hosted a fundraising evening with Wellington Hospitals and Health Foundation at Government House on May 7. The event raised more than $24,000 to support community programmes and medical equipment purchases for the Children's Hospital.

The planning phase of the reconfiguration of the existing Children's Hospital is well advanced with a concept design and architectural drawings nearing completion. A redesign of the paediatric oncology day unit has been incorporated into the project scope and completion is anticipated before April 2012.

Neonatal Intensive Care Unit

Two new transport incubators costing $200,000 each were unveiled to the Department in August 2010. These devices are CAA approved, better equipped and capable of carrying twins, which in turn will reduce travel time and staff resources required to safely transport babies to and from the unit.

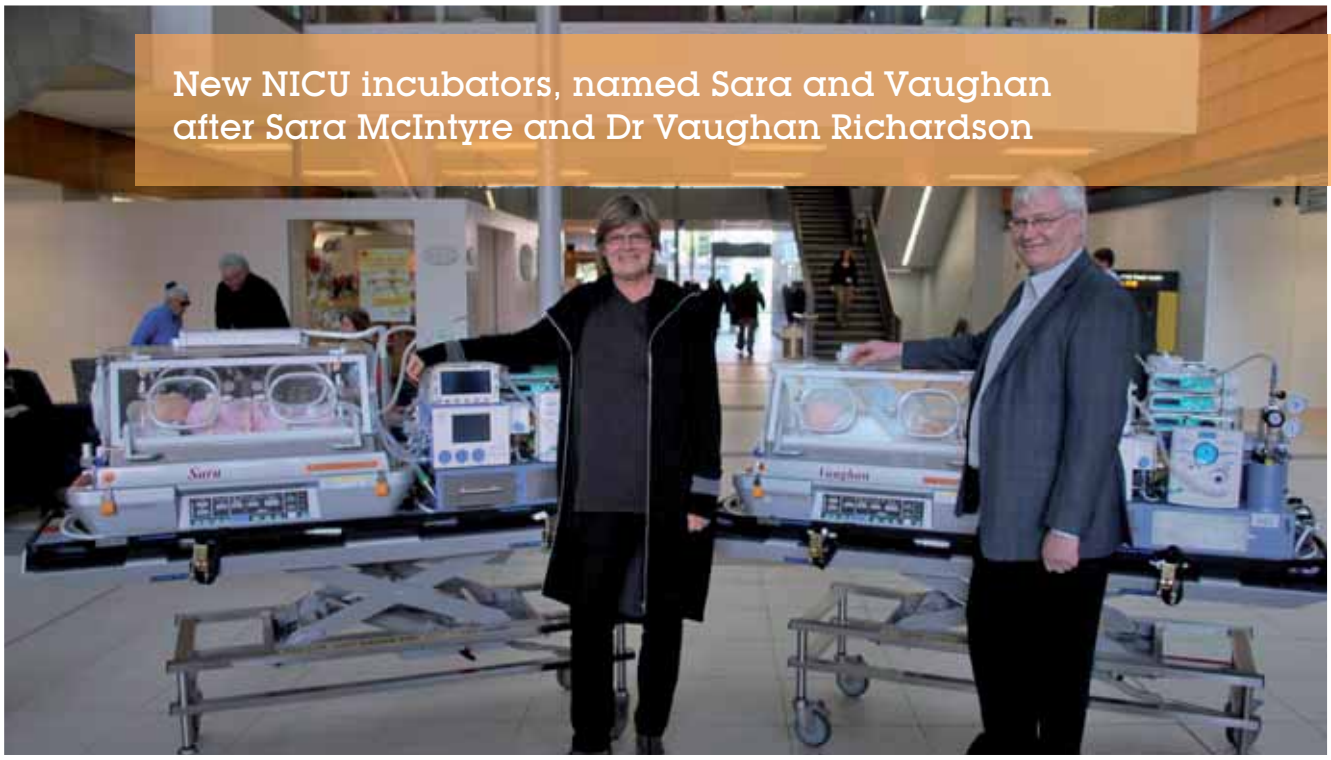
The past year has shown an increase in the average occupancy, from 32 in 2009/10 to 35 days in 2010/11. The increase was reflected in local patient discharges – 854 compared to 761 the previous year. IDF patient discharges have remained consistent with 2009/10 financial year.

Paediatric Surgery

2010/11 was another busy year for the service, with a 12.5% increase in the number of children who received elective surgery compared with the previous year. Local performances to both acute and elective contracts have been met. IDF case weight volumes for both acute and elective have been adjusted for 2011/12 to reflect the significant increase in IDF work performed during the past year.

The Child Development Team

Additional one off funding was provided by the Ministry of Health to reduce waitlists within the Child Development Service. A plan was made to reduce the psychology waiting lists and three private specialists with experience in child development were contracted. Their focus was single discipline assessments, which freed up the team's clinical psychologists to concentrate on children affected by Autistic Spectrum



New NICU incubators, named Sara and Vaughan after Sara McIntyre and Dr Vaughan Richardson

Disorder (ASD). The impact of this funding was dramatic; joint assessment wait lists (developmental paediatricians and psychologists) have reduced from 18 months to approximately four months and the wait list for ASD children under six years is down to four months.

The service has received positive feedback from the Ministry of Health after reporting their efforts and indicated further one off funding is available in 2011/12 to further reduce waiting times.

Police dogs visit the children's ward

Genetics

Clinical Genetics commenced the transitioning to a national service on 1 July 2011 under the guidance of the National Health Board. Clinical teams engaged by the two current providers already work together as a virtual team and there has been agreement reached by management and clinicians from both Auckland DHB and Capital & Coast that they would support a two DHB provider hosted national service.

Quality

Following the development of the Directorate structure in early 2010, the Surgery, Women & Children's (SWC) Directorate have embraced the new C&C DHB Quality Framework (Effectiveness, Risk, Consumer Value and Workforce), and has worked proactively within the DHBs Governance Structure and actively participated in achieving Capital & Coast's Quality Priorities.

Effectiveness

SWC Directorate staff have taken an active part in the implementation of C&C DHB Service Health Check (Capital & Coast's internal accreditation process), which commenced in the Medicine, Cancer & Community Directorate in April 2011. SWC Service Health Checks are to commence in November 2011.

Key staff participated in the National Pressure Area Audit in November 2010. From this, the directorate introduced a Pressure Area Improvement Plan for Surgical Wards that has resulted in a considerable reduction in pressure area occurrence across the surgical wards.

The Directorate continues to benchmark clinical practice through ACHS Clinical Indictor Programme. Clinical Indicators were submitted for Cardiothoracic, ENT, ICU, Obstetrics, Gynaecology, Paediatric Surgery, and, for the first time this year, Urology. These showed the services benchmarked favourably with peer group services and outcomes.

To improve clinical audit, the directorate is working with ICT to develop an electronic clinical audit system to enhance the capture and interpretation of data. This will be targeted at Orthopaedics and General Surgical Services initially, with a plan to roll out across other clinical specialities in the future.

SWC initiated an organisation review of the Patient Admission to Discharge Plan and the Maternity Care Plan to improve utility. Both have been piloted and are in the process of being rolled out across the DHB.

Risk

SWC Directorate has led the way with the legislative requirement gap analysis and have actions in place to reduce disparities. The quality and risk structure within the Directorate ensures our reportable events and subsequent adverse events are timely and appropriately managed.

Consumer group feedback

The SWC Quality Manager has led the training of the Consumer Committee members for the newly developed Kenepuru Consumer Group, with a Kapiti Consumer Group planned for later this year. The inclusion of the consumer voice in service feedback to influence improvement to care and planning for future service delivery is a key component of our DHB.

SWC actively engaged in the independent evaluation of the Tikanga Māori Programme at C&C DHB through focus groups.

VAC committee

The Vascular Access and Treatment Committee (VAC) was set up in 2010 following a peripherally inserted central catheter (PICC) adverse event review. The purpose of this Committee is to ensure PICC access complications are reviewed in a multidisciplinary team setting, relevant audits are undertaken and current/ draft policies are reviewed. The Committee reports to the Clinical Practice Committee and is currently co-chaired by a Specialist Anaesthetist and the Associate Director of Nursing for the Surgery, Women and Children's Directorate.

VAC is standardising vascular access policies and equipment across the organisation to improve current practise, quality of care and to reduce costs. The Intravenous (IV) Therapy CNS at C&C DHB is working with her counterparts in the Hutt and the Wairarapa to provide a standardised approach to IV access across the region.

A Vascular Access Service was commenced in May of this year and currently provides dedicated lists for PICC insertion by the Vascular Access Nurse and a Consultant Anaesthetist. This service is also standardising PICC documentation, providing formal training in PICC insertion and presently auditing practise. "Hospital in the Home" have already noticed an improvement in care for patients requiring IV access in the community.

Libby Spillane inserts a PICC line so the patient can continue treatment at home

MEDICINE, CANCER & COMMUNITY DIRECTORATE

MEDICAL SERVICES

Older Adult Rehabilitation and Allied Health service

A key initiative in the 2010/11 year was the development of Older Adult Rehabilitation and Allied Health service (ORA). This was achieved through the amalgamation of Therapies, Capital Coast Rehab and Ward 5 Kenepuru. The service aims to be responsive and flexible across the continuum of care and provide an enhanced specialist rehabilitation program to identify patient groups.

Concussion Service

A community based concussion service has been set up at Ewart, on the Wellington Regional Hospital campus, which provides some home visits. Patients who have mild to moderate concussion receive a co-ordinated approach to their care involving SMO, occupation therapy, physiotherapy and psychology working together to meet their needs. The service ensures patients are appropriately assessed, diagnosed and a treatment plan implemented.

Stroke Service

Excellent outcomes have been achieved through the implementation of a community stroke guideline. The community approach to patients discharged from hospital following a stroke is more responsive with specific stroke assessments being carried out. The guidelines focus on active rehabilitation immediately after a stroke, resulting in a number of patients remaining at home rather than needing residential care.

A & M

Following a pilot in the Wellington Emergency Department, physiotherapy input into the Kenepuru Accident and Medical centre has begun. This has meant patients who suffer an injury can be fast tracked to see a physiotherapist and receive treatment faster.

General Medicine

Medical Assessment and Planning Unit has undergone its post-implementation evaluation that has demonstrated that a significant decrease in the length of stay has been achieved. The flow of patients through ED has improved by the diversion of GP referred patients directly to the MAPU; between July 2010 and June 2011, 2100 patients were referred and directed to MAPU for their acute assessment without having to go through the Emergency Department and 829 patients were seen as ‘day cases’ or return for review. In addition MAPU admitted a total of 8868 patients, an average of 739 patients per month.

GP satisfaction has improved with direct mobile phone access to registrars as well as to the consultant of the day. Acute medical clinics have had some staffing problems at times but have mostly worked well.

Training for recognising and responding to family violence/partner abuse is now available to all DHB staff. This will raise the awareness of identifying patients at risk of domestic violence/elder abuse and give staff knowledge of what to do if they suspect this is occurring.

Two staff were employed via the new Māori graduate internship program, which offers new graduate physiotherapists and dietitians a one year internship to consolidate the skill they learned at university as well as being able to offer a more culturally responsive service to Māori patients they see.

CANCER SERVICES

At Kenepuru a haematology chemotherapy outreach service has been implemented. This pilot outreach service is an alternate and innovative way of providing haematology services and is precursor for delivering other Blood and Cancer Services at Kenepuru.

We have commenced implementation of Multi-Disciplinary Meeting framework for cancer. MDM are conducted by tumour type and are an important part of the patient treatment planning. A new MDM room has been established in the seminar room on

CANCER SERVICES

Level 5 of Wellington Regional Hospital and includes a microscope and high resolution data projectors for viewing pathology, imaging and clinical records.

Soprano medical software templates have been established to collect data and document patient management plans. The doctor dictates notes about a patient electronically, and then these notes are transmitted to a medical typist. This aids in creating accurate medical records. In future it is envisaged that this process will work well at a regional level by adding in a video conferencing capability.

A Cancer Service Directory was launched in conjunction with Hutt Valley and Wairarapa DHBs. The directory for patients and health care providers has information on support services available for Cancer Patients in the wider region.

New superficial X-ray equipment has been commissioned. This machine has its own dedicated room which will improve services to patients with certain types of skin cancer.

Purchase of a new Linear Accelerator was completed. It will be delivered in July 2011 and will replace a 14 year old Linac.

The Wellington Blood & Cancer Centre and the Wellington Cancer Society have collectively agreed to offer the Living Well Programme (LWP) at the hospital. Allied health team members from the hospital that have completed the training can run the programme with an experienced Cancer Society facilitator. Running the LWP in the hospital benefits clients by:

- Providing tangible information about the ‘cancer journey’
- Allowing patients to attend the programme in a familiar and supportive environment
- Giving long term benefits to overall wellbeing for clients throughout treatment and those transitioning into survivorship and/or palliative care
- Strengthening our partnership with the Cancer Society - for both staff and patients.

Renal Service

Renal Transplantation

The service continues to maintain an active live donor transplant service with two transplants undertaken most months. In 2010/11, 23 transplants were performed, of which 18 were live donors. The total number of transplants was down from 2009/10 when 35 total transplants were performed, of which 19 were live donors. The significant fall in the number of deceased donor transplants is due to a shortage of available organs and is a trend reflected nationally.

Haemodialysis

The increasing demand for in-centre haemodialysis treatment continues with a 12% increase in total treatment numbers for the past financial year. The dialysis areas are operating at above capacity. Plans are in place for further development of satellite dialysis services.

The hospital dialysis unit has a new fleet of dialysis machines which are all the same model. Home haemodialysis patients have also transitioned to a new machine which has involved a retraining period for patients. Patients have generally responded well to the change especially as many have been on home dialysis for a number of years.

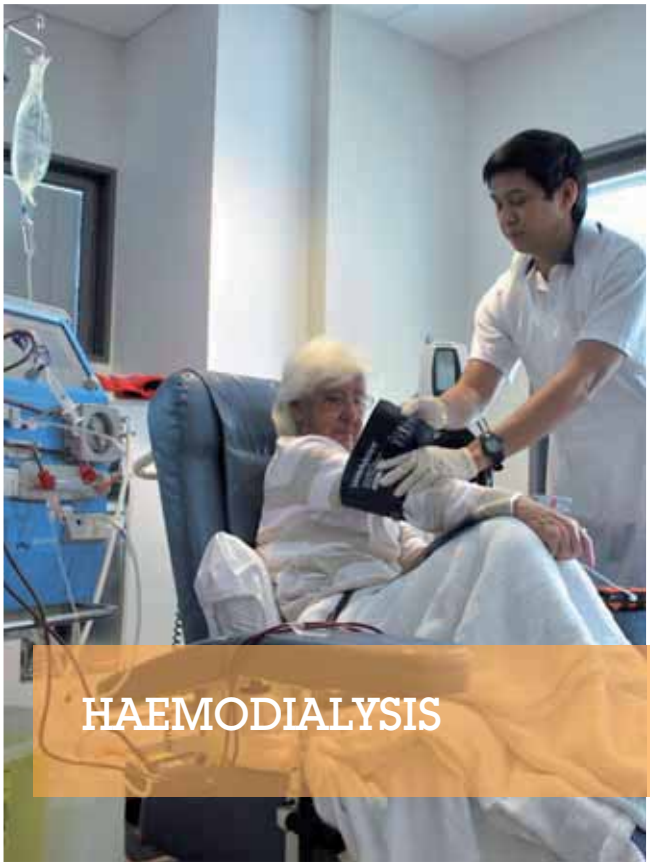
The CNS role recently developed to support renal inpatient care has proven to be effective in the coordination of seamless care for renal inpatients, improved discharge planning processes, and providing much needed support, guidance and mentoring of the nursing team.

Hospital Palliative Care Service

This year the hospital palliative care service has been increasingly busy seeing more patients and at earlier times in their illness, as well as expanding the services it provides.

There were 7% more referrals to the service, of which one third had non-malignant illness. Referrals were from all settings including Emergency, ICU, medicine, cancer and surgery. This reflects the ongoing major need for palliative care within acute hospitals – 20% of all acute admitted patients have palliative care needs, and hospitals remain the most common place of death within New Zealand.

A project focusing on improving care and best practice for people dying in hospital has been implemented. The care of the dying pathway has been successfully piloted and is being rolled out to all wards within Wellington Regional Hospital to help support, up-skill and empower staff when looking after patients who are within the last few days of life. The project also focuses on the needs of family and whanau during these difficult times, and ways that they can be best supported.



HAEMODIALYSIS

Other areas of service development include:

- Development of patient brochures explaining palliative care services, with translation into several languages, including Māori. Another explains the use of morphine for cancer pain, which is often misunderstood and therefore not used to best advantage.
- Rapid discharge guidance for patients wishing to go home to die. This helps streamline the complex process and facilitates successful transfers between hospital and community care providers.
- A user survey of the service showed high levels of satisfaction amongst C&C DHB staff (from both clinical and educational perspectives).
- A nurse practitioner in palliative care is planned for next year, which will enable the service to expand provision of both clinical and educational services, as well as better integration between primary and secondary care.
- Research has also been ongoing looking at the point of death in a hospital setting, the culture of an acute hospital with respect to end of life care, and communication training.

MINOR CARE ZONE

Emergency Department

ED continues to look at improvements to patient flow in and out of the Emergency Department with the opening of the Minor Care Zone and private triage assessment rooms alongside ED in April.

The Minor Care Zone is designed to stream patients presenting to the Emergency Department who require primarily senior nursing assessment and treatment for minor ailments. This means shorter waiting times for these patients and diverting patients with minor health issues away from the busy and acute Emergency Department.

Previously patients presenting to the ED were often required to provide details of their health issue in a public area. This did not support their right to privacy or enable a comprehensive triage and assessment. The new private triage assessment room improves this vital step in providing care.

A pilot of admission avoidance has begun in the community to pull patients from ED and medical wards that can be supported with treatment in their homes rather than hospital. Evaluation is to be done in 2011/12 but to date the results look promising.

ED PRESENTATIONS			
	2008-2009	2009-2010	2010-2011
TOTAL	48,389	51,383	50,426

Cardiology

The Cardiology Department hosted the Australasian CTO Club's Workshop in Wellington. This involved 80 cardiologists from Australia, Japan, New Zealand and Asia who attended a three day workshop on coronary artery intervention on Chronic Thombotic Occlusions. This workshop used live cases from our cath labs, beamed up to the large lecture theatre on Level 12 WSB where the audience were able to listen to Dr Scott Harding and the visiting specialists from Japan and Australia as they were conducting their

cases. Through a panel in the conference room, the audience or panel were able to converse with the cath lab operators.

Over the past 18 months, Cardiology has established a PFO closure service. This is a cath lab procedure, where a hole in one of the heart walls is closed with a specially designed device. The reason for doing the procedure is to remove a possible mechanism for stroke, particularly in young patients who may have to face a lifetime of medication otherwise. We have had good success with these procedures and good short term outcomes for patients.

Our Cardiac Imaging specialist, Dr Alex Sasse, has been utilising 3 Dimensional Echocardiography to better deliniate valve abnormalities and thus assist surgeons in performimg detailed repair surgery. Such technology has a role in closing heart defects.

Our 10 year experience of routinely manging elective coronary angioplasty patients as day cases has been presented, demonstrating excellent safety results. This decade of data places Wellington Hospital as the leading exponent of this approach in the Southern hemisphere. Furthermore the majority of our cases are now performed via the arm approach rather than the leg, allowing earlier and more comfortable mobilisation for the patients.

Our research into platelet function has revealed that approximately 30% of patients are resistant to a routine drug used after coronary stent placement, and that this resistance is doubled in our Maori population. This finding has major implications for the future treatment of many of our patients.

Neurology

A neurologist with special interest in strokes has been recruited. This will help support the future development of a collaborative stroke service with internal medicine and ORA.

An outpatient booking review has been undertaken and a review of first specialist appoints and follow-up ratios to improve service delivery to patients.

THE AUSTRALASIAN CTO WORKSHOP

COMMUNITY SERVICES

The under 65 Needs Assessment and Service Coordination service (NASC), have developed links with the Porirua Community Link service and is now part of the Governance Panel and operates a part time desk in the Community Link environment. This will enhance the exposure of disability support services in the local area.

To support access to NASC services Capital Support has developed a flip chart booklet for agencies and services as a way of removing barriers. The booklet provides a plain language approach to NASC and the services that can be provided.

A service manager is part of the NASC National Reference Group which will be looking at the future states of NASC. The service is maintaining up to date assessment reviews to ensure clients are receiving the correct package of support.

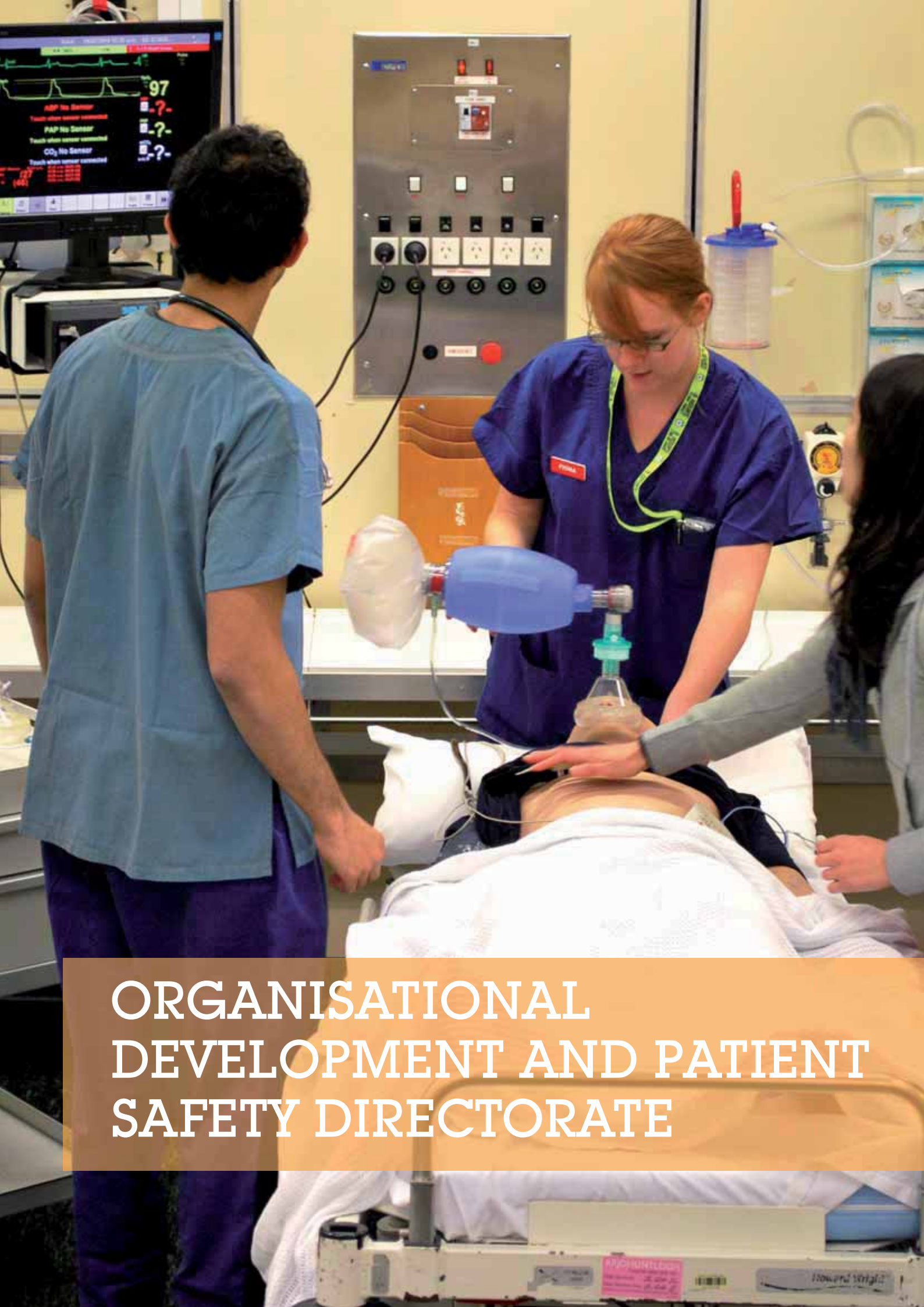
Ora Toa wound care clinic achieved improved access for Māori and Pacific people, better than benchmark wound healing results and high GP and patient satisfaction. Standardisation of wound care product use and evaluation has been undertaken across all sites to ensure best based practice is undertaken.

Collaborative work with Mary Potter Hospice has been undertaken to develop a memorandum of understanding for collaborative service delivery to patients. This has resulted in an agreement to share an electronic clinical record (PalCare) to allow access to shared knowledge and information about patients.

Kenepuru Consumer Group pilot has begun and they have already provided feedback for map layout, improved orientation for consumer committee orientation, and use of patient stories for staff training.

Other highlights include:

- Involved in Community Cellulitis Project to support admission avoidance
- Otago University recognition of the Pulmonary Rehabilitation Programme for excellence.



ORGANISATIONAL DEVELOPMENT AND PATIENT SAFETY DIRECTORATE

Introduction

The Organisational Development and Patient Safety directorate is responsible for leading and informing the organisation about quality and safety, learning development and research, and workforce. A key function of the Directorate is to provide leadership for the Clinical Governance structure which, in line with the devolved directorate structure, has been reviewed and evaluated in the past six months.

In August 2010, the Directorate formed the Learning, Development and Research group that encompasses all of the centralised training and development functions, including the Centre for Simulation and Skills Education, the Professional Development Unit and the post-graduate Medical Education and Training Unit (METU). METU is responsible for coordinating post-graduate medical education programmes, maintaining training quality, defining new training initiatives, and administering the Workforce NZ medical training contract. The application numbers for junior medical posts (RMOs) has significantly outweighed the number of posts available due to the excellent reputation of education and training at C&C DHB for RMOs. Strategic collaboration with other DHBs and the tertiary education providers will ensure that the Learning Development and Research Group align with the vision of Workforce New Zealand.

The Skills and Simulation Centre hosted 275 training days in 2010/11 with approximately 4200 participants. New courses provided this year included the Australian and New Zealand Surgical Skills Education and Training Course (ASSET) for the Royal Australasian College of Surgeons and Clinical Skills Training for Year Two House Officers.

The Patient Safety Officer role is now well embedded in the organisation and is heavily involved in working with peers to develop consistent processes relating to patient safety and quality.

A key focus over the year has been on participating in sub-regional, regional and national activities, including a project to improve and standardise the occupational health processes within and between local DHBs and we have, once again, retained tertiary level employment status with ACC through the leadership of the Occupational Health and Safety service. The Occupational Health and Safety service completed a very successful influenza vaccination programme with 40% of staff vaccinated.

The Tier 1 Health and Safety Committee now has wider staff representation from all Directorates and is attended by union organisers. The meetings are focusing on improving hazard management systems while recognising and supporting the work done by health and safety representatives and managers.

Risk management is one of Capital & Coast's core corporate control mechanisms, ensuring the organisation is aware of the operational and strategic risks which have the potential to impact on the delivery of hospital services. The most important part of a risk management system is the identifying controls and business changes to prevent identified risks from occurring. The Risk Maker, Risk Taker training pack continues to be widely used across the organisation to ensure all staff are aware of the process.

We have developed an internal system for ensuring that our services are delivering high quality and safe care services called the Service Health Check. It is already delivering valuable information which will help our services continue to deliver the best possible care to our patients with other DHB's expressing interest in this system.

Our Patient Liaison Service receives twice as many compliments as complaints and, where possible, feedback is followed up with a written response and also a telephone call. If a resolution can't be reached, complainants have the right to refer their complaint to the Health and Disability Commission. This change in approach has seen a significant reduction in Health and Disability Commission referrals.

The Quality and Safety in Health Care Remote Satellite Conference, held in May 2011, was attended by more that 120 people from across the region and featured three videoed sessions from the Quality and Safety in Health Care Conference, which was held in Nice, France in April 2010. The focus was striving for excellence in quality and safety whilst facing the challenges of reducing costs.

LEGAL

Legal Services introduced a new legislative compliance policy in August 2010 along with introducing a new legislative compliance manual and a legal knowledge repository. In addition, Legal Services holds regular workshops on medical law, which are very popular with clinical staff.

Our legal team were finalists for the 2010 New Zealand Law Awards in the In-House Legal Service category.

HUMAN RESOURCES

The emphasis of the work of the Human Resources Group has shifted during the course of the 2010/11 year. The focus of the first part of the year was on implementing a devolved model for human resource management within the DHB with the centralised functions of HR Services, Employment Relations, recruitment and the RMO and SMO Unit supporting the new model by establishing central administrative processes.

The Organisational Development team held various training and education programmes to support managers across the organisation. The HR Services Team has continued to maintain the human resources part of the HR intranet and management of the DHB's Healthy staff initiatives.

Centralised recruitment processes continued to be developed throughout the year, with previous work in this area being consolidated and built upon to enhance the recruitment services received by the organisation and applicants alike and this approach was validated by an external review of recruitment services.

Maintaining good collaborative relationships with unions has been a focus this year, both at a local level, and through participation in national collaborative forums.

The work of the RMO Unit has continued to build on our DHB's reputation as an employer of choice for Resident Medical Officers (RMOs). Entry interviews continue to show a high level of satisfaction among RMOs starting work with our DHB. RMO vacancy rates continue to be low in comparison with other DHBs.

A greater emphasis has been placed on sub-regional collaboration. This included negotiation of Service Level Agreements with the Hutt Valley and Wairarapa DHBs specifying the services the RMO Unit will provide to them. An external review is underway to determine whether it is possible to develop a co-operative model for HR across the three DHBs, consistent with Government direction.

BREAKDOWN OF EMPLOYEES	
EMPLOYEE TYPE	NUMBER OF STAFF
Permanent/Full-Time	2757
Permanent/Part-Time	1773
Casual	599
Fixed-Term/Full-Time	117
Fixed-Term/Part-Time	87
On Leave	22
Total	5355

WORKCHOICE DAY 2011

CLINICAL GOVERNANCE

The Clinical Governance Committee meets twice a month to provide direction and leadership to the HHS priorities (quality, continuous improvement and patient safety) and influences behaviours, and the design of systems and processes to help the HHS to achieve their priorities.

The Clinical Professional Leaders and Executive Directors of Organisational Development and Patient Safety attend monthly directorate performance meetings to integrate clinical and operational governance.

A review of the terms of reference and membership of the Clinical Governance Committee has seen key clinical and quality staff from HVDHB involved, and strengthened the membership from each directorate. The next step is the upcoming inclusion of the Disability Advisor and a consumer representative.

The new quality framework and two year action plan has been implemented, and integrated into the devolved directorate structure. All planned activity within the four governance pillars (consumer value, workforce, effectiveness, and risk) is monitored at directorate Clinical and Performance Meetings, which are attended by the professional leads.

Aside from the directorate clinical governance committees, there are a number of functional sub-committees within the Clinical Governance framework that are sponsored by a member of the Clinical Governance Committee and attended by a range of clinical staff, demonstrating clinical leadership and engagement in action.

These committees include the: Clinical Practice Committee, Resuscitation Committee, Infection Prevention and Control Committee, Clinical Ethics Committee, Health Information and Records Committee, Restraint Advisory Group, Blood Transfusion Committee, Consumer Advisory Committee, Medicines Committee, Clinical Practice Review Committee, and the Death Review Committee (which is under review).

HEALTH EDUCATION AND RESEARCH CENTRE

The Health Education and Research Centre is now a reality with the refurbishment of an education and research space on the Wellington Regional Hospital site.

Victoria University's School of Nursing and Biological Sciences laboratory, the Medical Research Institute of New Zealand, Massey University, and Whiteria Polytechnic all have a presence on site and represent the vision for a collaborative research and training hub. As part of this hub, 11 C&C DHB medical staff were appointed as adjunct professors and senior lecturers at Victoria in 2010.

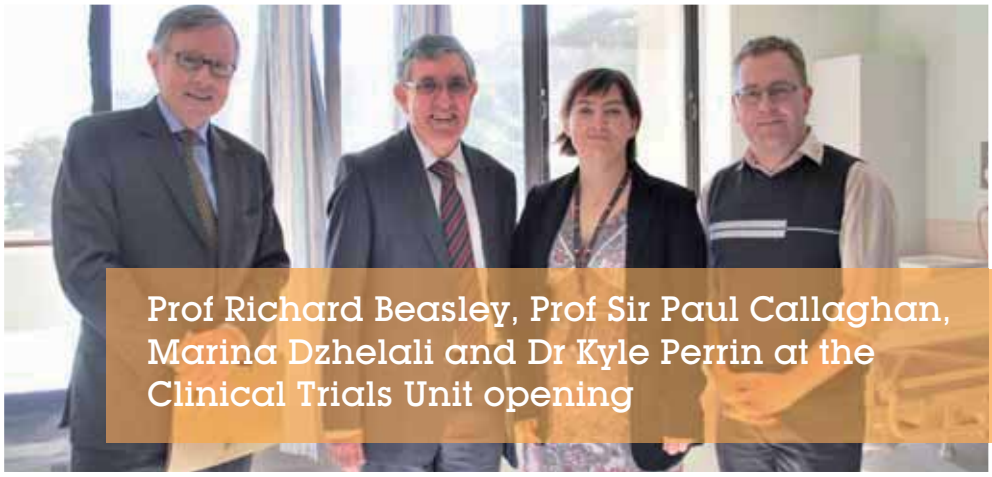
Since opening in August 2010, the new Education Centre's Horne Lecture Theatre and Easthope Seminar room have been well utilised for training and conference purposes. The most recent was the Cardiology Conference which received very good publicity for C&C DHB.

The Research Office was established mid-2010, and the 14 bed Clinical Trials Unit (CTU) was opened on 29 April 2011 by Professor Sir Paul Callaghan. The CTU aims to build on the research collaborations between Victoria University, Otago University and MRINZ. Several internal training days on research methodology, the use of statistical data and research training for nurses have been delivered in the past eight months. A monthly statistical clinic is held for researchers to access individual assistance with their research project.

Victoria University's P3 laboratory was commissioned in early 2011 and already has several PhD students using the facilities.

Dr Elaine Dennison, Professor of Clinical Research (pictured left), commenced employment on 27 June 2011. This position is a new position jointly appointed by C&C DHB and Victoria University to promote clinical research, continue to develop the post-graduate clinical research programme through to PhD level and to further develop the collaborative research relationship between the two organisations. Dr Dennison has a strong clinical research background from her various clinical and academic roles held in the UK, and will be responsible for promoting and marketing the Clinical Trials Unit to potential research agencies.

The Diploma of Clinical Research commenced in July 2010. Dr Jeremy Krebs (Endocrinologist and Clinical Leader at C&C DHB) is the programme director and works closely with the Research Office at Victoria University. The programme is now into its second year and has 26 enrolled students. The students are from a range of clinical disciplines including medical doctors, dentists, nurses, allied health and health administrators. The students are from all over New Zealand. Development of the Masters and PhD Programme is underway.



Prof Richard Beasley, Prof Sir Paul Callaghan, Marina Dzhelali and Dr Kyle Perrin at the Clinical Trials Unit opening

PACIFIC HEALTH

Directorate of Pacific Health contributes to C&C DHBs aims to improve health outcomes for Pacific people in the short, medium and long term. To do this, a whole of health sector approach is needed.

The Directorate also links the work of C&C DHB to the Ministry of Health's Pacific Strategy Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014. Ala Mo'ui sets out the priority outcomes and actions for the next five years for achieving better health outcomes for Pacific people, families and communities.

Pacific Reconfiguration

By Pacific, For Pacific Health Services are guided by the current political direction of Better, Sooner, More Convenient health services. An example of this is the current Pacific Reconfiguration programme that aims to integrate By Pacific, For Pacific services within mainstream Primary Health Organisations; prompted by recommendations from a Pacific Stocktake project in 2009 that identified the need for a significant shift in the way Pacific services were funded. A primary care Governance Steering group consisting of PHOs, Pacific primary care providers and senior Pacific primary clinical staff was set up and is developing the new PHO Pacific model of primary care.

Pacific Communications Programme

Improving health outcomes requires a whole of health and community sector approach. Engaging Pacific people in a way that promotes behaviour change is required to ensure Pacific people can make well-informed decisions about their food intake, responsibility to attend health appointments and overall general health. Being well-informed requires C&C DHB to ensure high quality professional information is available to Pacific people and the health sector.

Around 520 hours of health messages disseminated in seven Pacific Island languages has prompted a positive response by the Pacific community where English is a second language, discussions and interviews have been reported as having specific focus on high needs areas such as long term conditions, child health, the importance of attending outpatient appointments, HEHA and general health.

Pacific HEHA Church Programme

Ensuring C&C DHB promotes relationships with communities of interest, the Healthy Eating / Healthy Action Church programme funded six churches.

The overall aim of the programme is to reduce obesity through increasing levels of physical activity and improving nutrition, using a community action approach.The first year of the programme has been successful and short and medium term outcomes have been achieved.

Further, regular visits and contacts with the churches has strengthened the DHBs relationship with an evolving focus on improving relationships between these and other churches with their local PHO. This will also link the programme with the Pacific reconfiguration programme.

Many Pacific families are strong participants in church and community activities, making church communities an ideal mechanism for health education and promotion programmes that influence and change behaviour.

Workforce

Ensuring Pacific workforce supply meets service demand is one of the key goals of Ala Mo'ui. C&C DHB Pacific Directorate have focussed on developing Pacific nurses and midwives in 2010/11. This work has been undertaken in collaboration with the Director of Nursing and Midwifery and Director of Nursing Primary Health and Integrated Care.

Knowing where our Pacific nurses and midwives are based has prompted the development of a database for Pacific nurses and midwives which includes:

- A focus on developing Pacific Nurse and Midwife Mentors to assist new graduate nurses and midwives entering the Workforce
- Four Pacific Nurse development fono.

Both are key initiatives being implemented to support workforce development for Pacific Nurses.

Regional Pacific Strategic Health Group

Sub-regional collaboration across C&C DHB (22,000 Pacific people) and HVDHB (11,000 Pacific people) has prompted the two Pacific Advisory arms in both DHBs to reconsider how the DHBs could have a joint focus on Pacific people across both District Health Boards. Both Pacific Advisory arms have agreed to set up one Regional Pacific Strategic Health Group. This initiative has received support by the joint C&C DHB and HVDHB Board Chairperson, Board members and CEOs. An EOI process has been undertaken and the new group will commence in October 2011.

MĀORI HEALTH

Celebrating Māori Leadership

Charlene Williams, from Ora Toa Health Services, was presented with the Queens Service Medal for services to nursing.

Charlene received her QSM for services to the nursing profession having contributed more than 50 years to nursing. She has enjoyed an interesting and varied nursing career that included working as a district/public health nurse, a psychiatric nurse at Porirua hospital and as an almoner/medical social worker at Palmerston North hospital. She has worked in the Solomon Islands in a clinical teaching role and as charge nurse of outpatients at the hospital. During this time she also worked with the Australian eye team and had a secondment to the WHO as a field worker.

She has previously been awarded a certificate for meritorious services to the British Red Cross (for her work in the islands) and received a Capital & Coast DHB award for services to Māori nursing.

Charlene has worked tirelessly to ensure Ora Toa's services are recognized as being as good as general stream health services and this has been one of the key driving influences behind her desire to ensure our organisation achieved quality standards accreditations.

Māori Health Planning: 2011/12

District Health Boards are required by the Ministry of Health to produce an annual Māori Health Plan describing how the health of Māori will be improved and inequalities reduced in their district. 15 key indicators were identified across nine priority areas which will be monitored for improvement during 2011/12.

Cardiac and Aged Care

A number of actions and the key focus areas have been implemented, including:

- The profile and visibility of the Whānau Care Specialty Clinical Nursing roles is apparent with increasing referrals. DNAs (Do Not Attends) make up a major component of these referrals and this has created a new focus aligning with the organisations objective to reduce DNAs.

Proactive follow-ups include clinical assessment and education which often results in patients re-engaging with and improving access to Cardiac Services.

- Coordination, assessment, education and community follow-up make up a major component of the interventions. Of significance is the proportion of referrals to the Whānau Care Services team for multidisciplinary approaches to care that enables better, sooner, more convenient services for patients.
- Participation by Whānau Care Services in the Pulmonary Rehabilitation Programme has seen an increase in attendance and adherence by Māori patients, supporting improved access to services and we will continue to support this program.

Capability Development

Māori Health New Graduate Internships

Four Māori new graduate pilot internships were established in 2010. Two (dietetics and physiotherapy) were placed in teams within C&C DHBs Hospital Health Services and two new graduate nursing internships were placed in Primary Care roles within Māori health providers.

Māori Nurses Forum

The annual C&C DHB Māori Nurses forum held in February 2011 was well attended by nurses working in both hospital and primary care services across the district. This year the programme focused on professional development, cultural support and scholarship opportunities.

C&C DHB Māori Scholarship Programme

Scholarship funding has been approved for Māori studying in a health related pathway over the three years from 2010-12. Key areas for investment are nursing, medical, leadership and management and allied health. Scholarships will be distributed in 2011/12.

Responsiveness to Māori Health

Developing the capability of the C&C DHB health workforce to work with Māori patients and their whānau was a particular focus in 2010/11, in order to be more responsive to the needs of Māori patients, influence health outcomes and reduce disparities.

An analysis of patient satisfaction was completed in March 2011, showing higher satisfaction with service delivery reported by Māori patients and their whānau. This was a dramatic improvement from previous years in patient perception of staff attention paid to emotional and spiritual need (increase from 78% to 83.6%), treatment of visitors and family, (increase 81.7% to 86.9%), and cultural choices offered (increase 63% to 79%).

The increase in satisfaction is attributed to ongoing Tikanga Guidelines Education Training sessions. In 2010/11, 61 Tikanga training presentations have been delivered to 384 staff members. This is complimented by an online assessment tool which provides an instant assessment of competency for individual participants. During the same period, 660 staff members have completed the online assessment with a pass-rate of 88%.

The University of Otago has been contracted to evaluate the effectiveness of the Tikanga Māori Guidelines Programme for staff, Māori patients and their whanau.

Regional Involvement

Kia Ora Hauora - Māori Health Workforce Programme

Kia Ora Hauora is a national Māori health workforce development programme aimed at building Māori workforce capacity and capability. C&C DHB are leading and hosting the Central Region's Coordination Centre with the intention of enrolling and retaining 250 Māori on health-related career pathways. To date, there are approximately 665 Māori registered enrolments and 2670 total Māori registered nationally.

Key regional initiatives undertaken in 2011/12 have been:

TU KAHA CONFERENCE 2010

- A Rangatahi workstream delivered in conjunction with the regional Tu Kaha Conference.
- Career educator breakfasts to support the development of stronger intersectoral relationships between health, secondary schools and tertiary institutions.
- Identification of existing mentor programmes and developing a process for linking registered users to career advice, mentors and scholarships.

The focus for Kia Ora Hauora Central Region Coordination continues to be centred on three key areas: registered Kia Ora Hauora user follow-up; development of a regional science intervention and further educator engagement.

Tu Kaha 2010

In August 2010 C&C DHB led the implementation of the Central Regional DHB Biennial Māori Health Development Conference: Tū Kaha. The purpose of the conference was to strengthen the Central Region Māori health network; to promote, celebrate, learn from and build on the strengths of the network; and to identify specific priorities for Māori health development in the Central Region.

The call for abstracts resulted in over 50 presentations (including workshops) and included the Honourable Tariana Turia, Professor Sir Mason Durie, Professor Des Gorman, Mara Andrews, Hone Hurihanganui, Kim Tito and William Pua. The conference attracted 276 registrations making this one of the biggest Māori health development events in the country.

Regional Māori Health Planning

Capital & Coast has led the planning process to develop a regional Māori health plan: Tū Ora. It has been proposed performance indicators are integrated into the Regional Services Plan to ensure its proposed activities and measures are adhered to across all C&C DHB directorates.

Tū Ora provides the platform to embrace the current context and direction of Whānau Ora and calls for leadership to drive sustainable change in a challenging political and fiscal environment.

To achieve the vision and aims of the plan, four key focus areas have been identified as enablers of change:

- Māori Workforce Development
- Quality Service Provision
- Collaborative Action
- Sharing and Measuring Information.

CLINICAL & CORPORATE SUPPORT SERVICES DIRECTORATE

LABORATORY

A new state of the art Chemistry analyser, Roche Cobas C311, was installed at the Kenepuru laboratory to replace the two sets of Cobas C111 analysers.

The new Cobas C311 analyser is a stand alone, self contained floor model analyser comprised of an analytical unit and control unit. It is an automated, discrete clinical chemistry analyser intended for the in vitro quantitative/ qualitative determination of analytes in body fluids (serum/plasma, CSF and urines.) In comparison, the old C111 was manual labour intensive and used different assay applications to the Cobas C501.

The new analyser will improve the turn around time for biochemistry testing at Kenepuru and enables more testing to be done on site rather than having it processed in the main laboratory at Wellington Regional Hospital.

The haematology department of the laboratory went live with new normal reference ranges for Full Blood Count (FBC) tests, for both paediatric and adult patients. The new reference ranges were generated from the North Island Quality Assurance Group after completing a large normal reference range study, reviewing thousands of patient results across Hospital and Community laboratories. These normal reference ranges have also been adopted by Aotea Pathology and Hutt Hospital laboratory. We now have a regional reference range for FBC which makes it easier for clinicians who see patients and view results across three different laboratory sites.

The laboratory has been working at controlling the number of requests for some high costs tests. Our pathologists, in association with Aotea Pathology, have developed internal guidelines so that there are strict criteria for requesting thrombophilia screens and Vitamin D levels. These are examples of the rational use of laboratory tests so that the results are clinically valuable while the total cost of testing is contained.

The 2011 Antibiotic Guidelines for staff represents the evaluation of many years of microbiological surveillance activity and co-operation with Microbiologists, Infectious Disease Physicians and Pharmacologists to produce a clinically useful handbook. Antibiotic guidelines are essential as they direct the rational use of antibiotics in a cost-effective manner that minimises the risk of developing new antibiotic resistance patterns. Continually upgrading of these guidelines is necessary because of the changes in drug costs, increasing prevalence of antibiotic-resistant organisms and the complexity of case mix. Without the evidence of local resistance patterns, the provision of antibiotic treatment would become mostly guesswork. The development of laboratory databases and the interfacing of critical diagnostic instrumentation is fundamental to investigating antibiotic resistance within the hospital and providing information to both the Infection Prevention and Control team and all wards and departments.

PHARMACY

During 2010/2011 a multidisciplinary working group piloted and implemented a Medicines Reconciliation service to the Medical Assessment and Planning Unit (MAPU). Pharmacists identified the most accurate list of patients' current medications and compared it with the medications prescribed. Discrepancies are then recognised and documented and the medical teams can then review and resolve any issues. The process is a very effective method of preventing medication errors.

This project has been very successful and is having ongoing benefits to medication safety and to direct patient care in MAPU.

Vibe Cafe refurbishment

July 2010 saw the completion of the Vibe Cafe refurbishment. The floor space doubled in size, the surroundings were modernised and the cafe now caters for staff only. The transformation was significant; the counter moved position, a relaxing lounge area with skylight was created and an enlarged outdoor

seating area can be enjoyed in the summer months.

It is important for the staff of Wellington Hospital to have somewhere they can visit to relax, enjoy a meal or a coffee and recharge their batteries. The refurbishment took six months and involved builders, Tech services team, architects and Spotless all working closely together. Most importantly though, it relied on the patience and understanding of the hospital staff who persevered throughout the refurbishment, tolerating noise and dust, knowing that the end result would be all worth it.

Patient Satisfaction Survey

Patients are surveyed externally on their experience at Capital & Coast. The results are independently collated and are direct patient feedback. The patient satisfaction scores for food and cleaning services have continued to improve over the three years we have tracked them.

The most recent quarter results of patient satisfaction compared to previous quarters are tabled below and show steady improvement:

PATIENT SATISFACTION SURVEY RESULTS					
	FY 2009	Qtr 1 2010	Qtr 2 2010	Qtr 3 2011	Qtr 4 2011
Food	54%	57%	57%	57%	58%
Cleaning	78%	89%	89%	89%	90%

TECHNICAL SERVICES

A new challenge for Technical Services, following completion of the new Wellington Regional Hospital, and the accompanying significant jump in power demand, was how to provide sufficient back up generator capacity. For many years prior to the Wellington Regional Hospital building, two generators out of the four installed were more than adequate to support the whole site and consequently only those two would automatically start in a power outage. The challenge was to resurrect two generators which were

HOSPITAL KITCHEN

stood down from full time service 14 years ago.

Technical Services successfully removed the 30 year old outdated technology and replaced it with a modern digital control system and for the first time ever, in December 2010, we were able to autostart four generators in a blackstart test. All this work had to be done while minimising the potential risk of a power outage. While there was one outage that occurred as a result of the work undertaken, the successful completion amongst a level of complexity not found anywhere else in Wellington is something to be proud of.

Telephone Systems

Behind the scenes, Capital & Coast operates several large telephone exchanges. Most of these were installed between 1991 and 1993 and still serve around 3000 telephone extensions and fax machines throughout the organisation. The new Wellington Regional Hospital project installed a new Voice over IP system (VOIP), which was also rolled out to the community mental health bases.

For the 3000 users on the old system, the challenge was to keep the system running for several more years. This has been done by fitting new central processors and the latest operating software to five of our telephone exchanges.

All 3000 users were moved across to new hardware

and software platforms with minimal disruption to hospital function and we now have systems which will remain fully supportable for at least the next five years.

Goodbye paper

The Oracle FMIS system was further enhanced with the DHB wide rollout of its on-line iProcurement functionality.

Oracle iProcurement is part of the integrated suite of E-Business solutions designed to transform our heavily paper based requisitioning to e-business. This much needed enhancement was implemented across Capital & Coast and went live on 1 June 2011. A major gain from this change has been the ability to provide electronic authorisation at a level which meets audit requirements.

iProcurement has streamlined the procurement process with end-to-end business automation and provided powerful self service requisitioning capability with an intuitive, web shopping interface. It helps to process and manage the requisition of goods/services in an efficient and automated manner.

Fleet Management

Transport Services staged rollout of the Fleetwise Pool Vehicle Booking System (PVBS) through the 1st to 3rd quarters of 2010/11 allowing for a more comprehensive management of C&C DHB vehicles.

More than just a booking system, PVBS provides electronic support for the Transport Service in the maintenance of their fleet, and the registering of vehicle users. Extensive reporting on usage and billing is also available. A key factor of effective fleet management is to ensure clients are provided with a vehicle suitable for purpose and information from PVBS assists the transport team to make sure they make the right call.

Since its implementation, PVBS has resulted in using fewer cars for the same requirements. The system has also provided accurate data to ensure vehicles with excessive usage are balanced out with those under utilised, balancing the usage across C&C DHB.

Reduction in current expenditure of 2% to 3% is already being achieved and on completion of the rollout reduction is expected to reach 5%.

ICT

The implementation of the Orion Concerto Electronic Health Record has been a substantial improvement in providing electronic access to a patient's clinical records by clinicians across all clinical services within the DHB. Concerto replaces functions provided by the aging Allegra Clinical Record system, and additionally provides for electronic ordering of laboratory and radiology tests from within a single system.

Wellington Data Centre

In 2010, Technical Services, in conjunction with the Project Team and ICT, started to convert the former radiology records room on Level B of Clinical Services Block into a new data centre for ICT.

The data centre was built to mitigate risks associated with data loss and service interruption. The old computer rooms were operating at maximum capacity and the space they were in had become unsuitable.

A 26 rack system with in-row cooling was installed; these racks are mounted on base isolators to provide protection to hardware in the event of an earthquake. Three chillers and a buffer tank were installed to provide cooling to the racks.

The project saw the installation of a complex electrical system, large emergency power supplies, a significant environmental control system and a large gas flood system (rather than a water based sprinkler system) was also installed to protect hardware from fire.

WELLINGTON DATA CENTRE

PATIENT ADMINISTRATION SERVICE

During the past four years, our patient Did Not Attend (DNA) rates for appointments have been improving. The increase this year has been less significant because most available strategies have already been put in place. The organisation will focus on Māori and Pacific rates over the next year to identify barriers to attendance. Our Māori rates compare favourably with other similar sized DHBs whilst our Pacific Island rates are a little higher.

AVERAGE ANNUAL DNA RATES FOR ALL PATIENTS	
Financial Year	Average Rate
2010/11	8.2%
2009/10	8.4%
2008/09	9.7%
2007/08	10.6%

AVERAGE ANNUAL DNA RATES FOR MĀORI PATIENTS	
Financial Year	Average Rate
2010/11	16.1%
2009/10	16.6%
2008/09	18.3%
2007/08	19.5%

AVERAGE ANNUAL DNA RATES FOR PACIFIC ISLAND PATIENTS	
Financial Year	Average Rate
2010/11	18.7%
2009/10	19.1%
2008/09	20.9%
2007/08	23.2%

In the past year PAS services have been proactively working with the GP Practice Managers Group to improve the referral and clinical information interface which has resulted in the following improvements:

- A process for notification of community deaths has now been put in place
- A form is being developed to notify the GP Practice if an NHI number is merged
- Updated contact information within the DHB has been provided
- A greater awareness for primary care regarding C&C DHB requirements for information (e.g. eligibility for publically funded healthcare).

A trial is underway with six GP practices for the Outpatient Booking Centre to receive electronic referrals directly from the GP patient management system. These come in via third party software and provide instant acknowledgement on receipt.

MENTAL HEALTH DIRECTORATE

Refurbishment of Te Whare o Matairangi (Ward 27)

A feeling of energy and optimism surrounds the planned opening of the refurbished Te Whare o Matairangi, which is scheduled for April 2012. Since the project got the go ahead in 2010, both staff and consumers have really got behind the changes needed to make this refurbishment happen.

The building project means staff and clients have had to be relocated into three locations at Kenepuru. Planning for the February move started well ahead of schedule and management were really pleased with how smoothly the shift went.

The upgrade will make Te Whare o Matairangi more secure and user friendly for patients and their families.

Youth Intellectual Disability Inpatient Unit

Construction of a brand new facility Youth Intellectual Disability inpatient unit on the Ratonga Rua o Porirua campus also began in 2011.

The new six-bed unit will give some of the country's most serious youth offenders a much greater chance of turning their lives around. The new secure unit, costing just under $1 million to build, will have a lounge area, individual bedrooms and a self-catering kitchen.

Community House for Forensic Clients

A second community house for forensic clients has opened in Palmerston North. This is staffed by the Richmond Fellowship and the care is co-ordinated by the forensic staff in that area.

This additional facility will help provide the significant support most of these clients need when returning to the community.

Research and Publication

Staff have been involved in the research and publication of "The Good Lives Model of Offender

"LEARNING TO FLY" BOOK LAUNCH

Rehabilitation". The paper provides a step-by-step framework for assessment, formulation, treatment planning, and monitoring with a high-risk violent offender residing in the community. It has been published internationally.

Training Initiatives

The new convention centre on the Ratonga Rua campus has opened up training opportunities for not just Mental Health Directorate staff but the wider community. Recent examples of its use include:

- A two day Challenging Incident course for Te Rakau Hua o Te Wao Tapu Trust
- Psychological First Aid Training for central region Civil Defence emergency response personnel
- Calming & Restraining Programmes for the Elderly and Youth.

The learning and development team are also introducing a range of e-learning programmes.

Consumer Activities

A number of creative programmes were initiated in the 2010/2011 year. The Anthology of Writing was published and was so successful it is now into its second print run. In addition, poetry and art workshops have been held with well know artists.

Another positive experience for consumers was getting involved in recreational endeavours. Those who took part in the Ruaumoko Fitness programme are now members of the Mountaineers Club. One of the challenges of the programme was to climb Colonial Knob in the Tawa-Porirua Basin.

Funding for the first year for the "Choir of Hope" has been sourced and will be a fun and uplifting activity for consumers.

APIRANA TAYLOR

RESPONDING TO CHRISTCHURCH

PHOTO BY JULIE DALY

This years biggest operation was in support of Canterbury DHB following the series of earthquakes in their region which resulted in loss of lives, mass casualties, and widespread damage.

Capital & Coast personnel were among the first health staff to respond.

Over 30 staff including surgeons, anaesthetists, emergency physicians, nurses, mortuary technicians, social workers, nurse managers and emergency managers were involved in providing assistance in Canterbury and at the National Health Coordination Centre in Wellington. All staff were gratefully received by Christchurch and brought valued expertise and relief to exhausted Canterbury DHB staff.

Capital & Coast also provided engineering equipment and sterile supplies.

The emergency management service is focused on ensuring the C&C DHB is ready to manage emergencies ranging in severity from small incidents on DHB sites through to major disasters.

The disaster confirmed that the planning for a similar event in the Wellington region is realistic; and the lessons learned from Canterbury are being reflected in our procedures and our training. This year good progress was made with a number of local earthquake resilience projects involving emergency communications, shelter, power and heating.

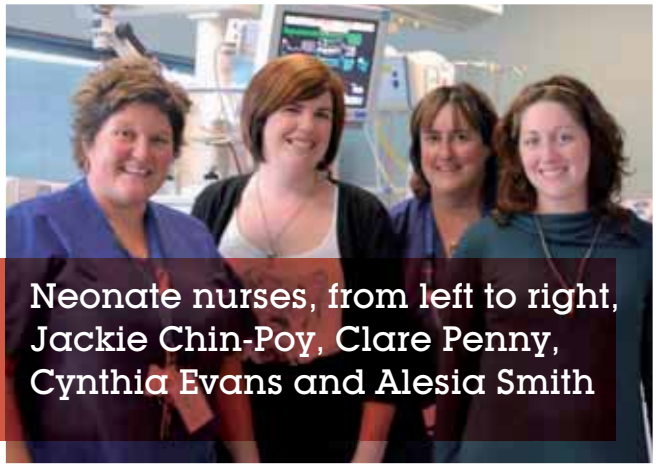
TRAVEL

The Christchurch earthquake in February had a huge effect on our transfer service. Immediately following the earthquake the Central Coordination Hub in Auckland got underway. C&C DHB's adult and NICU Flight Teams were asked to retrieve eight critically ill patients from Christchurch Hospital. Life Flight transported NICU and ICU staff to Christchurch, to relieve staff there. Life Flight also transported seven orthopaedic surgeons, supplies and care packages for teams in Christchurch, and bought home C&C DHB patients who had been in Christchurch at the time of the earthquake and couldn't get commercial flights home.

C&C DHB with Wellington Free Ambulance also helped relocate 17 rest home residents from Christchurch. The residents arrived on an Air Force plane with their belongings, walking sticks and frames. It was a new task for WFA to carry these patients off the plane and into the Air Force waiting room. It was then up to them and Capital & Coast staff to sit and calm these residents, and not mix up belongings.

The DHB then arranged local accommodation for these age care residents, whose rest homes had been badly damaged.

The frequency of transfers from the West Coast and Nelson Marlborough DHBs increased post the Christchurch earthquake because of the extra support Capital & Coast was able to offer these regions with patients that would normally be transferred to Christchurch.



Neonate nurses, from left to right, Jackie Chin-Poy, Clare Penny, Cynthia Evans and Alesia Smith

NICU NURSES

Neonate nurse Jackie Chin-Poy arrived in Christchurch on February 24 after volunteering to assist her colleagues in the Christchurch NICU. Jackie was part of a combined group of NICU nurses that included Clare Penny, Alesia Smith, Cynthia Evans, Evelyn Mahapure, Jenny Meyer and Karen Bennington, who all volunteered to work in Christchurch.

Clare and Alesia were holidaying in the South Island and volunteered to stop off in Christchurch to help. Both expressed how grateful everyone was that they were there, from the taxi driver who took them to the hospital to the staff inside.

"It was very eerie arriving at the hospital, which is on the edge of the cordon. The Emergency Department was empty and staff were milling at the reception area. Everyone was appreciative of the food and treats we had brought. Staff in Christchurch NICU were lovely to work with," Jackie said.

Despite losing friends, property and dealing with the devastation the earthquake brought, the NICU nurses said they were awed by how calm everyone was. "Aftershocks are frequent but everyone carried on as normal and never let the situation faze them. There was a real sense of community spirit with nurses from all over the country helping out," said Jackie.

While the neonatal ward was structurally undamaged by the earthquake some of the babies were suffering from trauma after the quake, which shows even the smallest among us can be affected.

Returning to Wellington Jackie was blown away by the support shown in Wellington towards Christchurch. "It was amazing to see everyone dressed in black and red, it brought tears to my eyes".

SHARING EQUIPMENT

Capital & Coast sent a diesel storage tank and a steam boiler hot well to Christchurch as part of ongoing support to Canterbury DHB following the recent earthquake.

"By liaising with the Ministry of Health National Health Coordination Centre, we identified that we had surplus decommissioned equipment that was required by Christchurch. A plan was put in place to remove the diesel tank and steam boiler hot well and transfer them to Christchurch Hospital. Once we had overcome the obstacle of removing the equipment from on site everything ran smoothly," said C&C DHB Technical Services Manager Leon Clews.

Moving the equipment meant a part of the roof in the storage area had to be lifted and the weather conditions had to be favourable. Once the equipment was out of the storage building transportation was provided by the NZ Army. "It was a truly joint effort by all involved," said Leon.

The boiler and tank left Wellington Hospital on Saturday March 5 and arrived in Christchurch the next day after travelling by truck and sea. The equipment will allow Christchurch to implement contingency plans in case of further damage.

"We are delighted to assist Christchurch in anyway possible. It is great to see everyone pulling together to help Christchurch recover from the earthquake."

SOCIAL WORKER: JUDE

Capital & Coast DHB Social worker Jude Kelly's military background immediately swung into action when she was deployed to Christchurch to provide assistance in the days following the earthquake.

For 13 days Jude Kelly assisted the social work team at Canterbury DHB. In the spare hours when she wasn't working at the hospital, home for Jude was a camper van in Hagley Park.

"The combination of being a trained army officer and a social worker was hugely advantageous. I was equipped with really good coping strategies and could hit the ground running. I was dealing with highly stressed people whose immediate reaction was flight or fight," Jude Kelly says.

Up to 10,000 people arrived at the hospital seeking information on family members in the first five days after the quake. Jude says it was up to the social work team to direct them to a relative's information centre, and help link them up with people they needed to talk to.

"People mainly wanted an assurance that they were okay and could get through it. For some people the earthquake was a real awakening. A number of women I spoke to had left their partners after putting up with years of domestic abuse."

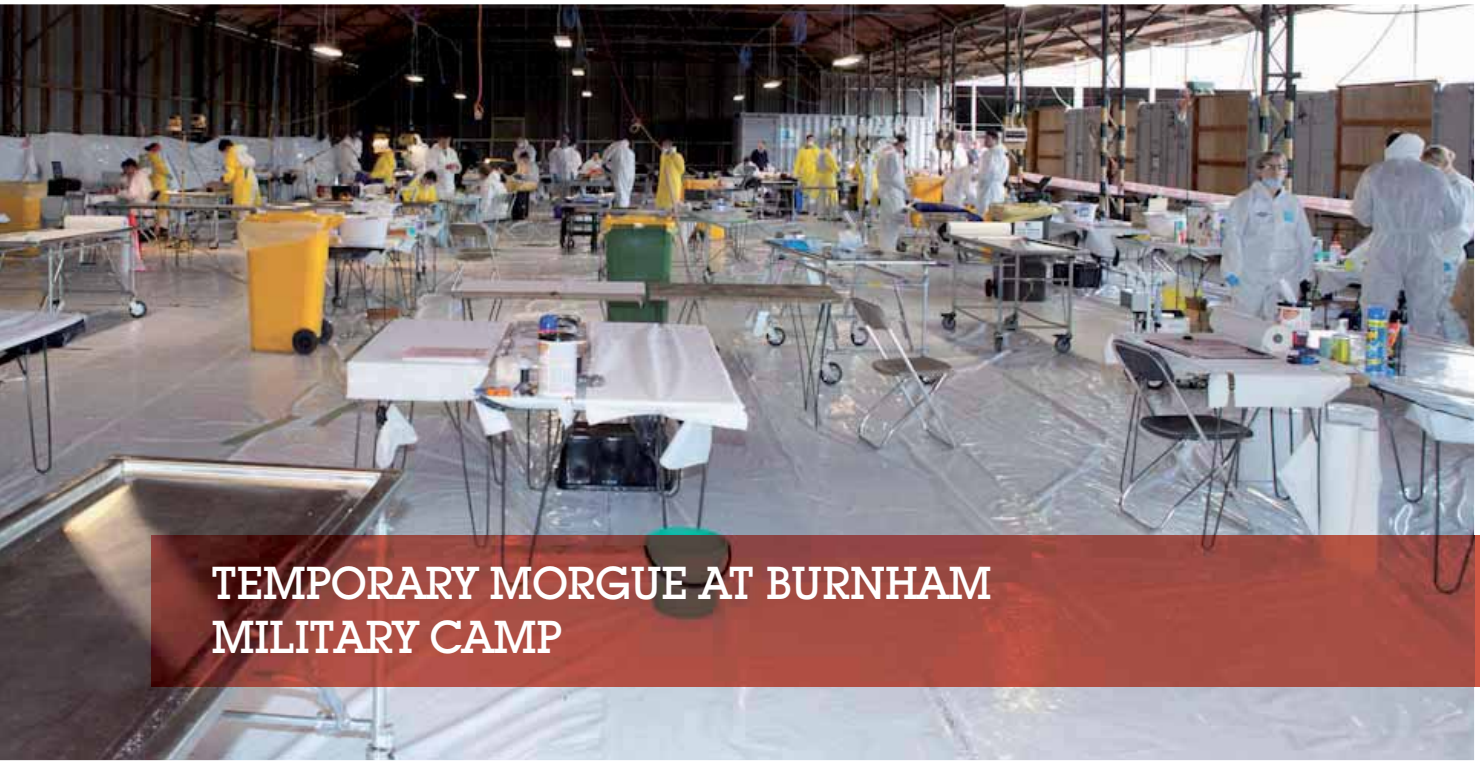
Jude says the images of children traumatised by the earthquake are still strong in her mind. "The children were all sombre, silent and still, holding on hard to the hand of an adult."

Jude Kelly says it was a real privilege and honour to work the people of Christchurch and hear their stories. "I'm in awe of the people of Christchurch. They had an amazing hope that things would get better. Cantabrians really love their city and are going to stay there no matter what."

MORTUARY: DAVID

Dealing with death is all in a days work for Capital & Coast mortuary technician David Walker but nothing had quite prepared him for the aftermath of the Christchurch earthquake.

"People mainly wanted an assurance that they were ok and could get through it. For some people the earthquake was a real awakening. A number of women I spoke to had left their partners after putting up with years of domestic abuse."



TEMPORARY MORGUE AT BURNHAM MILITARY CAMP

David was asked by the MOH co-ordination centre to assist in the Disaster Victim Identification (DVI) process being carried out at Burnham Military camp. He agreed and immediately flew down to Christchurch and spent a week helping process the bodies.

The DVI was co-ordinated by police, mortuary co-ordinators, funeral directors, and the Coroner's Office.

At the Burnham Military camp the army cleared out an unused storage shed to step up a temporary mortuary. Ten chilling container units were brought on site to store the bodies and three work stations were set up in each section: Property, Pathology, Dentistry, Finger Prints and Quality Assurance. The three Pathology stations each had a pathologist, a mortuary technician, registrar and a police photographer.

"I was initially quite anxious and wasn't sure what to expect from an earthquake zone. The most difficult aspect was the volume and conditions of the bodies, said David "You tend to forget that in an earthquake a lot of buildings catch fire so what we were seeing were badly burnt bodies starting to decompose."

The Coroner had ruled the earthquake as the mode of death so the teams were instructed to only carry out limited post-mortems.

"We did neck incisions and removed the lower jaw for dental information. We took a list of all the injuries and any identifying features. We recorded anything that could help with identification of that person. Every body had a unique number attached to them and to ensure correct procedures were followed the police photographer would take a photo of every piece of evidence with the corresponding number alongside.

"It was a totally humbling experience. I worked on baby's right through to the elderly. One person who was crushed in the earthquake was still holding on to a table leg when they were conveyed to the temporary mortuary. When rescuers located the person they had to cut the leg off the table in order to remove them."

David says the team spirit on site was fantastic.

"Everyone was willing to help everyone out. It was extremely well organised and a lot of thought had gone into reducing the stress associated with this type work. A coffee cart was on site, volunteers came into do neck and shoulder massages and a Mr Whippy van would arrive in the afternoon so we could have an icecream.

"It was amazing to be able to contribute to the process. I felt very privileged to have been able to help a body go through the necessary stages so they could be returned to their loved ones as soon as possible. I would go to another DVI process tomorrow if I was needed."

PRIMARY CARE

A "welfare centre" in Abel Tasman Street set up by Civil Defence and the Wellington City Council following the earthquake was a life line for hundreds of tourists stranded in Christchurch.

Within an hour of being asked to help Capital & Coast DHB and Compass Health put together a primary health team consisting of a GP, a team of primary care nurses and a team of mental health workers.

Planes flew tourists from Christchurch into the capital every few hours and they were then transported by bus to the welfare centre where they were met by a co-ordinated response team.

Primary Care Clinical Advisor Adrian Gilliland says most tourists arrived at the centre with only the clothes on their back and because of the horror of what they had been through they wanted to get home as soon as possible.

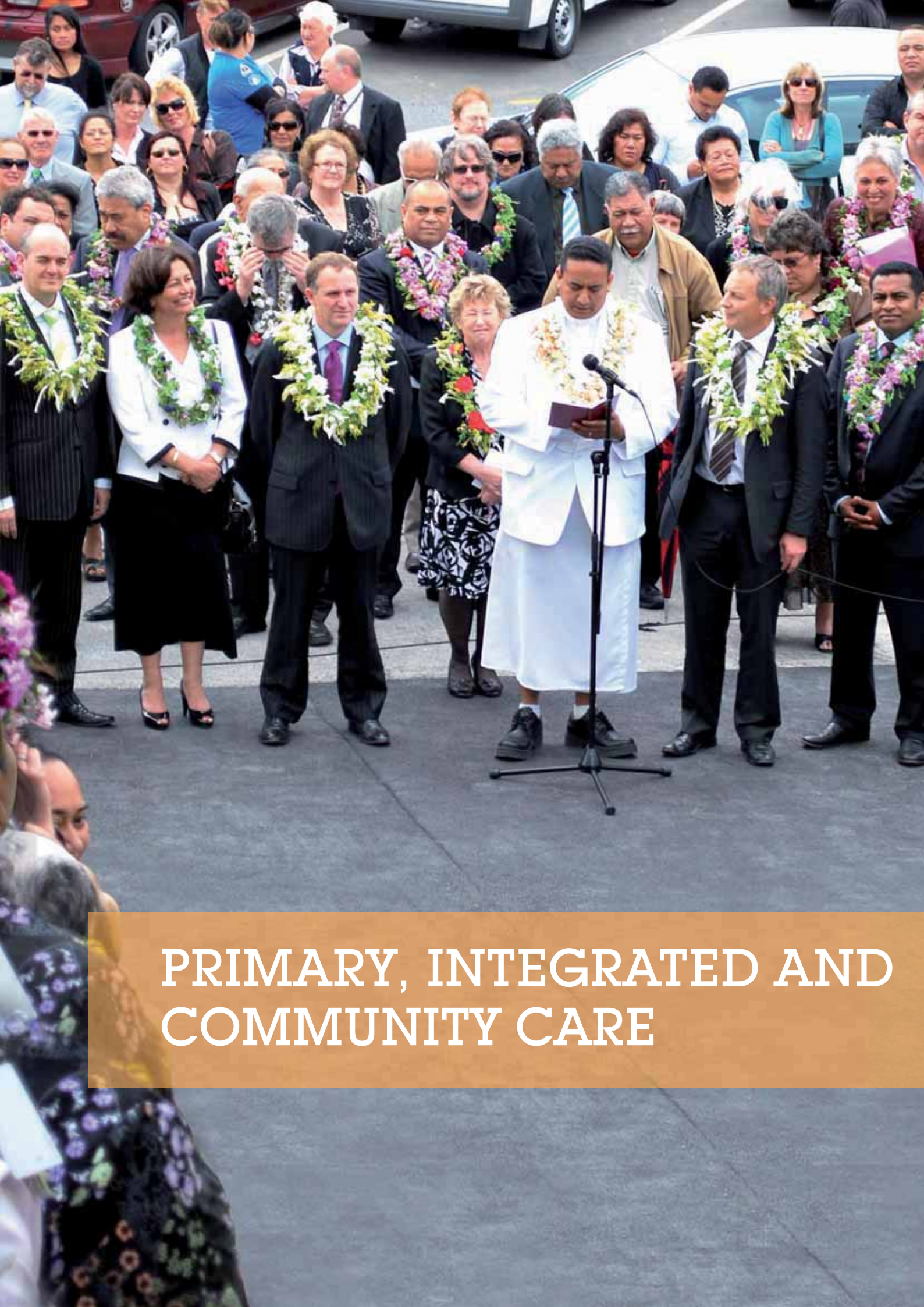
"Many people were on medication, for example blood pressure pills and insulin so we had to firstly address their health needs. Nurses worked out what medications people needed and the equivalent if from overseas. They then obtained these free of charge from a local pharmacy. We also treated people for minor injuries such as cuts, bruises and broken bones. The team of mental health workers stepped in to help people who were traumatised."

Adrian Gilliland says the welfare centre was calm, organised and well co-ordinated.

"People were directed to embassy and airline representatives so their flights home could be organised. Their accommodation requirements were quickly sorted out." He says the organisation at the welfare centre was amazing. "I was most impressed with how people dropped their day jobs and pulled together as a cohesive and efficient team. There was an enormous amount of good will from everyone."

WELFARE CENTRE

PHOTOS BY MARK TANTRUM



PRIMARY, INTEGRATED AND COMMUNITY CARE

Better, Sooner, More Convenient

This year Primary Health Care has actively taken up the government directive of Better, Sooner, More Convenient health care in the community. The policy is being used to create better services for patients through primary and secondary health professionals working together more collaboratively – sharing patient information more readily and working together with patients to provide effective health care.

"Better, Sooner, More Convenient" creates an environment where health professionals in the community are actively encouraged to work with one another and hospital-based clinicians to deliver health care in a co-ordinated and co-operative manner. In effect the new approach is removing barriers and creating a continuous health service.

Oral Health for Adolescents

A shuttle service directly to the dentist is making a huge impact on reducing tooth decay in teenagers in Wellington and Porirua. Since securing a contract from Capital & Coast in May 2010, dental provider Simply Dental NZ has provided onsite oral health services to over 1200 adolescents at 10 secondary schools and two activity centres in the Wellington region.

Simply Dental NZ screens college students and those needing dental work are transported to Simply Dental's Lambton Quay clinic and delivered back to school after their dental work has been completed. The programme has already contributed to a 9% increase in adolescent utilisation of dental services in 2010/11.

"We are definitely seeing young people who would have ended up at hospital if we hadn't been here. Some of the kids we are seeing haven't gone to a dentist in years and it's not unusual for us to see individuals who have more than nine teeth that need work," says Simply Dental Operations Manager Robin Groves.

"We had one young student who had a mouth abscess who was about to head off on his school holiday break. The school nurse rung us about the situation and we quickly acted on it. If the situation had been left for longer than 24 hours there is no doubt this boy would have ended up in emergency care."

Long term Robin Groves says getting teenagers to go to a dental appointment is a big challenge. "By providing a shuttle service to and from the dentist we tackle the problem head-on and make it a fun experience. If teenagers get into good dental habits they are more likely to continue them into the future which ultimately will have a positive impact on their overall health."

Public Health Nurse Chris Campbell with Cannon Creek primary school student Lupe Aitogi-Paese.

Porirua Kids Action Group – Swabbing

Standing in line for a throat swab isn't glamorous stuff but thanks to rugby star Robbie Fruean the children at Cannons Creek primary school in Porirua East think it's pretty cool.

The "Strong Hearts in Porirua" campaign features Robbie Fruean in a poster telling kids "if you have a sore throat get it checked out", and that message is getting through.

Porirua East's rate of rheumatic fever, a disease that has disappeared from most developed countries, is the worst in New Zealand. As a preventative approach to combat rheumatic fever, a pilot programme of throat swabbing to identify Strep throat early in children is being carried out in Porirua East.

Porirua East GP Larry Jordan says already the clinic at schools is demonstrating its value. "Sore throats are highly infectious amongst this age group of children. The great thing about going into schools is that you have a high risk group who is a captive audience. We are now making huge in-roads into the treatment of infected children."

Team Leader for School Health and Immunisation Group Brenda Little says "every day the school rings and let us know the kids who have sore throats – even if there's only one swab we still go in".

Brenda says nurses are swabbing and providing the script in partnership with GP's. "It's a multi-agency approach working together to bring down rheumatic fever rates in Porirua East."

Porirua Kids Project has been identified as one of four existing projects in New Zealand to receive funding for school based swabbing. Brenda says they are hoping to get additional funding to roll out the programme to 13 other primary schools in the region.

Diabetes

If common sense is "the knack of seeing things as they are and doing things as they ought to be done" then Clinical Nurse Specialist Lorna Bingham has it in spades.

A three day stay in MAPU for a Type 1 diabetes patient was averted early this year by spending just $48 dollars on a lock up box for medication. Lorna says it was the patient's second admission to hospital

and he was in a very agitated state wanting to go home.

“For a large number of years this man had been taking his medication four times a day. This had just been changed to just twice a day and there were safety concerns around whether the patient would remember the new regime.

“It was very simple really, all we needed to do was purchase a locked box for the patient’s medicine and have district nurses come into his home and administer his medication till he understood the new system.

“We also wanted to make sure this particular individual had food in his house so we got a food parcel and then we took the patient home. While at his house we cleaned out his fridge of old food, sorted out his medication and informed his next of kin and neighbours that he was home.”

ORA TOA GYM

It was all down to clear communication and common sense, says Lorna. “We saved money, sorted out the home environment and made the patient really happy.”

In New Zealand the incidence of Type 1 diabetes is on the increase - up to 16, 000 people now have the insulin dependent disease. Last year 164 people were admitted to Wellington Regional Hospital due to Type 1 diabetes. Nationally diabetes accounts for 12% of hospital admissions in 2007.

Ora Toa Gym

The new gym at Te Runanga o Toa Rangatira in Takapuwahia is proving a huge success with teenagers in the local community. The Ora Toa health unit already has a number of programmes for whanau, from immunisation, eczema/skin clinics; asthma treatment; and nutrition workshops through to car seat clinics, mothers groups, Saturday clinics for working parents and other support groups.

But it’s the opening of a free gym which has galvanised the community and brought people together. Health Unit Manager Teiringa Davies says they offer zumba, tai chi, and light pace programmes as well as a weekly kiddies gym. However, Teiringa says, it’s the Rangitahi - teenagers – who are really embracing the service.

The service works alongside crisis intervention agencies and police to collectively meet the social, psychological and legal needs of an individual, in addition to their medical needs.

"We find young people are using the gym like a meeting place – it's fantastic that they are coming here as we find that age group hard to get engaged in our programmes."

Teiringa Davies says the gym has a relaxed and friendly atmosphere. "We have full time staff on site – it's a safe environment and there's a real sense of fun and camaraderie among the young people who come here.

"In the past it would have been hard to get teenagers to come along to our workshops on hygiene, sexual health, problem gambling, and drugs and alcohol but because of the connections we have built up through the gym Rangitahi are now happy to attend."

Ora Toa provides a range of health services for people across the life span including the Tamariki Ora service and Rangatahi health services. The service is continuing to grow and two full-time Smoking Cessation staff have been employed to provide face-to-face and ongoing support to people who want to quit smoking, with a focus on Māori, Pacific people and pregnant woman.

The Tamariki Ora service has six staff employed – four registered nurses with post-graduate certificate in Wellchild, and two community health workers.

Wound Clinic

A collaborative Wound Care Clinic at Cannons Creek has set an international bench mark for healing rates. The pilot programme which began in April 2010 has seen 102 patients in 12 months – and no patients needed to be admitted to hospital.

In New Zealand about $50 million a year is spent on treatment for skin ulcers which in some cases could have been avoided.

It's a collaborative programme run by district Nurses, GPs and the Ora Toa primary health organisation. By working together they have achieved a wound healing rate of 68% in 12- 24 weeks. This is 13% higher than the national average of 55%.

Doug Tait, from Tawa, reckons he would have lost his leg if it wasn't for the "fabulous" care he got from the clinic in Cannons creek. "My leg was just weeping and so painful but no one could understand why. The people there really did wonders, and I'm grateful for that."

Project Manager Anne Boland says patients are waiting just a week to be seen. She says in the past patients were being managed without the specialised care it takes to heal legs.

"The benefits are huge. Patients don't need to come into hospital, their wounds are healing faster, and the programme is co-located in an area where people live and patients are able to make a self-referral."

Anne says the relationship between vascular inpatient services has been strengthened through the clinic due to the thorough assessment of patients. "The wound healing clinic is now seen as an essential service so it will continue."

Sexual Health Services

A custom-built specialist medical forensic unit is co-located with Wellington Sexual Health Service in the Cuba Street Clinic. Named Tū Pakari Ora for its mission of helping people experiencing sexual violence to stand tall and strong, the Sexual Assault Assessment and Treatment Service (SAATS) opened its new doors after relocating from the After Hours service on Adelaide Road in April 2010. The service is run by a dedicated team of nurses and doctors, including a 24/7 specialist roster to respond to acute calls. The Cuba Street centre complements the already existing unit located within the Hutt Rape Counselling Network in Lower Hutt, which is a collaborative effort by both agencies.

The service provides private, sensitive, confidential care and specialises in the collection of forensic evidence. After a medical/forensic examination is

SEXUAL HEALTH SERVICES
Clinical Manager Kim Lund and Dr Jenny Haywood

SAATS doctor Jenny Haywood says follow up care after a sexual assault is crucial to the recovery of an individual.

carried out, evidence can be handed over to police immediately or stored anonymously for six months. This gives the patient time to come to grips with what has happened and make an informed decision about how they would like to proceed.

SAATS doctor Jenny Haywood says follow up care after a sexual assault is crucial to the recovery of an individual. The service works alongside crisis intervention agencies and police to collectively meet the social, psychological and legal needs of an individual, in addition to their medical needs.

The care for people who have been assaulted is more effectively co-ordinated than in previous years where the forensic services were provided by a group of committed and caring volunteers. The unit is here to support and compliment services and also improve choice. Follow up medical care can now be provided by the SAAT Service if this is desired. “We now have a face and a phone number, where in the past we didn’t.”

Clinical Manager Kim Lund says through their collaborative, multimedia campaign, the “Who Are You?” project, they hope to influence the culture of our community and the way we look at sexual assault.

Kim says the campaign will challenge people to move from a casual observer to an “ethical bystander”, someone who can effect change and lead to a positive outcome. The principles of the campaign, that people will intervene if they identify a problem and know what to do, have been developed from the “Sex & Ethics” programme of partner agency Wellington Sexual Abuse Network.

The “Who Are You?” campaign focuses on what everyone of us can do to stop a possible sexual assault from happening. For more information on the project, go to www.whoareyou.co.nz

Most of us want help if we are in an unsafe situation but most of us aren’t sure how to step in and help others even when it’s happening right in front of us. “Sexual assault isn’t spoken about, yet we see it every day.”

The Gastroenterology Clinical Pathways Collaborative

Making simple food changes is helping keep patients out of hospital and off medication.

Irritable Bowel Syndrome affects one in seven adults in New Zealand and a new diet programme for patients, developed as part of Capital & Coast's Gastroenterology Clinical Pathways Collaborative, is having a profound effect on patient outcomes and reducing the need for specialist referrals to Wellington Hospital.

The Gastroenterology Clinical Pathway Collaborative was set up in 2009 and carried out studies with General Practices on the management of Irritable Bowel Syndrome through the use of an alternative diet.

In appropriate cases instead of doctors referring low risk patients to a gastro-enterologist they are provided with advice on an alternative diet.

Dr John Wyeth, Clinical Leader Gastroenterology and GI Endoscopy, says normal gut function relies on muscles and nerves. "Irritable bowel syndrome is some disorder of the nerves and muscles. The study led to a better understanding of the low-FODMAP diet."

FODMAPs are fermentable carbohydrates and reducing them in the diet can reduce or eliminate irritable bowel symptoms.

"A common one is fructose (fruit sugar) – some people have difficulty absorbing fructose. As a result it goes through the small intestine into the large intestine and it is fermented. Other problem nutrients include wheat and lactose."

Adherence to the low-FODMAP diet after 12 months is about 70%. "That tells us it is working," Dr Wyeth.

"When I talk to patients, the fact they are getting benefit makes them committed." Aside from patient benefits, the new measures have resulted in a 10% reduction in referrals to Gastroenterology.

Dr Adrian Gilliland, C&C DHB Primary Care Clinical Advisor, said as a working GP from Porirua he found the education sessions and information resources developed very useful.

"It meant that I could make the diagnosis of IBS on the basis of some simple diagnostic criteria and blood tests for this debilitating condition without having to refer my patients for unnecessary invasive tests such as gastroscopies and colonoscopies. Previously I had very little to offer my patients to treat this debilitating condition. The information resource developed in association with C&C DHB Dietitians provides a three step plan for the dietary management of this condition that has improved the symptoms of most of the patients that I have provided it to," said Dr Gilliland.

Adherence to the low-FODMAP diet after 12 months is about 70%. "That tells us it is working," Dr Wyeth says.

"When I talk to patients, the fact they are getting benefit makes them committed."

interRAI implementation 2010/11

The national implementation of interRAI outlined by the Ministry of Health commenced in 2008/09 and there has been significant activity in rolling out interRAI assessment tools across C&C DHB over the 2010/11 year (year three of the four year project).

interRAI is now the sole needs assessment tool for older people in their own home, supporting service planning by using the results to develop personalised care plans for older people. We have a Systems Clinician role which also provides support to Hutt Valley and Wairarapa DHBs and have been part of case mix development with Auckland University with Auckland DHB and Canterbury DHB. We have Working with Central Region DHB-wide to develop consistent and equitable criteria and processes for access to Aged Residential Care.

Health of Older People

In 2010/11 the Health of Older People team reviewed respite services for aged residential care and day care. As a result of this work, Planning and Funding have been able to strengthen our respite care model by improving funding and service access.

Dedicated respite beds have been developed in Kapiti which enable carers to book a placement in advance so to make it easier for them to plan their time away from care responsibilities. A new dementia day care will also be developed in 2011/12 for the Kapiti area.

C&C DHB Planning & Funding have taken a stronger, more proactive approach to performance managing aged residential care (ARC) providers to complete necessary quality improvements as identified in Certification audits against the Health & Disability Service Standards. This work has helped us identify and action issues that impact on quality as well as targeting educational resources to improve service delivery.

We are working to deliver education to meet identified needs within the sector which has been targeted to suit senior managers, clinical managers, registered nurses and staff providing hands on care. Some of the educational themes delivered included responsibilities in clinical delegation and supervision, tools for robust nursing assessment, and care planning and documentation. There has also been a significant amount of work to remedy issues that have arisen from the investigation of complaints within the ARC sector.

The “Yellow Envelope” was developed and launched to improve the patient journey between aged residential care and acute hospital services. On each side of the envelope there is a check list of information that must be placed inside the envelope to accompany the patient between the services. This simple method of keeping all the required documentation in one place ensures that care services can be planned effectively and has improved the experience of patients from aged residential care in the emergency department and on arrival back in the aged residential facility.

Suzanne Miller won this year’s Ellen Dougherty Award for development of the “Yellow Envelope”.

GOVERNANCE OF C&C DHB

STRUCTURE

The governance structure is based on the DHB's three key roles:

- Planning and funding health and disability services for the Capital & Coast district.
- Providing health and disability services to its communities. These services include: Medicine, Cancer and Community Services; Surgery and Outpatients; Anaesthesia, Intensive Care Unit and Patient Services Coordination Unit (PSCU); Women's and Children's Health; Mental Health; Clinical and Corporate Support Services; Primary, Integrated & Community Care; Māori Health; Pacific Health; and Organisational Development and Patient Safety.
- Governing the District Health Board.

BOARD MEMBERS

Dr Virginia Hope - *Deputy Chair, Elected Member (until Nov 2010) - Board Chair, Elected Member (from Dec 2010)*
Peter Glensor - *Deputy Chair, Appointed Member (from Dec 2010)*
Sir John Anderson - *Board Chair, Appointed Member (until Nov 2010)*
Dr Judith Aitken - *Elected Member*
Debbie Chin - *Crown Monitor*
David Choat - *Elected Member (from Dec 2010)*
Barbara Donaldson - *Elected Member (from Dec 2010)*
Peter Douglas - *Appointed Member*
Margaret Faulkner - *Elected Member*
Ruth Gotlieb - *Elected Member (until Nov 2010)*
Keith Hindle - *Appointed Member*
Helene Ritchie - *Elected Member*
Peter Roberts - *Elected Member (until Nov 2010)*
Darrin Sykes - *Appointed Member (from Dec 2010)*
Donald Urquhart-Hay - *Elected Member (deceased 13 August 2011)*

The Board is responsible for the governance of the organisation and is accountable to the Minister of Health. The governance structure for DHBs is set out in the New Zealand Public Health and Disability Act 2000. The Capital & Coast DHB Board consists of 11 members who have overall responsibility for the organisation's performance. Seven Board members are elected as part of the three-yearly local body election process (being held again in October 2010) and four are appointed by the Minister of Health. A Crown Monitor was appointed in the 2007/08 year and replaced by a new Crown Monitor in November 2009.

OUR OBJECTIVES AS A DISTRICT HEALTH BOARD

The objectives of DHBs are described in the section 22 of the New Zealand Public Health and Disability Act 2000 and are:

- to reduce health disparities by improving health outcomes for Māori and other population groups
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
- to improve, promote, and protect the health of people and communities
- to promote the integration of health services, especially primary and secondary services
- to promote effective care or support for those in need of personal health services or disability support services
- to promote the inclusion and participation in society and independence of people with disabilities

- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
- to be a good employer.

The Board delegates specific matters to the Chief Executive Officer of our DHB. The Board has established four committees to the Board and these are made up of Board members, DHB staff and community representatives. Three are required under the NZPHD Act 2000 – that is, they are statutory committees. Each Board committee operates within a formal terms of reference.

Hospital Advisory Committee (HAC)

The functions of the hospital advisory committee are to: monitor the financial and operational performance of the hospitals (and related services) of the DHB; assess strategic issues relating to the provision of hospital services by or through the DHB; and give the board advice and recommendations on that monitoring and that assessment.

Community and Public Health Advisory Committee (CPHAC)

The CPHAC provides the Board with advice on the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the DHB and priorities for use of the health funding provided.

The aim of the Committee's advice must be to ensure that all service interventions the DHB has provided or funded or could provide or fund for the care of that population; and all policies the DHB has adopted or could adopt for the care of that population, maximise the overall health gain for the population served.

Disability Support Advisory Committee (DSAC)

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

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

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

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

Other Committees

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

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

STATEMENT OF RESPONSIBILITY

For the year ended 30 June 2011:

1. In terms of the Crown Entities Act 2004, the Board and Management of Capital & Coast District Health Board accepts responsibility for the preparation of the annual Financial Statements and the judgements used in them.
2. The Board and Management of Capital & Coast District Health Board accepts responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial and non financial reporting.
3. In the opinion of the Board and Management of Capital & Coast District Health Board, the annual Financial Statements for the year ended 30 June 2011, fairly reflect the financial position and operations of Capital & Coast District Health Board.

Virginia Hope
Chair
31 October 2011

Mary Bonner
Chief Executive Officer
31 October 2011

Peter Glensor
Deputy Chair
31 October 2011

Theo Koenders
Chief Financial Officer
31 October 2011

STATEMENT OF SERVICE PERFORMANCE

The Statement of Service Performance sets out Capital & Coast DHB's (C&C DHB) key milestones and performance measures as described in the Statement of Intent for the period 1 July 2010 to 30 June 2011. Whilst the forecast performance targets are expressed in specific terms, actual performance is likely to vary, positively or negatively, in each case.

Highlights:

- Immunisation rates for 2 year olds are a key government priority, as evidenced by its position as a Health Target. C&C DHB has achieved target and is well placed for the increase to a 95% target by 30 June 2012. Immunisation rates for Maori and Pacific 2 year olds remain consistently high with one Primary Health Organisation achieving 100% for their Maori and Pacific 2 year old cohort. This demonstrates C&C DHB's success in reducing inequalities in immunisation rates.
- Better help for smokers to quit, another Health Target, has seen a dramatic increase in performance due to the diligence of C&C DHB's clinical staff. C&C DHB has exceeded the target for the 2010/11 year. Progress is on track for the expansion of this health target to primary care in 2011/12.
- C&C DHB had a considerable improvement in performance against the three measures of the Better Diabetes and Cardiovascular Services health target. C&C DHB exceeded target for all age groups for the percentage of predicted diabetics receiving an annual check and for the proportion of diabetics with a Hb1Ac less than or equal to 8. Although target was not achieved for the percentage of people receiving a cardiovascular risk assessment, the number of people who received an assessment increased by over 10%.
- C&C DHB achieved target for the rate of mortality within 30 days of discharge, at 1.32% for the 2010/11 year, below the target of less than 1.5%. C&C DHB was one of the top performing DHBs for this measure.

One of the functions of the Statement of Intent and in particular Statement of Service Performance, as stated in the Crown Entities Act (s142), is to show how what Capital and Coast DHB did in 2010/11 is measured. These performance measures, targets and milestones are subject to annual audit by auditors appointed by the Office of Auditor General.

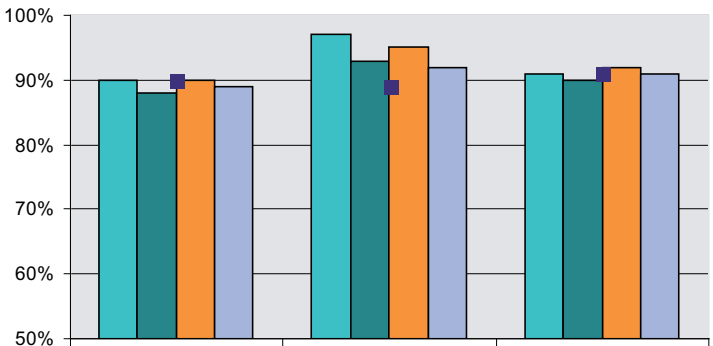
RATING	CRITERIA
Achieved	Where the target has been reached.
Partially Achieved	Where some of the targets within the performance measure have been achieved.
Progress towards Target	Where there has been improvement over baseline and work programme(s) established to continue progress.
Not Achieved	Where no targets within the performance measure have been achieved.

OUTPUT CLASS: PUBLIC HEALTH SERVICES

Public health services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.

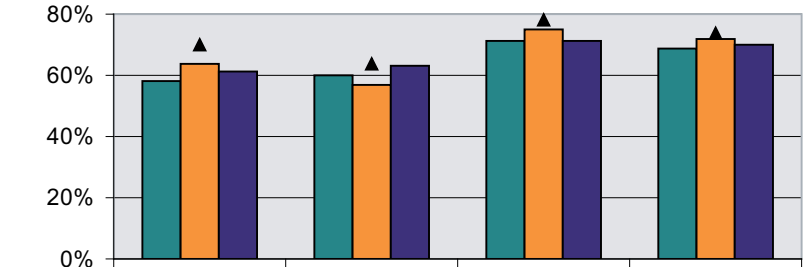
Public health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

Performance Measure	Performance Result	Target Achievement
Immunisation Services – Provided by Primary Care, Well Child Providers, and Regional Public Health. Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides not only individual protection for some diseases but also population-wide protection by reducing the incidence of diseases and preventing them spreading to vulnerable people.[1]		
Proportion of two year olds fully immunised Target: Māori: 90% Pacific: 89% Total: 91%	**Proportion of Two Year Olds Fully Immunised**  This is the measure of the Government's health target for Increased Immunisation. C&C DHB has exceeded target for the Pacific population and met target for the total population for all four quarters. In the last quarter of 2010/11 Maori were 1% below target, although have an average over the year of meeting target. Having accurate, real-time data enables timely interventions where issues around coverage are identified. PHOs are advised weekly of immunisation coverage data which promotes increased awareness and desire to improve both coverage and timeliness for their population. Community Immunisation Outreach services are noteworthy for their commitment and responsiveness. C&C DHB immunisation services are preparing for an increase to 95% by 30 June 2012.	**Achieved**

	Maori	Pacific	Total
Jul - Sept	90%	97%	91%
Oct - Dec	88%	93%	90%
Jan - Mar	90%	95%	92%
Apr - Jun	89%	92%	91%
Target	90%	89%	91%

[1] *Ministry of Health DHB Performance Monitoring Framework 2010/11*

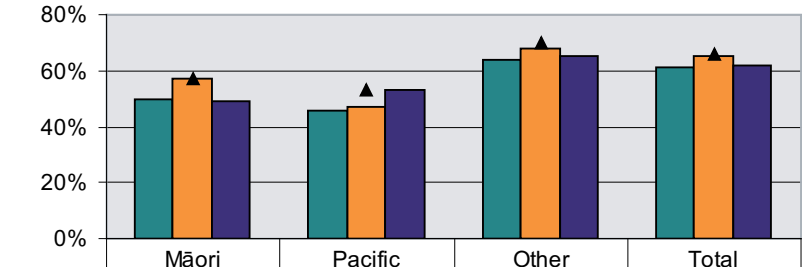
Performance Measure	Performance Result	Target Achievement
Improving breastfeeding rates – Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden.[2]		
Proportion of infants fully or exclusively breastfed at 6 weeks. [3] Targets: Māori: 70% Pacific: 64% Other: 78% Total: 74%	**Full or Exclusive Breastfeeding at 6 Weeks** Full or exclusive breastfeeding at 6 weeks in C&C DHB is comparable to national performance. The Baby-Friendly Hospital Initiative encourages new mothers to continue to breastfeed once returning home.	**Not Achieved**



	Māori	Pacific	Other	Total
2008	58%	60%	71%	69%
2009	64%	57%	75%	72%
2010	61%	63%	71%	70%
▲ Target	70%	64%	78%	74%

Source: Royal New Zealand Plunket Society

Proportion of infants fully or exclusively breastfed at 3 months. Targets: Māori: 57% Pacific: 53% Other: 70% Total: 66%	**Full or Exclusive Breastfeeding at 3 Months** C&C DHB is performing above the national average for full or exclusive breastfeeding at three months.	**Partially Achieved**

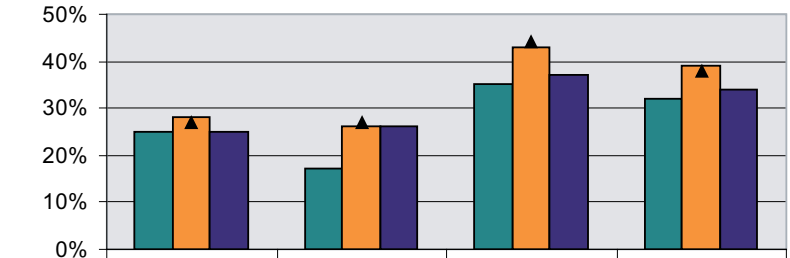


	Māori	Pacific	Other	Total
2008	50%	46%	64%	61%
2009	57%	47%	68%	65%
2010	49%	53%	65%	62%
▲ Target	57%	53%	70%	66%

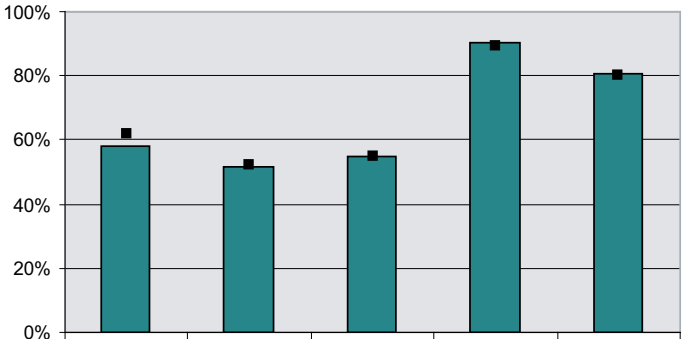
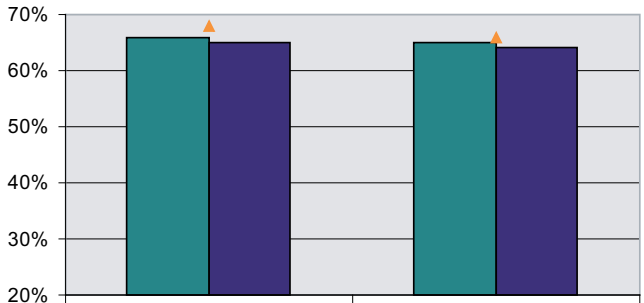
Source: Royal New Zealand Plunket Society

[2] *DHB non-financial Monitoring Framework 2010/11, detailed indicator dictionary for the measures included in the Systems Integration Dimension, December 2009, p 21.*

[3] *Data is based on Plunket figures for the 2010 calendar year.*

Performance Measure	Performance Result	Target Achievement
Prportion of infants fully or exclusively breastfed at 6 months. Targets: Māori: 27% Pacific: 27% Other: 44% Total: >=38%	**Full or Exclusive Breastfeeding at 6 Months** C&C DHB is performing above the national average for full or exclusive breastfeeding at six months.  Source: Royal New Zealand Plunket Society Pacific figures across the three time periods show an increase reflecting the stable Pacific breastfeeding support workforce and major breastfeeding promotion in the Pacific community by the breastfeeding team. There is a Healthy Eating Healthy Activity (HEHA) Breastfeeding Administrator working with Maori providers in addition to a Community Lactation Coordinator / Consultant in Women's Health. These positions work to encourage breastfeeding. C&C DHB was reaccredited to the Baby Friendly Hospital Initiative (BFHI) for the third year running this year which has effectively raised the rate of mothers exclusively breastfeeding their babies on discharge from maternity to over 80%. The next step is taking this initiative beyond the hospitals and collaborating with community providers.	**Not Achieved**

	Māori	Pacific	Other	Total
2008	25%	17%	35%	32%
2009	28%	26%	43%	39%
2010	25%	26%	37%	34%
▲ Target	27%	27%	44%	38%

Performance Measure	Performance Result	Target Achievement
Percentage of eligible women having cervical screening in the last 3 years[4] Targets: Māori: 62% Pacific: 52% Other: >=89% Asian: 55% Total: >=80%	**Percentage of Eligible Women Having Cervical Screening in the Last 3 Years**  C&C DHB achieved target for some population groups for the percentage of eligible women having cervical screening in the past three years. Targets for Maori and Pacific were not attained, and initiatives for these groups are underway to improve the percentage having cervical screening.	**Partially Achieved**
Proportion of PHO enrolled 65+ population who have received a flu vaccination Targets: Total: 68% High Needs: >=66%	**Proportion of PHO Enrolled 65+ Population who have Received a Flu Immunisation** C&C DHB has flu immunisation rates for the over 65 population above the national average.  C&C DHB has not achieved targeted flu vaccination coverage to 30 June 2011; however, performance is above the national average. For the High Needs population, coverage for C&C DHB is slightly higher than for the total population, and is also above the national average.	**Not Achieved**

	Maori	Pacific	Asian	Other	Total
3 yrs to Dec 2010	58%	51%	55%	91%	81%
Target	62%	52%	55%	89%	80%

	Total	High Needs
C&C DHB	66%	65%
National Average	65%	64%
C&C DHB Target	68%	66%

[4] *Data provided by Ministry of Health for three years to December 2010.*

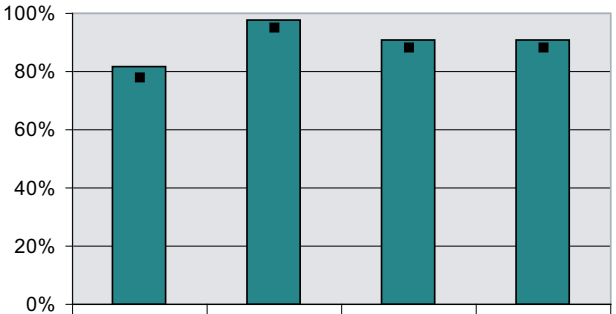
OUTPUT CLASS: PRIMARY HEALTH AND COMMUNITY SERVICES

Primary health and community services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maori health services, pharmacist services, Community Pharmaceuticals, and child and adolescent oral health and dental services.

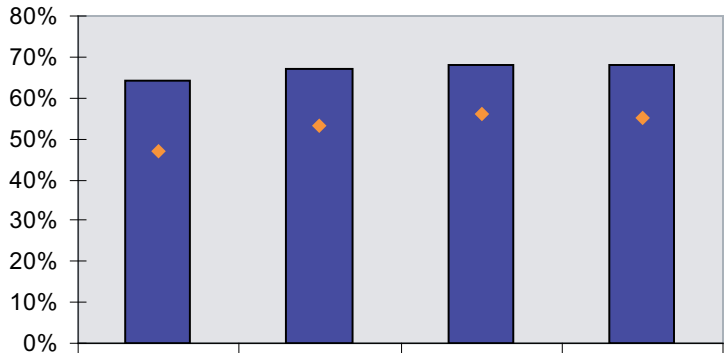
These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Preventative and treatment services are focussed on individuals and smaller groups of individuals.

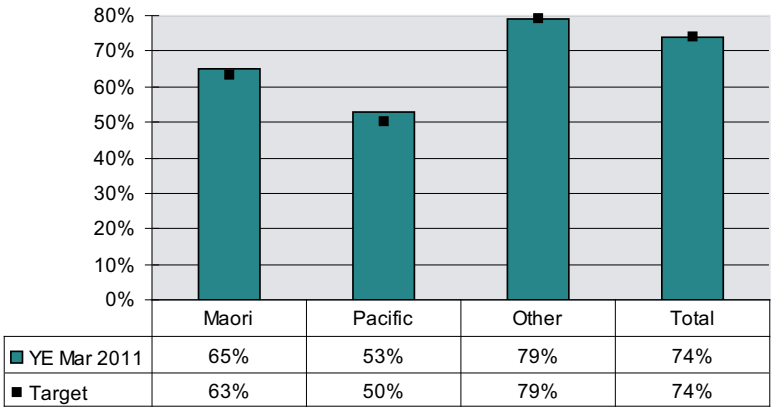
<table>
<tr><th>Performance Measure</th><th>Performance Result</th><th>Target Achievement</th></tr>
<tr><td colspan="3">Primary Health Care Services. Primary health care relates to the professional health care received in the community, usually from a GP or primary health care nurse. A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequalities between different groups. The launch of the Primary Health Care Strategy in 2001, followed by the establishment of the Primary Health Organisations (PHOs), set a new direction and vision for primary health care services in New Zealand. Primary Health Care Services are subsidised via a national contract between DHBs and PHOs based on the number of people enrolled.</td></tr>
<tr><td>PHO Enrolment

Targets:
Māori: 78%
Pacific: 95%
Other: 88%
Total: 88%</td><td>Proportion of the Population Enrolled with a PHO
 

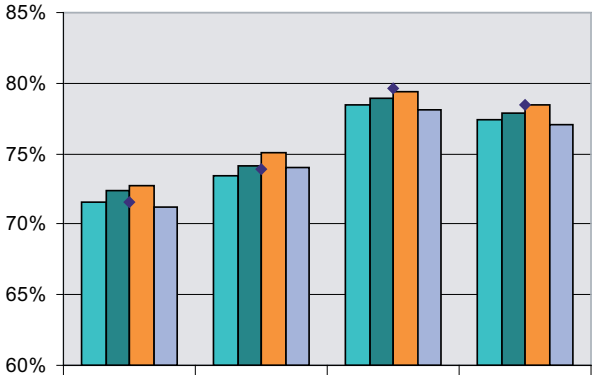
<table>
<tr><th></th><th>Maori</th><th>Pacific</th><th>Other</th><th>Total</th></tr>
<tr><td>Enrolment at 30 June 2011</td><td>82%</td><td>98%</td><td>91%</td><td>91%</td></tr>
<tr><td>Target</td><td>78%</td><td>95%</td><td>88%</td><td>88%</td></tr>
</table>
C&C DHB has met target for all population groups for PHO enrolment in the 2010/11 year. Enrolling with a PHO enables continuity of care with the same GP in addition to people being able to access a greater range of services provided on a PHO level, such as treatment programs for chronic conditions.</td><td>Achieved</td></tr>
<tr><td>Proportion of patients aged 15 to 75 attending primary care provided with smoking cessation advice</td><td>This measure is not reported for the 2010/11 year due to the delay of implementation of systems to capture this data. With a primary care smoking health target for 2011/12, this will be measured in the future.</td><td></td></tr>
</table>

Performance Measure	Performance Result	Target Achievement
Long-term conditions comprise the major health burden for New Zealand now and into the future. This group of conditions is the leading cause of morbidity in New Zealand and disproportionately affects Maori and Pacific peoples. As the population ages, and lifestyles changes, these conditions are likely to increase. Taking a patient centred approach, better coordinating care pathways, and better supporting health professionals to work across service settings and share information, for the benefit of the patient, will improve long-term conditions care.		
Proportion of predicted diabetics receiving an annual check Target: Māori: 47% Pacific: 53% Other: 56% Total: 55%	**Percentage of Predicted Diabetics Receiving an Annual Check**  This is a portion of the measure of the Government's health target for Better Diabetes and Cardiovascular Services. C&C DHB has achieved the target set for annual diabetes checks for all ethnicities. The best result is for Maori and Pacific populations that exceeded target by 17% and 14% respectively. Over the past 12 months C&C DHB has seen an absolute increase in the number of annual reviews by 9%.	**Achieved**

	Maori	Pacific	Other	Total
YE Mar 2011	64%	67%	68%	68%
Target	47%	53%	56%	55%

Performance Measure	Performance Result	Target Achievement
Proportion of diabetics checked with satisfactory blood glucose control (HbA1c less than or equal to 8) Target: Māori: 63% Pacific: 50% Other: 79% Total: 74%	**Percentage of Diabetics with Hb1Ac<=8**  Maori | Pacific | Other | Total YE Mar 2011: 65% | 53% | 79% | 74% Target: 63% | 50% | 79% | 74% **This is a portion of the measure of the Government's health target for Better Diabetes and Cardiovascular Services.** C&C DHB has met all targets for the proportion of people with diabetes who have a HbA1c of less than or equal to 8% (satisfactory or better blood sugar level). Māori and Pacific patients achieved results favourable to target. This indicates that investment in these populations is having a positive effect.	**Achieved**

Performance Measure	Performance Result	Target Achievement
Percentage of people receiving a cardiovascular risk assessment in the last 5 years Target: Māori: 71.6% Pacific: 73.9% Other: 79.6% Total: 78.4%	**Percentage of People Receiving a Cardiovascular Risk Assessment in the Last 5 Years**	**Partially Achieved**

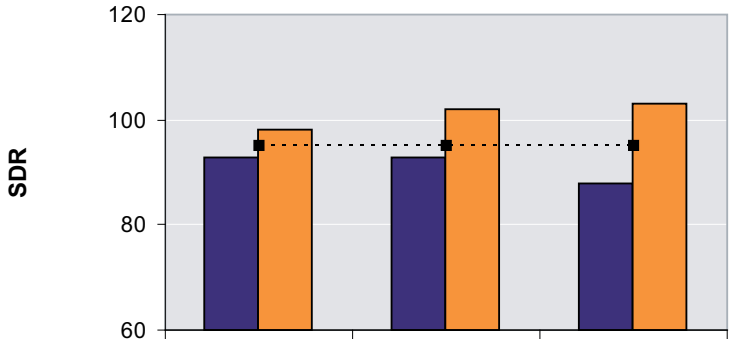


	Maori	Pacific	Other	Total
1 Jul 2005 - 30 June 2010	71.6%	73.4%	78.4%	77.4%
1 Oct 2005 - 30 Sept 2010	72.4%	74.1%	78.9%	77.9%
1 Jan 2006 - 31 Dec 2010	72.7%	75.1%	79.4%	78.5%
1 Apr 2006 - 31 Mar 2011	71.2%	74.0%	78.1%	77.1%
Target	71.6%	73.9%	79.6%	78.4%

This is a portion of the measure of the Government's health target for Better Diabetes and Cardiovascular Services.

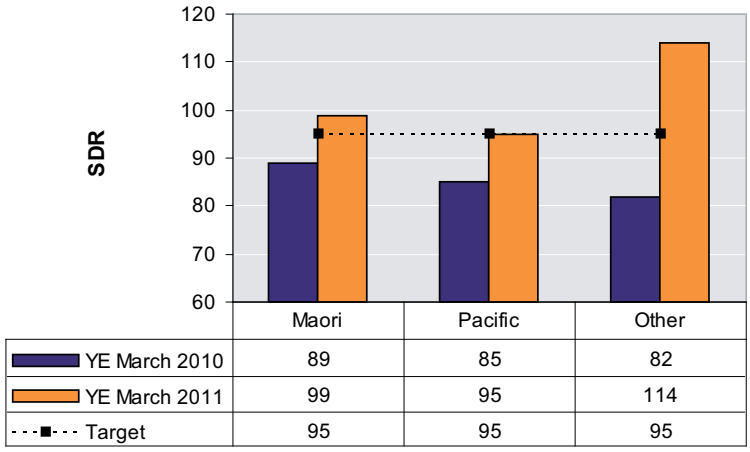
This measure uses the number of cardiovascular lab tests conducted over a five year period to determine the number of risk assessments completed. Although C&C DHB has not met target for this period, C&C DHB screened 6,046 (10.8%) more people and the rate of growth in the eligible population was 11.2% (8,078). By contrast the entire district's population grew by 1.1%[5] (3,280) over the same period.

[5] *Statistics New Zealand projections for 2010.*

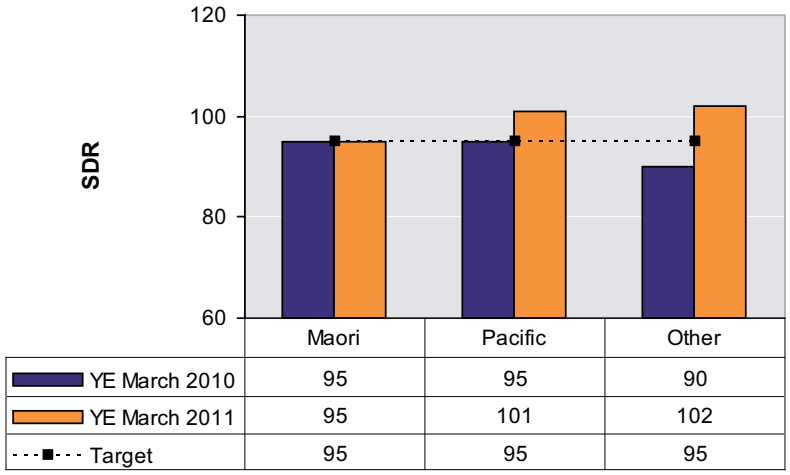
Performance Measure	Performance Result	Target Achievement
Ambulatory Sensitive Hospitalisations[6] (ASH) are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors. If there is good access to effective primary health care for all population groups, then it is reasonable to expect that there will be lower levels of ambulatory sensitive hospitalisations.		
Ambulatory Sensitive Hospitalisation standardised discharge ratio for 0-74 years[7] Targets: Māori: <95 Pacific: <95 Other: <95	**Ambulatory Sensitive Hospitalisations, 0-74 years** Ambulatory Sensitive Hospitalisations (ASH) are measured by standardised discharge ratios; which compare DHB rates with national averages (where the national average = 100). The top conditions leading to these admissions are skin and dental conditions. The DHB has initiatives in place working to treat and prevent skin and dental conditions.  In 2010/11, rates for ASH for 0-74 years have increased above the target of 95. In C&C DHB, dental and skin conditions are the leading causes of ASH for this age group. The large number of dental admissions is driven by children, and approaches to address this are discussed below. Currently, at the community based Eczema Nurse Clinics, urgent new appointments are being made available, referrals are prioritised and extra clinics have been consistently provided. C&C DHB also has established specialist nursing clinics for wound care and the evaluation of this pilot shows there is a higher rate of wound healing using this model of care when compared to the international benchmarks. The pilot has also indicated that this model of care results in improved access for Māori and Pacific patients.	**Not Achieved**

	Maori	Pacific	Other
YE March 2010	93	93	88
YE March 2011	98	102	103
Target	95	95	95

[6] *ASH data is provided by the Ministry of Health for the 12 months to September and March.*
[7] *ASH data covers a 12 month period judged against national performance baselines from September 2008.*

Performance Measure	Performance Result	Target Achievement
Ambulatory Sensitive Hospitalisation standardised discharge ratio for 0-4 years Targets: Māori: <95 Pacific: <95 Other: <95	**Ambulatory Sensitive Hospitalisations, 0-4 years**  Rates for Ambulatory Sensitive Hospitalisations (ASH) have increased above the target of 95 in 2010/11. The leading causes of ASH admissions for the 0-4 age group are dental and skin conditions. This may be a reflection of the lower than national rates of preschool dental enrolment in the Capital & Coast district. Work to increase the number of enrolled pre-schoolers will help to improve outcomes for this age-group. Regional Public Health's Healthy Skin Project works with partner organisations, such as PHOs, Public Health nurses and Work & Income, to prevent and treat skin infections. In the 2011/12 year, plans are to expand this work by coordinating with early childhood education centres.	**Partially Achieved**

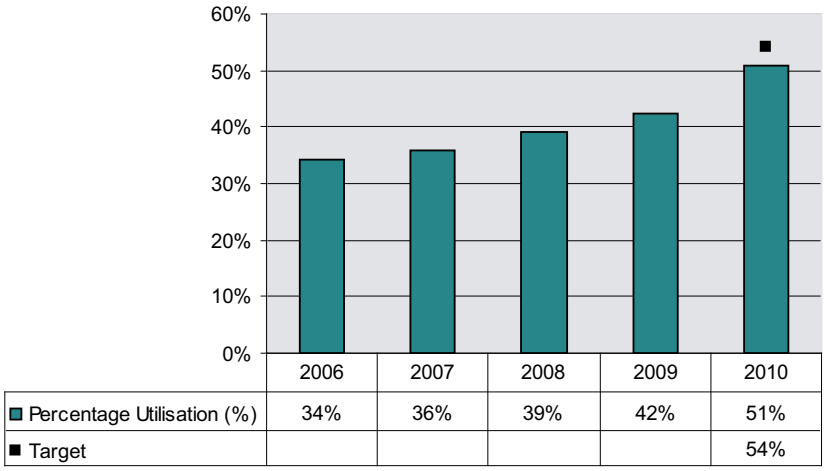
	Maori	Pacific	Other
YE March 2010	89	85	82
YE March 2011	99	95	114
Target	95	95	95

Performance Measure	Performance Result	Target Achievement
Ambulatory Sensitive Hospitalisation standardised discharge ratio for 45-64 years Targets: Māori: <95 Pacific: <95 Other: <95	**Ambulatory Sensitive Hospitalisations, 45-64 years**  Target for this measure has been achieved for Māori, but not Pacific and other ethnicities. The leading conditions for this age group are angina and chest pain and cellulitis. With improving performance in the diabetes and cardiovascular health target, a reduction in the number of ASH presentations for angina and chest pain may occur. A strategy that comprises primary, secondary & public health measures is underway for cellulitis treatment and prevention. C&C DHB will continue working to reduce ASH admissions.	**Partially Achieved**

	Maori	Pacific	Other
YE March 2010	95	95	90
YE March 2011	95	101	102
Target	95	95	95

CarePlus is a primary health care initiative targeting people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness. CarePlus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

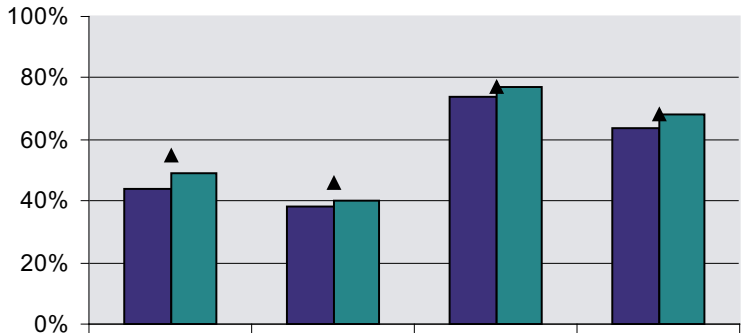
Percentage of eligible people enrolled in CarePlus Target: >=81%		2010/11 Target*	Enrolment at 30 June 2011
	Maori		85%
	Pacific		99%
	Other		91%
	Total	>=81%	91%
	*There were no ethnic specific targets for this measure in the 2010/11 SOI C&C DHB has exceeded target, including by ethnic breakdown, for the percentage of the eligible population enrolled in CarePlus. Enrolling in CarePlus allows improved access for those with chronic or high-need conditions.		**Achieved**

Performance Measure	Performance Result	Target Achievement
Oral Health Services[8] Include services provided by Hutt Valley DHB to Capital & Coast DHB as well as services contracted with private dentists. Child Oral Health Service is the provision of a range of dental care to bring about an improvement in oral health status of the population. It includes preventive care, oral health promotion and education, treatment of oral disease and the restoration of tooth tissue. The objective is to achieve a standard of oral health that leads to all children retaining good use of their natural teeth for life.[9]		
Percentage of adolescents using DHB funded oral health services Target: 54%	**Percentage of Adolescents Using DHB Funded Oral Health Services** C&C DHB improved performance by 9% in the 2010/11 year. Improved utilisation of DHB oral health services will improve the oral health of adolescents in addition to reducing the incidence of dental conditions.  Adolescent oral health utilisation for the 2010 calendar year has improved from that of 2009 calendar year. Adolescent oral health utilisation for 2010 is 51%, which is less than the target of 54%. While disappointed not to have achieved the target, C&C DHB has increased utilisation by 9%, and believes that this strong growth will continue in the 2011 calendar year.	**Progress towards Target**

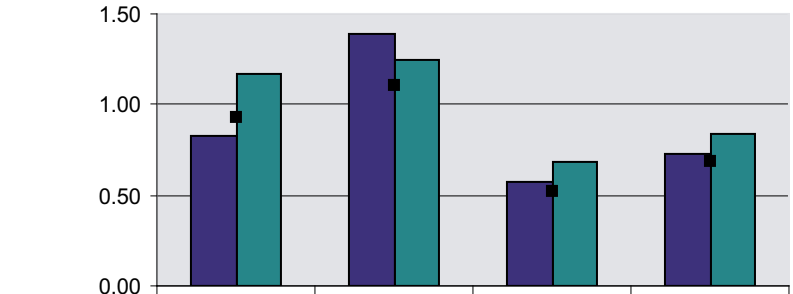
	2006	2007	2008	2009	2010
Percentage Utilisation (%)	34%	36%	39%	42%	51%
Target					54%

[8] *Ministry of Health Oral Health data covers calendar years, therefore the reportable period for the 2010/11 year pertains to the 2010 calendar year.*

[9] *Nationwide Service Framework; Service Specifications; Child Oral Health, Ministry of Health 2010/11*

Performance Measure	Performance Result	Target Achievement
Percentage of children caries free at five years Target: Māori: 55% Pacific: 46% Other: 77% Total: 68%	**Percentage of Children Caries Free at 5 years** Planning for new initiatives as part of the oral health business case has taken plan. It is anticipated that once these are in place there will be improvements in the oral health of children.  Through this measure C&C DHB is looking to increase the percentage of children age 5 who are caries free. Caries free means that a child has no teeth that are decayed, missing, or filled. The proportion of children caries free has improved in 2010, however, it is much lower for Maori and Pacific than for Other. Work to increase the number of enrolled pre-schoolers will help to improve outcomes for this age-group. This work will be focused on Maori and Pacific children.	**Partially Achieved**

	Maori	Pacific	Other	Total
2009	44%	38%	74%	64%
2010	49%	40%	77%	68%
▲ 2010 Target	55%	46%	77%	68%

Performance Measure	Performance Result	Target Achievement
Mean number of Decayed, Missing or Filled Teeth (DMFT) at year 8 Target: Māori: 0.93 Pacific: 1.1 Other: 0.52 Total: 0.68	**Mean Number of Decayed, Missing or Filled Teeth (DMFT) at Year 8** Implementation of the oral health business case has started with the construction of two clinics in the C&C DHB area. Another four clinics, in addition to new mobile units, are planned and it is expected that this will improve oral health outcomes.  Through this measure C&C DHB is looking to reduce the mean DMFT in Year 8 students. In 2010 the DMFT results are significantly different than previous years, in particular for Maori. The change in DMFT is reflective of the increased number of children who are being seen in a timely way. Increased access for children with higher needs has a short to medium term impact on DMFT rates. Over the longer term the oral health outcomes should show improvement from this increased access.	**Not Achieved**

	Maori	Pacific	Other	Total
2009	0.83	1.39	0.57	0.73
2010	1.17	1.25	0.68	0.84
2010 Target	0.93	1.10	0.52	0.68

Community Pharmaceutical Services Capital & Coast DHB funds Community Pharmaceutical Services for community prescribing by GPs and hospital specialists. Pharmacy Services are funded to enable people to have access to Pharmaceuticals and advice services that are responsive to their health needs and priorities.		
Number of community pharmaceut-ical items dispensed Target: 3 – 3.2 million	The 'target' number of community pharmaceutical items dispensed is a range in which C&C DHB expected the actual result to fall. The number of items dispensed in 2010 was 3,133,901 which is within the target range. Community pharmaceutical dispensing is a demand driven service and C&C DHB is neither seeking to reduce nor increase overall volumes. Activity in this area is focussed on ensuring prescribing behaviour follows best practice, which will increase the volume of some drugs (eg those for cardiovascular disease) and decrease the volume of others.	**Achieved**

OUTPUT CLASS: HOSPITAL SERVICES

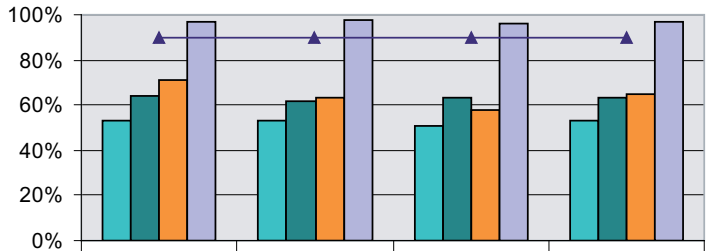
Hospital services are delivered by a range of secondary and tertiary providers. These services are usually provided out of hospital or other facilities that enable co-location of clinical expertise and specialised equipment. These services are generally more complex and are provided by health care professionals that work closely together. They include:

Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventative, diagnostic, therapeutic and rehabilitative services.

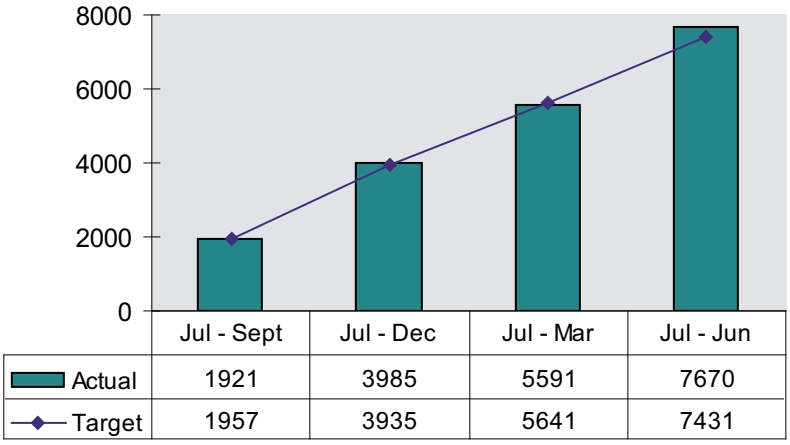
Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.

Emergency Department services including triage, diagnostic, therapeutic and disposition services.

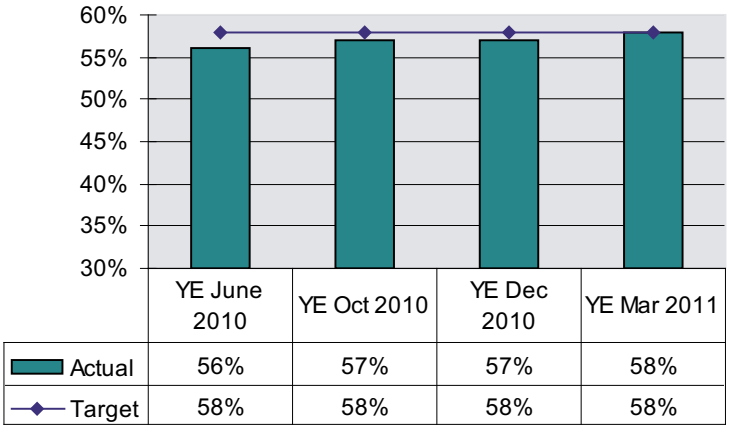
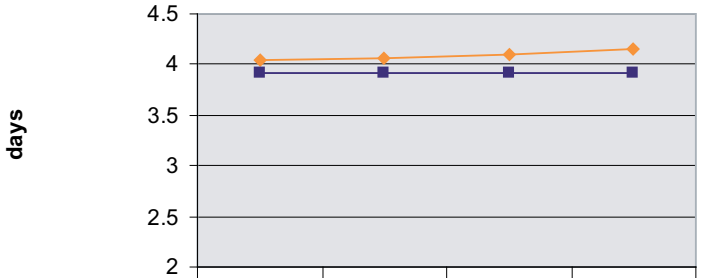
On a continuum of care these services are at the complex end of treatment services and are focussed on individuals.

Performance Measure	Performance Result	Target Achievement
Better Help for Smokers to Quit – Smoking kills an estimated 5000 people in New Zealand every year, and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there area simple effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.		
Percentage of hospitalised smokers offered advice to quit Target: 90% by 30 June 2011	**Percentage of Hospitalised Smokers Offered Advice to Quit**  This is a measure of the Government's health target for Better Help for Smokers to Quit. C&C DHB significantly improved performance for this health target over the 10/11 year. Due to the implementation of new measures to improve data capture, C&C DHB achieved 97% in quarter four.	**Achieved**

	Maori	Pacific	Other	Total
Jul - Sept	53%	53%	51%	53%
Oct - Dec	64%	62%	63%	63%
Jan - Mar	71%	63%	58%	65%
Apr - Jun	97%	98%	96%	97%
Target 10/11	90%	90%	90%	90%

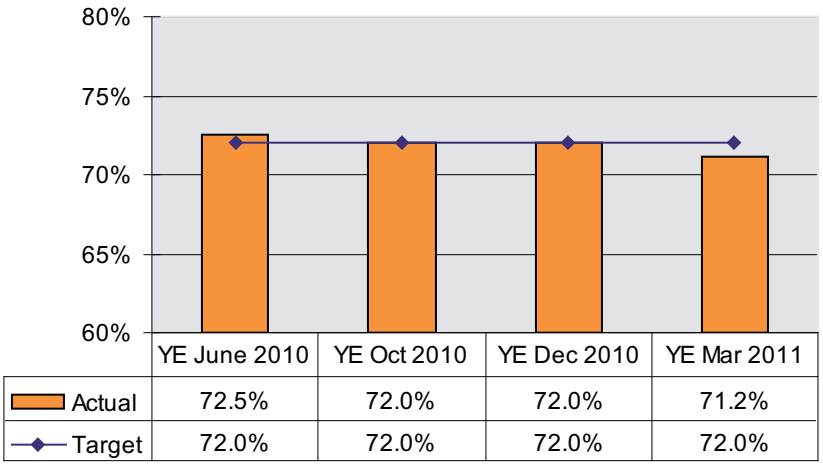
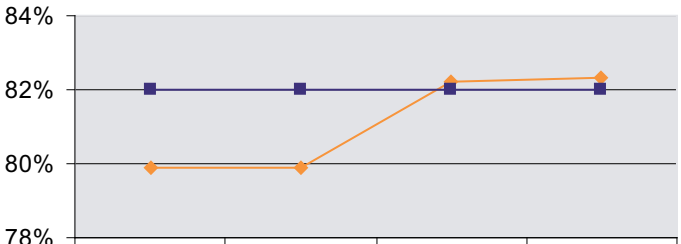
Performance Measure	Performance Result	Target Achievement
Elective (Inpatient and Outpatient) Services: Includes: Services provide by the DHB's hospital services to the population (provider and population view as measured by Health Targets); services provided by other DHBs for the C&C DHB population (population view as measured by Health Targets); and services provided by the DHB's hospital services for other DHB populations (provider and other DHB population view as measured by their Health Targets). The Minister has set an expectation that the national annual increase in elective surgical discharges will improve. The growth in elective surgical discharges will increase access and should achieve genuine reductions in waiting times for patients. The following indicators measure quality, timeliness and effectiveness.		
Number of surgical elective discharges Target: 7,431	**Number of Surgical Elective Discharges**  This is a measure of the Government's health target for Improving Elective Services, calculated cumulatively through the year. The original target of 7,200 discharges was revised up to reflect an increase in the Government's national health target. An increased focus on elective surgery throughput and productivity has resulted in C&C DHB exceeding the elective surgery health target by 239 discharges.	**Achieved**

	Jul - Sept	Jul - Dec	Jul - Mar	Jul - Jun
Actual	1921	3985	5591	7670
Target	1957	3935	5641	7431

Performance Measure	Performance Result	Target Achievement
Percentage of elective and arranged day surgery performed as day cases (standardised) Target: 58%	**Elective and Arranged Day Surgery**  C&C DHB achieved the target for elective and arranged day surgery. By increasing the proportion of surgery carried out on a day surgery basis, C&C DHB can increase hospital throughput and allow resources to be used efficiently.	**Achieved**
Standardised average length of stay for elective and arranged inpatients Target: <3.92 days	**Elective and Arranged Length of Stay** C&C DHB is at the median national performance for this measure. To assist patients' return to their homes, C&C DHB has recently implemented an initiative targeting patients with an average length of stay greater than 7 days.  C&C DHB did not achieve its target for elective and arranged inpatient length of stay. C&C DHB has recently commenced some targeted work at addressing patients with average length of stay greater than 7 days, for all admission types. This work is a reasonably recent initiative and is anticipated to have an impact on 2011/12 elective and arranged inpatient length of stay results.	**Not Achieved**

	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	56%	57%	57%	58%
Target	58%	58%	58%	58%

	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	4.04	4.06	4.09	4.16
Target Threshold	3.92	3.92	3.92	3.92

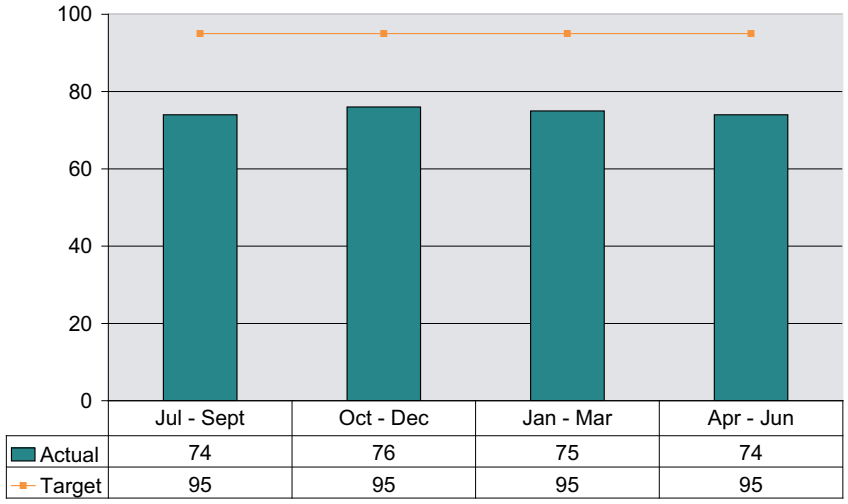
Performance Measure	Performance Result	Target Achievement
Percentage of elective and arranged surgery occurring on the day of admission (standardised) Target: 72%	**Elective and Arranged Day of Surgery Admission**  C&C DHB met the 72% target for monitoring across most of 2010/11, however, the year end result comprising the 12 months to 31 March 2011 dropped just under target. C&C DHB anticipates achievement of the target for 2011/12.	**Partially Achieved**
Theatre Utilisation: Proportion of Available Elective Theatre Time Used Target: >82%	**Proportion of Available Elective Theatre Time Used**  C&C DHB has achieved its target for theatre utilisation in the 2010/11 year.	**Achieved**

	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	72.5%	72.0%	72.0%	71.2%
Target	72.0%	72.0%	72.0%	72.0%

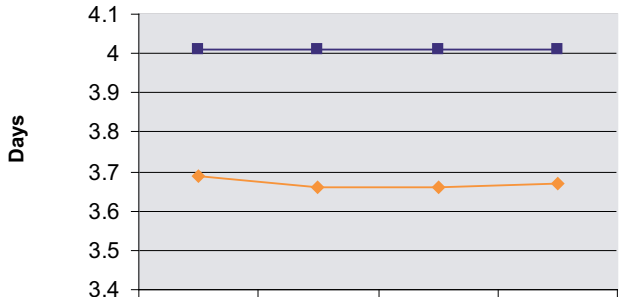
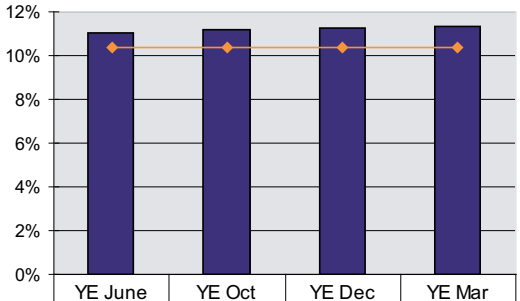
	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	79.9%	79.9%	82.2%	82.3%
Target	82.0%	82.0%	82.0%	82.0%

Performance Measure	Performance Result	Target Achievement
Number of surgical First Specialist Assessments (FSAs) Target: 15,022	The number of surgical First Specialist Assessments for the 2010/11 year was 15,716. This compares favourably to 2009/10 performance of 14,818 First Specialist Assessments.	**Achieved**

Acute Services include services provided by the DHB hospital services to its population and also for people from other DHB areas. Includes ED – this service is a 24-hour, clinically integrated service that is part of a secure pathway from pre-hospital to definitive care. A hospital Emergency Department treats patients with injury, illness, or obstetric complications. Key roles for the Emergency Department include: assessment and initial management for medical, surgical and psychiatric emergencies; assessment and initial management for serious injury; and assessment and initial management for obstetric emergencies. Access to the service may be initiated by an emergency ambulance callout, a primary care provider, a mental health crisis team, or an individual presenting in an emergency department. The service contributes to the regional system for emergency care and operates in synergy with pre-hospital care, ambulance services, and specialised referral services.

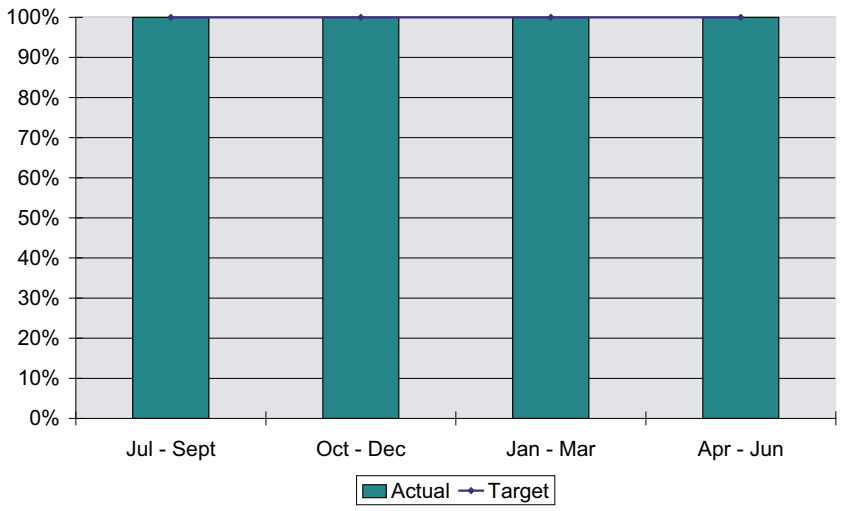
Percentage of patients admitted, discharged or transferred from ED within six hours Target: 95%	**Percentage of Patients Admitted, Discharged or Transferred from ED within Six Hours** C&C DHB has implemented new strategies with the aim to improve performance for the percentage of patients admitted, discharged or transferred from ED within six hours.  This is a measure of the Government's health target for Shorter Stays in Emergency Departments. Compliance with the six-hour rule at C&C DHB has been steady across all quarters of the 2010/11 year. New initiatives have been implemented, resulting in a month-on-month increase in performance in quarter four.	**Not Achieved**

	Jul - Sept	Oct - Dec	Jan - Mar	Apr - Jun
Actual	74	76	75	74
Target	95	95	95	95

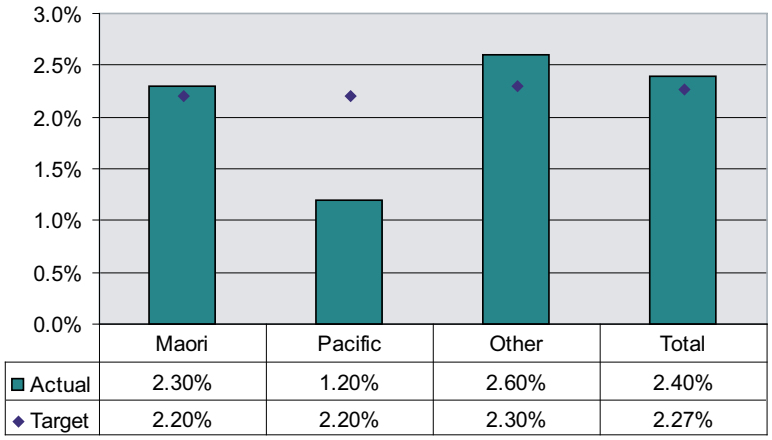
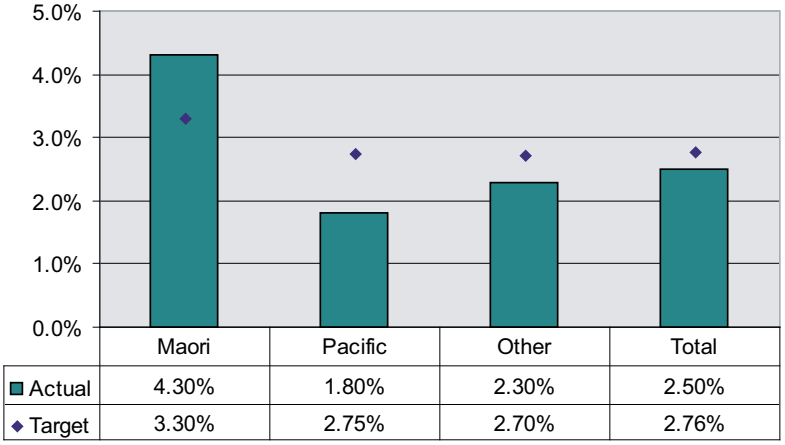
Performance Measure	Performance Result	Target Achievement
Standardised average length of stay for acute inpatients (days) Target: <4.01 days	**Average Acute Inpatient Length of Stay**  C&C DHB has achieved its target of reducing inpatient length of stay. By reducing the length of stay patients are enabled to return to their own homes, allowing for increased capacity to treat more patients and contribute to goals such as decongestion of emergency departments, or increases in elective surgery.	**Achieved**
Percentage of acute hospital readmission within 30 days of discharge Target: 10.4%	**Percentage of Acute Readmissions to Hospital** C&C DHB has commenced several new projects to ensure quality and continuity of care is provided to patients. An example is providing discharge coordination for complex patients and those who frequently present at hospital.  C&C DHB did not achieve its target for acute readmissions in the 2010/11 year. C&C DHB has been working to reduce readmissions in the following ways: service specific monitoring of complications and implementation of mitigation strategies; increased discharge coordination for complex patients and those who frequently present; a significant project in community services to align clinical and care pathways; the development /refinement of patient care pathways looking at specifically managing complications and readmission risk. This is just a snap shot of some of the activities and strategies in place to reduce readmissions; there are activities across all specialties and sites. C&C DHB is also supporting independent clinical analysis of events included in the acute readmission data set.	**Not Achieved**

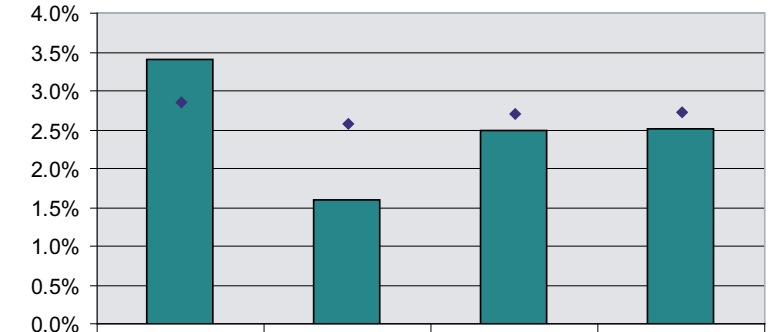
	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	3.69	3.66	3.66	3.67
Target Threshold	4.01	4.01	4.01	4.01

	YE June 2010	YE Oct 2010	YE Dec 2010	YE Mar 2011
Actual	11.03%	11.21%	11.28%	11.34%
Target Threshold	10.40%	10.40%	10.40%	10.40%

Performance Measure	Performance Result	Target Achievement
Rate of mortality within 30 days of discharge (standardised) Target:<=1.5%	Rate of mortality within 30 days of discharge is a way of measuring the quality of hospital services. At 1.32%, C&C DHB has achieved its target and is one of the best performing DHBs for this measure.	**Achieved**
Specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Development of indicators that mark quality cancer treatment is however restricted by the lack of routinely collected information on common treatment. In the interim, waiting times for radiation oncology treatment have been chosen as a representative indicator of specialist treatment, and is an area with waiting time issues for patients. This is justifiable because radiotherapy has been proven effective in reducing the impact of a range of cancers, and delay to radiotherapy is likely to lead to poorer outcomes of treatment.		
Percentage of patients receiving treatment within six weeks of specialist assessment, and within four weeks from December 2010. Target: 100%	**Patients Starting Radiation Therapy within Four Weeks**  This is a measure of the Government's health target for Shorter Waits for Cancer Treatment. All C&C DHB patients requiring radiotherapy in 2010/11 received this within four weeks of the first specialist assessment. Note that this measurement is for people living in the Capital & Coast District, and any patients waiting longer than four weeks for reasons outside the department's control are excluded (eg patient request, awaiting other procedures).	**Achieved**

Performance Measure	Performance Result	Target Achievement
Maternity Services: Includes services provided at hospital and in the community. C&C DHB offers its main maternity services and tertiary obstetrics at Wellington Regional Hospital, while also providing primary maternity facilities at Kenepuru and Kapiti Health Centre.		
Percentage of births in primary maternity facilities Target: >=11%	In the 2010 calendar year, 9.3% of births occurred in primary maternity facilities. Unfortunately this did not reach target of 11%. There were a similar number of births in the maternity facility at Kapiti Health Centre to previous years, whereas the number at Kenepuru Hospital decreased.	**Not Achieved**
Percentage of deliveries by caesarean section Target: <=28	In C&C DHB 29.8% of deliveries were by caesarean section in the 2010 calendar year. Unfortunately this did not reach target of less than or equal to 28%.	**Not Achieved**
Number of resourced post-natal beds Target: 32	C&C DHB has invested in additional staffing to support an increase in the length of post-natal stays. The average number of beds occupied has increased from 28 to 30.7 however did not meet the target of 32.	**Progress toward target**

Performance Measure	Performance Result	Target Achievement
Mental Health – This measure targets improved access, as sufficient access to services will lead to improvements in quality of outcomes. The Mental Health and Addiction Plan 2006-2015 confirms that the government remains committed to providing services for people who are severely affected by mental illness, especially those who have enduring severe illness.		
Percentage of population accessing secondary mental health services **Age 0-19** Target: Māori: 2.2% Pacific: 2.2% Other: 2.3% Total: 2.27%	**Percentage of the 0-19 population accessing secondary mental health services** C&C DHB has a service dedicated to Pacific youth mental health and is hopeful this will positively impact upon access rates.  Maori / Pacific / Other / Total Actual: 2.30% / 1.20% / 2.60% / 2.40% Target: 2.20% / 2.20% / 2.30% / 2.27%	**Partially Achieved**
Age 20-64 Target: Māori: 3.3% Pacific: 2.75% Other: 2.7% Total: 2.76%	**Percentage of the 20-64 population accessing secondary mental health services** C&C DHB continues to work towards improving access to mental health services.  Maori / Pacific / Other / Total Actual: 4.30% / 1.80% / 2.30% / 2.50% Target: 3.30% / 2.75% / 2.70% / 2.76%	**Partially Achieved**

Performance Measure	Performance Result	Target Achievement
Age 65+ Target: Māori: 3.6% Pacific: 3.5% Other: 3.5%Total: 3.5%	**Percentage of the 65+ population accessing secondary mental health services** C&C DHB aims to provide accessible mental health services for the over 65 population and is working to improve the access rates of this group.  Maori / Pacific / Other / Total Actual: 2.70% / 2.50% / 3.10% / 3.10% Target: 3.60% / 3.50% / 3.50% / 3.50%	**Not Achieved**
Total Target: Māori: 2.86% Pacific: 2.58% Other: 2.71% Total: 2.72%	**Percentage of the Total population accessing secondary mental health services**  Maori / Pacific / Other / Total Actual: 3.40% / 1.60% / 2.50% / 2.52% Target: 2.86% / 2.58% / 2.71% / 2.72% For access to secondary mental health services, C&C DHB met the targets for Maori and Other children and young people, and Maori adults aged 20 to 64. Although some targets were not met, rates have been consistently improving with an overall increase in the proportion of the DHB population accessing secondary mental health services. C&C DHB is moving towards the national target of 3%. A discrepancy between actual and reported rates for clients accessing mental health services is largely due to the DHB's inability to directly link key activity data to client referrals. During 2011/12 the DHB will implement a referral management system, which will significantly reduce the current issues and result in more accurate reporting to better reflect the actual access rates being achieved by C&C DHB Mental Health & Addiction Services.	**Partially Achieved**

OUTPUT CLASS: SUPPORT SERVICES

Support services are delivered following a needs assessment process and coordination input by Needs Assessment and Service Coordination Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals.

Performance Measure	Performance Result	Target Achievement
Disability Support Services - Disability relates to the interaction between the person with the impairment and the environment. The focus for C&C DHB is two fold, 1) to work cross-sectorally to ensure that disability needs are met as part of C&C DHB health (business as usual) services and 2) where business as usual cannot meet a need, examine and implement activity to ensure that there is ease of access to services for disabled people.		
Number of disability responsiveness training sessions (for C&C DHB staff) Target: >=4	The strategy toward disability responsiveness training changed at C&C DHB to better meet the needs of staff. Further, the implementation of the Health Passport at C&C DHB required a large number of training sessions to engage staff on this project. 250 sessions were conducted in 2010/11 on disability responsiveness and the implementation of the Health Passport.	**Achieved**
Number of GP practice accessibility audits Target: 12	C&C DHB has an ongoing programme to audit the accessibility of health service providers (including general practices) in the district. With 48 out of 50 general practices now accredited, the focus for 2010/11 shifted to mental health service providers. Nineteen administration premises and facilities of mental health service providers were audited to assess their potential to be up-graded to comply with the access requirements of the Building Act 2004, NZS 4121:2001, the Building Code and the Human Rights Act 1993.	**Achieved**
Percentage of DHB workforce identifying as having a disability Target: >=3%	The percentage of DHB workforce identifying as having a disability as at 30 June 2011 was 2.57%. This measure is difficult to use for determining the actual number of workforce having a disability as many staff do not wish to identify. A new, more positive method of identifying disability is being negotiated in addition to an active campaign to invite people with disabilities to apply for roles with C&C DHB.	**Not Achieved**
Number of (electronic) disability newsletters published Target: 12	Seven newsletters were published, and partway through the year the newsletter was re-launched as a monthly consultation document, covering different topics. Three newsletters in the new format were published, totalling 10 newsletters in the 2010/11 year. The intended objectives were achieved and the communication has greatly improved in quality.	**Partially Achieved**

Performance Measure	Performance Result	Target Achievement
Health and Support Services for Older People – In 2003 responsibility was devolved to C&C DHB for planning and funding support services for people aged 65 and over. The DHB also funds services (including aged residential care) for people aged between 50 and 64 who have been clinically assessed by the DHB and/or a needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people. The Health of Older People Strategy (2002) sets the strategic framework for older peoples' health and support services. The focus is on developing a 'continuum of care' to support the Strategy's vision that older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau, and community life. Health and support services for older people are delivered in a variety of settings, including home, community, hospital (inpatient and outpatient) and residential care. Older people's health outcomes are significantly affected by broader social and economic issues – particularly housing, access to transport and social isolation. C&C DHB has been tasked to ensure it develops sustainable and effective relationships with other government agencies and NGOs across a range of sectors to address the broader needs of their older populations. C&C DHB encourages services' development and delivery that reflects the vision and objectives of the Health of Older People Strategy, and that will have implications for the health of older people. These include: • an increased range of services, including specialist services, available in the community • a focus on approaches that restore, maintain or maximise older people's independence, participation and contribution to their community • development of services that focus on reducing inequalities, particularly for older Maori and for other ethnicities, including older Pacific peoples • increased partnership and joint initiatives with local government, private businesses and not-for-profit organisations • increased emphasis on improving health outcomes • effective integration of interRAI assessment process		
Number of assessments completed Target: >=4800	The total number of interRAI assessments completed in the 2010/11 year was 5433. This exceeded target of >=4800. interRAI is a not for profit collaborative of international clinicians and researchers who develop evidence based clinical assessment tools that can be utilised across a range of healthcare service areas. The New Zealand Guidelines Group recommended interRAI to be the nationally implemented assessment tool which the Ministry of Health has now rolled out to all DHBs. By 1 July 2012 all DHBs must be using the interRAI Home Care and Contact Assessment tools with clients who are receiving publicly funded home based support services or aged residential care. C&C DHB has been using these tools since 2006 with older adults as well as people under 65 years of age with chronic conditions.	**Achieved**
Number of clients over 65 receiving home based support Target: 3,800	In the 2010/11 year, 3,494 clients over 65 received home based support services. New standards were implemented for household management services during the 2010/11 year. This has resulted in a decrease in numbers of clients receiving household management services; however, the numbers of clients receiving higher levels of services has increased, in line with the C&C DHB intention to target services and resources on those with greatest need.	**Partially Achieved**
Number of rest home bed days Target: <153,000	The actual number of rest home bed days for 2010/11 was 132,310, achieving target of <153,000. This demonstrates the beneficial results of improved home based support, allowing people to remain in their own homes.	**Achieved**

AUDITOR'S REPORT

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

INDEPENDENT AUDITOR'S REPORT

To the readers of the Capital and Coast District Health Board's financial statements and statement of service performance for the year ended 30 June 2011.

The Auditor-General is the auditor of the Capital and Coast District Health Board (the Health Board). The Auditor-General has appointed me, Stephen Lucy, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and statement of service performance of the Health Board on her behalf.

We have audited:

- the financial statements of the Health Board on pages 108 to 155, that comprise the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and
- the statement of service performance of the Health Board on pages 78 to 104.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 108 to 155:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2011; and
    - financial performance and cash flows for the year ended on that date; and
- the statement of service performance of the Health Board on pages 78 to 104
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2011, including:
    - its performance achieved as compared with forecast targets specified in the statement of forecast service performance for the financial year; and
    - its revenue earned and output expenses incurred, as compared with the forecast revenues and output expenses specified in the statement of forecast service performance for the financial year.

Our audit was completed on 31 October 2011. This 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 our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and statement of service performance are free from material misstatement.

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and statement of service performance. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and statement of service performance, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health Board's preparation of the financial statements and statement of service performance that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board;
- the adequacy of all disclosures in the financial statements and statement of service performance; and
- the overall presentation of the financial statements and statement of service performance.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and statement of service performance. We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Board

The Board is responsible for preparing financial statements and a statement of service performance that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board's financial position, financial performance and cash flows; and
- fairly reflect its service performance achievements.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and a statement of service performance that are free from material misstatement, whether due to fraud or error.

The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

Responsibilities of the Auditor

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

Independence

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

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

S B Lucy
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2011

in thousands of New Zealand Dollars

	Note	2011 Actual	2011 Budget	2010 Actual
Revenue	1	885,332	837,883	832,161
Total income		**885,332**	**837,883**	**832,161**
Employee benefit costs	3	351,029	340,508	350,565
Depreciation and amortisation expense	6,7	43,151	17,675	37,983
Outsourced services		22,330	15,342	20,255
Clinical supplies		98,406	93,282	97,998
Infrastructure and non-clinical expenses		48,368	50,528	41,621
Payments to non-health board providers		310,795	316,796	304,184
Other operating expenses	2	13,212	10,794	(665)
Finance costs	4	20,821	25,730	20,940
Capital charge	5	8,807	7,360	6,763
Total expenses		**916,919**	**878,015**	**879,644**
Surplus/(deficit) for the year		**(31,587)**	**(40,132)**	**(47,483)**
Other comprehensive income				
Revaluation reserve movement of property, plant & equipment		(4,756)	-	(164)
Other comprehensive income for the year		**(4,756)**	**-**	**(164)**
Total comprehensive income for the year		**(36,343)**	**(40,132)**	**(47,647)**

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

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

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2011

in thousands of New Zealand Dollars

		Other reserves			
	Crown equity	Revaluation Reserve (Land)	Revaluation Reserve (Plant & Equipment, Furniture & Fittings)	Retained earnings	Total equity
Balance at 1 July 2009	298,628	24,269	7,581	(213,441)	117,037
Contribution from the Crown	87,148	-	-	-	87,148
Repayment of equity	(3,484)	-	-	-	(3,484)
Total comprehensive income of the year	-	-	(164)	(47,483)	(47,647)
Balance at 30 June 2010	**382,292**	**24,269**	**7,417**	**(260,924)**	**153,054**
Balance at 1 July 2010	382,292	24,269	7,417	(260,924)	153,054
Contribution from the Crown	45,908	-	-	-	45,908
Repayment of equity	(3,484)	-	-	-	(3,484)
Restatement plant & equipment, furniture & fittings	-	-	(4,909)		(4,909)
Total comprehensive income for the year	-	(2,248)	(2,508)	(31,587)	(36,343)
Balance at 30 June 2011	**424,716**	**22,021**	**-**	**(292,511)**	**154,226**

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

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 2011

in thousands of New Zealand Dollars

	Note	2011 Actual	2011 Budget	2010 Actual
Assets				
Current assets				
Cash and cash equivalents	11	14,881	15	2,868
Trade and other receivables	10	30,346	47,310	37,837
Inventories	8	6,339	7,500	6,406
Trust/special funds	12	7,728	7,300	7,383
Total current assets		**59,294**	**62,125**	**54,494**
Non-current assets				
Property, plant and equipment	6	547,835	525,545	550,061
Intangible assets	7	11,121	32,658	15,921
Investments in joint ventures	9	-	-	-
Total non-current assets		**558,956**	**558,203**	**565,982**
Total assets		**618,250**	**620,328**	**620,476**
Equity				
Crown equity		424,716	423,098	382,292
Revaluation reserve		22,021	31,686	31,686
Retained earnings/(losses)		(292,511)	(301,396)	(260,924)
Total equity		**154,226**	**153,388**	**153,054**
Liabilities				
Current liabilities				
Bank overdraft	11	-	15,354	-
Trade and other payables	16	65,130	52,235	70,797
Borrowings	13	108,276	28,000	28,279
Employee entitlements	14	51,434	48,338	49,316
Provisions	15	1,007	5,000	1,125
Patient and restricted funds	17	167	-	156
Total current liabilities		**226,014**	**148,927**	**149,673**
Non-current liabilities				
Borrowings	13	231,540	311,000	311,816
Employee entitlements	14	6,116	6,769	5,773
Provisions	15	354	-	160
Patient and restricted funds	17	-	244	-
Total non-current liabilities		**238,010**	**318,013**	**317,749**
Total liabilities		**464,024**	**466,940**	**467,422**
Total equity and liabilities		**618,250**	**620,328**	**620,476**

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

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 2011

in thousands of New Zealand Dollars

	Note	2011 Actual	2011 Budget	2010 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		841,578	838,750	815,013
Other receipts		24,674	20,156	29,363
Cash paid to suppliers		(488,222)	(470,721)	(465,686)
Cash paid to employees		(348,568)	(341,052)	(352,093)
Cash generated from operations		**29,492**	**47,133**	**26,597**
Goods and Services Tax and other taxes (a)		(2,388)	(25,294)	3,622
Capital charge paid		(9,057)	(11,350)	(6,388)
Net cash flows from operating activities	11	**18,047**	**10,489**	**23,831**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		3,300	17,000	13,429
Interest received		1,115	120	425
Acquisition of property, plant and equipment		(31,173)	(27,309)	(49,089)
Advances to associates		-	-	-
Acquisition of intangible assets		(264)	(15,000)	(19,042)
Appropriation from trust /special funds (b)		(334)	-	(530)
Net cash flows from investing activities		**(27,356)**	**(25,189)**	**(54,807)**
Cash flows from financing activities				
Proceeds from equity injection		45,908	46,514	87,150
Borrowings raised		-	-	4,000
Repayment of equity		(3,484)	-	(3,484)
Repayment of finance leases		(279)	-	(168)
Interest paid		(20,823)	(21,510)	(20,940)
Net cash flows from financing activities		**21,322**	**25,004**	**66,558**
Net increase in cash and cash equivalents		12,013	10,304	35,582
Cash and cash equivalents at beginning of year		2,868	(18,343)	(32,714)
Cash and cash equivalents at end of year	11	**14,881**	**(8,039)**	**2,868**

(a) The Goods and Services Tax (net) component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The Goods and Services Tax (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial reporting purposes.

(b) Appropriation from trust /special funds in investing activities reflects the net of trust /special fund revenue received and expenses paid during the year.

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

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

STATEMENT OF CONTINGENT LIABILITIES

As at 30 June 2011

in thousands of New Zealand Dollars

	Note	2011 Actual	2010 Actual
Legal proceedings against the DHB		1,603	82
Other contractual matters		649	9
		2,252	**91**

The DHB has been notified of 4 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2011 (2010: 3).

The claims are both patient and employment related. The DHB is contesting the claims, and whilst there is an element of uncertainty as to what the courts may award, the DHB believes that any damages awarded in relation to patient claims will be met by its insurers.

The DHB has no contingent assets (2010: $nil).

STATEMENT OF COMMITMENTS

As at 30 June 2011

in thousands of New Zealand Dollars

	Note	2011 Actual	2010 Actual
Capital commitments		**12,839**	**9,969**
Non-cancellable commitments *			
Not more than one year		148,143	128,376
One to two years		43,648	23,459
Two to five years		50,154	39,463
Over five years		1,866	2,145
		243,811	**193,443**
Non-cancellable commitments – operating leases			
Not more than one year		2,407	2,210
One to two years		1,905	1,768
Two to five years		986	2,056
Over five years		-	37
		5,298	**6,071**

* includes primary care demand driven contracts

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

NOTES TO THE FINANCIAL STATEMENTS

Statement of accounting policies for the year ended 30 June 2011

Reporting entity

Capital & Coast District Health Board (the DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, and the Crown Entities Act 2004.

The primary objective of the DHB is to provide goods or services for the community or social benefit rather than making a financial return. Accordingly, the DHB has designated itself as a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS). The DHB is a public benefit entity, as defined by NZIAS 1.

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

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes a requirement of compliance with New Zealand Generally Accepted Accounting Practice (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Changes in accounting policies

The DHB has changed its accounting policy during the year, whereby it has ceased to revalue plant and equipment and furniture and fittings. Management consider it appropriate to only revalue assets that have an appreciating nature, such as land and buildings. DHB plant and equipment and furniture and fittings does not typically appreciate in value. There are also significant logistics and costs involved in accurately revaluing assets. Any item of plant and equipment and furniture and fittings which had been previously revalued have been restated to the higher of zero or their original cost less accumulated depreciation. The total effect of this change in accounting policy for the year is $7.4m which is reflected in the statement of comprehensive income, comprising: $4.9m in revenue and $2.5m revaluation movement of plant and equipment and furniture and fittings.

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

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

- NZ IAS 24 Related Party Disclosures (Revised 2009) replaces NZ IAS 24 Related Party Disclosures (Issued 2004) and is effective for reporting periods commencing on or after 1 January 2011. The revised standard:
  - i) Removes the previous disclosure concessions applied by the DHB for arms-length transactions between the DHB and entities controlled or significantly influenced by the Crown. The effect of the revised standard is that more information is required to be disclosed about transactions between the Ministry and entities controlled or significantly influenced by the Crown.
  - ii) Provides clarity on the disclosure of related party transactions with Ministers of the Crown. Further, with the exception of the Minister of Accountability, the DHB will be provided with an exemption from certain disclosure requirements relating to transactions with other Ministers of the Crown. The clarification could result in additional disclosures should there be any related party transactions with Ministers of the Crown.
  - iii) Clarifies that related party transactions include commitments with related parties

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014.

- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

As the External Reporting Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefit entities. This means that the financial reporting requirements for public benefit entities are expected to be effectively frozen in the short term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Basis of preparation

The financial statements for the year ended 30 June 2011 were approved by the Board on 31 October 2011.

The financial statements have been prepared for the period 1 July 2010 to 30 June 2011. Comparative figures and balances relate to the period 1 July 2009 to 30 June 2010.

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand.

The financial statements are prepared on the historical cost basis except where modified by the revaluation of certain items of land, buildings and the measurement of equity instruments and derivative financial instruments at fair value.

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

The preparation of financial statements in conformity with NZIFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

NOTES TO THE FINANCIAL STATEMENTS

Statement of accounting policies for the year ended 30 June 2011

Basis for consolidation

Joint ventures

Joint ventures are those entities over whose activities the DHB has joint control, established by contractual agreement.

The DHB has a 16.7% shareholding in a joint venture, Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial and financial policy decisions. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region.

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

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Foreign exchange differences arising on translation are recognised in the statement of comprehensive income. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings
- leasehold improvements
- plant and equipment
- furniture and fittings
- work in progress

Owned assets

Except for land and buildings assets are stated at cost, less accumulated depreciation and impairment losses.

Land and buildings are valued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive income. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of comprehensive income.

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

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

Disposal of property, plant and equipment

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

Leased assets

Finance Leases

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

Operating Lease

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Subsequent costs

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

Depreciation

Depreciation is charged to the statement of comprehensive income using the straight line method. Land is not depreciated.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets are as follows:

Class of asset	Estimated life
freehold buildings	1 to 75 years
leasehold improvements	1 to 5 years
plant and equipment	1 to 25 years
furniture and fittings	1 to 15 years

The residual value of assets is reassessed annually.

Leasehold improvements are depreciated over their lease term.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Research and development

Expenditure on research activities, undertaken with the prospect of gaining new scientific or technical knowledge and understanding, is recognised in the statement of comprehensive income as an expense as incurred. Other development expenditure is recognised in the statement of comprehensive income as an expense as incurred.

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
software	10 years
licences	10 years

Financial instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise of trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value. A financial instrument is recognised if the DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the DHB's contractual rights to the cash flows from the financial assets expire or the DHB transfers the financial asset to another party without retaining control or substantially all the risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, i.e., the dates that the DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the DHB's obligations specified in the contract expire or are discharged, or cancelled.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

Inventories

Inventories are held for the DHB's own use, and are stated at the lower of cost and net realisable value. Cost is based on weighted average cost. Inventories held for distribution are stated at cost, adjusted where applicable for any loss of service potential.

Cash and cash equivalents

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

Impairment

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

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit, value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on items of property, plant and equipment carried at fair value is reversed through the revaluation reserve. All other impairment losses are reversed through the statement of comprehensive income.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Employee benefits

Short-term employee entitlements

Employee entitlements that the DHB expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date.

Defined contribution plans

Certain employees are members of defined contribution schemes and the DHB contributes to those schemes. A defined contribution scheme is a plan under which the employee and the DHB pay fixed contributions to a separate entity. The group has no legal or constructive obligation to pay further contributions in relation to employee service in the current and prior periods. Obligations for contributions to defined contribution plans are recognised as an expense in the statement of comprehensive income as incurred.

Defined benefit plan

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

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

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

Annual leave

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

Provisions

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

Restructuring

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

Trade and other payables

Trade and other payables are initially recognised at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments

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

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the statement of comprehensive income. However, where derivatives qualify for hedge accounting, recognition of any resultant gain or loss depends on the nature of the item being hedged.

The fair value of interest rate swaps is the estimated amount that the DHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price.

Hedging: cash flow hedges

Where a derivative financial instrument is designated as a hedge of the variability in cash flows of a recognised asset or liability, or a highly probable forecast transaction, the effective part of any gain or loss on the derivative financial instrument is recognised directly in equity.

When the forecast transaction subsequently results in the recognition of a non-financial asset or non-financial liability, or the forecast transaction becomes a firm commitment, the associated cumulative gain or loss is removed from equity and included in the initial cost or other carrying amount of the non-financial asset or liability. If a hedge of a forecast transaction subsequently results in the recognition of a financial asset or a financial liability, the associated gains and losses that were recognised directly in equity are reclassified into the statement of comprehensive income in the same period or periods during which the asset acquired or liability assumed affects the statement of comprehensive income (i.e. when interest income or expense is recognised). For cash flow hedges, other than those covered by the preceding two policy statements, the associated cumulative gain or loss is removed from equity and recognised in the statement of comprehensive income in the same period or periods during which the hedged forecast transaction affects the statement of comprehensive income. The ineffective part of any gain or loss is recognised immediately in the statement of comprehensive income.

When a hedging instrument expires or is sold, terminated or exercised, or the entity revokes designation of the hedge relationship but the hedged forecast transaction is still expected to occur, the cumulative gain or loss at that point remains in equity and is recognised in accordance with the above policy when the transaction occurs. If the hedged transaction is no longer expected to take place, the cumulative unrealised gain or loss recognised in equity is recognised immediately in the statement of comprehensive income.

Income tax

The DHB is a Crown entity under the New Zealand Public Health and Disability Act 2000 and is therefore exempt from income tax under the Income Tax Act 2004.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Commitments and contingencies are disclosed exclusive of GST. The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST related to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred, except to the extent that they are directly attributable to the acquisition or construction of a qualifying asset, in which case, they are capitalised as part of the cost of that asset.

Capital charge

The capital charge is recognised as an expense in the period to which the charge relates.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods sold and services rendered

Revenue from goods sold is recognised when the DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to the DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the DHB.

Interest

Interest income is recognised using the effective interest rate method.

Rental income

Rental income from property is recognised in the statement of comprehensive income on a straight-line basis over the term of the lease.

Vested assets

Where a physical asset is gifted to or acquired by the DHB for nil or nominal cost, the fair value of the asset received is recognised as income. Such assets are recognised as income when control over the asset is obtained.

Expenses

Operating lease payments

Payments made under operating leases are recognised as an expense in the statement of comprehensive income on a straight-line basis over the term of the lease.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Cost of service (statement of service performance)

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

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

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

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area. For the year ended 30 June 2011, indirect costs accounted for 1.47% of the DHB's total costs (2010: 2.00%).

Accounting estimates and judgements

Management discussed with the Finance Risk & Audit Committee the development, selection and disclosure of the DHB's critical accounting policies and estimates and the application of these policies and estimates.

Key sources of estimated uncertainty

In preparing these financial statements the DHB has made estimates and assumptions concerning the future. These assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Property, plant and equipment

At each balance date the DHB reviews the useful lives and residual values of its property plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property plant and equipment requires the DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of comprehensive income, and carrying amount of the asset in the statement of financial position. The DHB minimises the risk of estimation uncertainty by

- physical inspection of assets
- asset replacement programmes
- obtaining valuations

The DHB has not made significant changes to past assumptions concerning useful lives and residual values. The carrying amounts of property, plant and equipment are disclosed in note 6.

Retirement, long service leave, sick leave and continuing education

Assessing the exposure to long term employee benefits involves making estimates of future length of service and interest rates. The risk is minimised by utilising the services of an actuary.

Critical accounting judgements in applying the DHB's accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards to the DHB.

Finance and operating leases

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

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

1 Revenue

	Note	2011 Actual	2010 Actual
Ministry of Health contract funding		650,277	624,222
Other government		15,709	18,459
Inter district flows (other DHBs)		168,899	161,402
Non government & crown agency sourced		26,990	27,653
Reversal of impairment previously recognised		17,433	-
Restatement plant & equipment, furniture & fittings		4,909	-
Interest Income		1,115	425
		885,332	832,161

2 Other operating expenses

		2011 Actual	2010 Actual
Impairment loss on associate investment		-	2,966
Impairment of trade receivables (bad debts)		2,682	830
Increase in provision of trade receivables (doubtful debts)	10	(713)	714
(Gain) / loss on disposal of property, plant and equipment		7,990	(9041)
Fees for auditors:			
Fees for financial statements audit		190	191
Fees for other assurance services		-	10
Board member fees	20	340	380
Rental and other operating expenses		2,723	3,262
Litigation settlement		-	23
		13,212	(665)

3 Employee benefit costs

	2011 Actual	2010 Actual
Direct staff costs (excluding increases in employee benefit provisions)	330,951	330,626
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	11,993	12,828
Contributions to defined contribution plans	7,042	6,279
Increase/(decrease) in employee benefit provisions	1,043	832
	351,029	350,565

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

in thousands of New Zealand Dollars

4 Finance costs

	2011 Actual	2010 Actual
Interest on bank overdraft	1,202	1,256
Interest on term borrowings	19,548	19,595
Interest on finance leases	71	89
	20,821	20,940

5 Capital charge

	2011 Actual	2010 Actual
The DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month. The capital charge rate for the period ended 30 June 2011 was 8 per cent (2010: 8 per cent)	8,807	6,763

in thousands of New Zealand Dollars

6 Property, plant and equipment

	Free-hold land	Freehold buildings	Lease improve ments	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Cost							
Balance at 1 July 2009	30,850	422,028	2,685	68,176	21,780	26,878	572,397
Additions	-	45,505	18	16,229	18,871	100,304	180,927
Disposals	(4,488)	(578)	-	(711)	(37)	-	(5,814)
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(99,319)	(99,319)
Other movements	-	-	-	-	-	-	-
Balance at 30 June 2010	26,362	466,955	2,703	83,694	40,614	27,863	648,191
Balance at 1 July 2010	26,362	466,955	2,703	83,694	40,614	27,863	648,191
Additions	-	33,671	161	6,000	2,996	29,985	72,813
Disposals	-	(6,886)	(170)	(6,321)	(3,396)	-	(16,773)
Revaluations	(2,248)	(55,391)	-	-	-	-	(57,639)
Transfer to fixed assets	-	-	-	-	-	(44,227)	(44,227)
Restatement plant & equipment, furniture & fittings	-	-	-	(13,810)	(830)	-	(14,640)
Transfer between Categories	-	7,802	-	(3,130)	(4,977)	828	523
Balance at 30 June 2011	24,114	446,151	2,694	66,433	34,407	14,449	588,248
Depreciation and impairment losses							
Balance at 1 July 2009	-	(37,670)	(1,211)	(15,376)	(10,597)	-	(64,854)
Depreciation charge for the year	-	(18,796)	(131)	(10,990)	(4,007)	-	(33,924)
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	319	-	309	20	-	648
Revaluations	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-
Balance at 30 June 2010	-	(56,147)	(1,342)	(26,057)	(14,584)	-	(98,130)

in thousands of New Zealand Dollars

6 Property, plant and equipment (continued)

	Free-hold land	Freehold buildings	Lease Improve ments	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Depreciation and impairment losses							
Balance at 1 July 2010	-	(56,147)	(1,342)	(26,057)	(14,584)	-	(98,130)
Depreciation charge for the year	-	(20,539)	(1,081)	(10,579)	(5,904)	-	(38,103)
Impairment losses	-	-	-	-	-	-	-
Reversal of impairment losses	-	-	-	-	-	-	-
Disposals	-	4,551	88	5,456	1,077	-	11,172
Revaluations	-	72,823	-	-	-	-	72,823
Restatement plant & equipment, furniture & fittings	-	-	-	11,227	905	-	12,132
Transfer between categories	-	(2,668)	-	(146)	2,535	(28)	(307)
Balance at 30 June 2011	-	(1,980)	(2,335)	(20,099)	(15,971)	(28)	(40,413)
Carrying amounts							
At 1 July 2009	30,850	384,358	1,474	52,800	11,183	26,878	507,543
At 30 June 2010	26,362	410,808	1,361	57,637	26,030	27,863	550,061
At 1 July 2010	26,362	410,808	1,361	57,637	26,030	27,863	550,061
At 30 June 2011	24,114	444,171	359	46,334	18,436	14,421	547,835

in thousands of New Zealand Dollars

6 Property, plant and equipment (continued)

Revaluation

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with NZIAS 16, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions.

The revaluation of land and buildings was carried out as at 30 June 2011 by Milton Bevin, FPINZ, an independent registered valuer with Darroch Limited. The valuation conforms to International Valuation Standards. Land revaluation was determined by reference to its highest and best use. The revaluation of buildings was based on depreciated replacement cost methodology.

The total fair value of land valued by the valuer amounted to $24.1m.

The total fair value of buildings valued by the valuer amounted to $446.2m.

Buildings revaluation recognised in statement of comprehensive income

Year	Particulars	Actual
2002	Revaluation loss	(65,939)
2004	Revaluation gain	11,898
2006	Revaluation gain	16,257
2011	Revaluation gain	17,433
	Revaluation loss carried forward	(20,351)

The initial revaluation loss on buildings as at 30 June 2002 of $65.9m was recognised in the Statement of comprehensive income. IAS 16 states that any subsequent revaluation increase in buildings shall be recognised in the Statement of comprehensive income to the extent that it reverses a revaluation decrease, of the same asset, previously recognised in the Statement of comprehensive income. As at 30 June 2011 net revaluation losses of $20.4m are carried forward to future years.

Plant & equipment, furniture & fittings revaluation reserve movement

Particulars	Actual
Balance at 1 July 2010	7,417
Recognised in revenue (Refer Note 1)	4,909
Recognised in Other Comprehensive Income	2,508
Balance at 30 June 2011	-

Borrowing costs

The revaluation of land and building carried out as at 30 June 2011 had an inherent borrowing cost component of $16.9m.

Restrictions

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

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

Leased assets

The net carrying amount of property, plant and equipment held under finance leases is $0.8m (2010: $1.1m).

6 Property, plant and equipment (continued)

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $13.6m (2010: $27.9m) which includes $3.2m of refurbishment of existing buildings.

Property, plant and equipment acquired by finance leases

During the period the DHB acquired property, plant and equipment totalling $nil (2010: $0.1m) by means of finance leases.

In thousands of New Zealand Dollars

7 Intangible assets

	Software	Licences	Total
Cost			
Balance at 1 July 2009	923	1,406	2,329
Additions	18,944	98	19,042
Disposals	-	(2)	(2)
Balance at 30 June 2010	19,867	1,502	21,369
Balance at 1 July 2010	19,867	1,502	21,369
Additions	1,503	515	2,018
Disposals	(1,946)	(31)	(1,977)
Transfer between categories	(523)	-	(523)
Balance at 30 June 2011	18,901	1,986	20,887
Amortisation and impairment losses			
Balance at 1 July 2009	(277)	(1,114)	(1,391)
Amortisation charge for the year	(3,981)	(78)	(4,059)
Impairment losses	-	-	-
Disposals	-	2	2
Balance at 30 June 2010	(4,258)	(1,190)	(5,448)
Balance at 1 July 2010	(4,258)	(1,190)	(5,448)
Amortisation charge for the year	(4,954)	(110)	(5,064)
Impairment losses	-	-	-
Disposals	406	31	437
Transfer between categories	308	-	308
Balance at 30 June 2011	(8,498)	(1,269)	(9,767)
Carrying amounts			
At 1 July 2009	646	292	938
At 30 June 2010	15,609	312	15,921
At 1 July 2010	15,609	312	15,921
At 30 June 2011	10,404	717	11,121

There are no restrictions over the title of Capital & Coast District Health Board's intangible assets, nor are any intangible assets pledged as security for liabilities.

In thousands of New Zealand Dollars

8 Inventories

	2011 Actual	2010 Actual
Pharmaceuticals	1,206	1,186
Surgical & medical supplies	4,983	5,110
Other supplies	150	110
	6,339	6,406

The amount of inventories recognised as an expense during the year ended 30 June 2011 was $50.8m (2010: $44.8m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2010: $nil). There have been no reversals of write-downs.

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

9 Investments in joint ventures

a) Carrying amount of investments in joint ventures

	2011 Actual	2010 Actual
Central Region TAS	-	-
	-	-

Owing to the minor nature of the joint venture no carrying value is recorded the DHB's financial statements

b) Summary of the DHB's interests in Central TAS joint venture (16.67%)

	2011 Actual	2010 Actual
Non-current assets	30	38
Current assets	146	124
Non-current liabilities	-	-
Current liabilities	52	59
Net assets/(liabilities)	124	103
Income	696	509
Expense	676	484
	20	25

c) The DHB's share in contingent liabilities

Central Region TAS has no contingent liabilities. (2010: $nil)

d) The DHB's share in commitments

The DHB share of capital commitments for Central Region TAS is $nil (2010: $0.07m).

In thousands of New Zealand Dollars

10 Trade and other receivables

	2011 Actual	2010 Actual
Trade receivables from non related parties	7,036	12,295
Ministry of Health receivables	10,941	17,420
	17,977	29,715
Accrued income	10,552	6,274
Prepayments	1,817	1,848
	30,346	37,837

Trade receivables are shown net of provision for doubtful debts amounting to $1.7m (2010: $2.4m)

The carrying value of receivables approximates their fair value.

As at 30 June 2011, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2011			2010		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	16,577	-	16,577	25,066	-	25,066
Past due 1-30 days	342	-	342	1,318	-	1,318
Past due 31-60 days	291	-	291	617	-	617
Past due 61-90 days	116	-	116	795	-	795
Past due > 91 days	2,301	1,650	651	4,282	2,363	1,919
Total	19,627	1,650	17,977	32,078	2,363	29,715

Each year trade receivables are reviewed as to collectability, and where a doubt is identified a provision is made. Factors considered are the age of the debt, domicile of the debtor, and the type of service provided. Large receivables are individually reviewed, whilst for small debts the historical pattern is used as a guide.

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

	2011 Actual	2010 Actual
Balance at 1 July 2010	2,363	1,649
Additional provisions made during the year	777	2,713
Provisions reversed during the year	-	-
Receivables written-off during period	(1,490)	(1,999)
Balance at 30 June 2011	1,650	2,363

In thousands of New Zealand Dollars

11 Cash and cash equivalents

	2011 Actual	2010 Actual
Petty cash	13	14
Bank accounts	5,568	2,854
Call deposits	9,300	-
Cash and cash equivalents	14,881	2,868
Bank overdraft	-	-
Cash and cash equivalents in the statement of cash flows	14,881	2,868

Patient funds

The DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and interest earned is allocated to the individual patients.

Working capital facility

The DHB has a working capital facility supplied by ASB Bank Limited, which was established in October 2004. The facility consists of a bank overdraft. The facility utilisation was $ nil as at 30 June 2011 (2010: $ nil). The facility has a limit of $25m.

The ASB working capital facility is secured by a negative pledge. Without ASB's prior written consent, the DHB cannot perform the following actions:

- create any security over its assets except in certain circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

In thousands of New Zealand Dollars

11 Cash and cash equivalents (continued)

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

	2011 Actual	2010 Actual
Surplus/(deficit) for the year	(31,587)	(47,483)
Add back non-cash items:		
Depreciation & amortisation	43,151	37,979
Revaluation gain	(17,433)	-
Share of (profit)/loss from associate Companies	-	-
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	3,081	(9,043)
Interest income on financial assets	(1,115)	(425)
Add back items classified as financing activity:		
Interest expense on financial liabilities	20,821	20,940
Movements in working capital:		
(Increase)/decrease in trade and other receivables	4,191	20,134
(Increase)/decrease in trust funds	(345)	-
(Increase)/decrease in inventories	67	401
Increase/(decrease) in trade and other Payables	(5,321)	1,873
Increase/(decrease) in employee benefits	2,461	(1,529)
Increase/(decrease) in provisions	76	816
Net movement in working capital	1,129	21,695
Net cash inflow/(outflow) from operating activities	18,047	23,663

12 Trust/special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived, and are accounted for separately through the DHB's trust ledger. The revenue and expenditure in respect of these funds is included in the statement of comprehensive income.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as both an asset and a liability.

All trust and patient funds are held in bank accounts that are separate from the DHB's normal banking facilities.

In thousands of New Zealand Dollars

12 Trust/special funds (continued)

Non patient trust funds	2011 Actual	2010 Actual
Balance at 1 July 2010	7,242	6,710
Monies received	2,264	2,222
Interest received	266	267
Payments made	(2,195)	(1,957)
Balance at 30 June 2011	7,577	7,242
Patient funds		
Balance at 1 July 2010	141	141
Monies received	239	229
Interest received	2	2
Payments made	(231)	(231)
Balance at 30 June 2011	151	141
Total trust/special funds	7,728	7,383

13 Interest-bearing loans and borrowings

	2011 Actual	2010 Actual
Non-current		
Secured CHFA loans	231,000	311,000
Finance leases	540	816
	231,540	311,816
Current		
Secured CHFA loans	80,000	-
Secured bank loans	28,000	28,000
Finance leases	276	279
	108,276	28,279

Secured loans

The DHB secured loans are from the Crown Health Financing Agency (CHFA) and a bank. The Crown Health Financing Agency is the entity used by the Ministry of Health for the financing requirements of DHBs. The details of terms and conditions are as follows:

Interest rate summary	2011 Actual	2010 Actual
Crown Health Financing Agency	5.16% - 7.13%	5.16% - 7.13%
Bank loan	3.18% - 4.54%	3.17% - 3.22%
Finance leases	6.50%	6.50%
Repayable as follows:		
Within one year	108,000	28,000
One to two years	70,000	80,000
Two to five years	99,000	141,000
Later than five years	62,000	90,000

In thousands of New Zealand Dollars

13 Interest-bearing loans and borrowings (continued)

Term loan facility limits	2011 Actual	2010 Actual
Crown Health Financing Agency	311,000	311,000
Bank loan	28,000	28,000

Security and terms

The loan facility is provided by the bank and Crown Health Financing Agency, which is a Crown entity aligned with the Ministry of Health. The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent the DHB cannot perform the following actions:

- create any security over its assets except in certain defined circumstances,
- lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee,
- make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; and
- dispose of any of its assets except disposals at full value in the ordinary course of business.
- Provide services to or accept services from a person other than for proper value and on reasonable commercial terms

The DHB is not required to meet any covenants.

The Government of New Zealand does not guarantee term loans.

Analysis of finance leases	2011 Actual	2010 Actual
Minimum lease payments payable		
Within one year	329	350
One to two years	313	329
Two to five years	279	592
Later than five years	-	-
Total	921	1,271
Future finance charges	(105)	(177)
Present value of minimum lease payments	816	1,094
Present value of minimum lease payments payable		
Within one year	309	328
One to two years	276	290
Two to five years	231	476
Later than five years	-	-
	816	1,094

NOTES TO THE FINANCIAL STATEMENTS

In thousands of New Zealand Dollars

14 Employee entitlements

	2011 Actual	2010 Actual
Non-current liabilities		
Liability for long-service leave	3,399	3,191
Liability for sabbatical leave	383	345
Liability for retirement gratuities	2,334	2,237
	6,116	5,773
Current liabilities		
Liability for long-service leave	1,711	1,700
Liability for sabbatical leave	240	240
Liability for retirement gratuities	830	800
Liability for annual leave	31,835	31,513
Liability for sick leave	1,734	1,880
Liability for continuing medical education leave and expenses	7,822	7,225
Salary and wages accrual	7,262	5,958
	51,434	49,316

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

Other employee entitlement liabilities:
Liability for salaries and wages accrued is recognised as at current actual salaries.

Liability for annual leave is calculated as the greater of average weekly earnings for the 12 months immediately before the end of the last pay period before the annual holiday is taken or the employee's ordinary weekly pay as at the beginning of the annual holiday.

Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 3.0%, (2010:3.0%) and a discount rate ranging from 3.09% to 6.14% (2010: 3.69% to 5.64%) from 1-10+ years.

In thousands of New Zealand Dollars

15 Provisions

	2011 Actual	2010 Actual
Current Provisions		
ACC Partnership Programme	307	1,125
Provision for demolition	700	-
	1,007	1,125
Non Current Provisions		
ACC Partnership Programme	354	160
	1,361	1,285

ACC Partnership Programme	2011 Actual	2010 Actual
Undiscounted amount of claims at balance date	562	1,108
Discount	34	50
Central estimate of present value of future payments	596	1,158
Risk margin	65	127
	661	1,285

The movement in provisions is represented by:

	ACC Partnership Programme
2010	
Balance at 1 July 2009	469
Additional provisions during the year for the risks borne in current period	423
Additional provisions relating to a reassessment of risks in a previous period	693
	1,585
Amounts used during the year	300
Total liability	1,285
Increase in provision for claims liability	816

2011	
Balance at 1 July 2010	1,285
Additional provisions during the year for the risks borne in current period	302
Reduction in provisions relating to a reassessment of risks in a previous period	(567)
Subtotal	1,020
Amounts used during the year	359
Total Liability	661
(Decrease) / increase in provision	(624)

15 Provisions (continued)

ACC Partnership Programme

ACC Partnership Program (APP) offers the DHB the option to accept injury management and financial responsibility for employees who suffer work-related illness or injury for a specified period. In return, the accredited employer's ACC premiums are reduced. Participation in the APP is an insurance contract between the employer and the employee, as the employer (insurer) accepts significant insurance risk from the employee (policyholder) by agreeing to compensate the employee if a work-related injury (the insured event) adversely affects the employee.

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

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

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

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

The DHB is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee.

An external independent actuarial valuer, Mr B Higgins, Bsc.FIA of Aon New Zealand Ltd, has calculated the DHB's liability. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

Average inflation has been assumed as 4.0% for the year ending 30 June 2011. A discount rate of 3.8% has been used for the year ended 30 June 2011.

The value of the liability is not material for the DHB's financial statements; therefore any changes in assumptions will not have a material impact on the financial statements.

Provision for demolition

The Riddiford hostel (SR3) was designed in 1953 as nurses hostel. It has been used as residential accommodation all its life and this remains its current use.

A structural verification of SR3 in 2003, by consultants Octa Associates Limited, and subsequent meetings with Wellington City Council reached an agreement that the building could continue its current use for another 8 years, until August 2011, after which it would need to be demolished or seismically strengthened.

In thousands of New Zealand Dollars

16 Trade and other payables

	Note	2011 Actual	2010 Actual
Trade payables to other related parties	20	412	3,301
Trade payables to non-related parties		5,909	5,581
GST and other taxes payables		9,412	11,800
Income in advance		554	340
Capital charge due to the Crown		976	1,226
Other non-trade payables and accrued expenses		47,867	48,549
		65,130	70,797

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

17 Patient and restricted funds

Patient funds	2011 Actual	2010 Actual
Balance at 1 July 2010	141	141
Monies received	239	230
Interest received	2	2
Payments made	(231)	(231)
Balance at 30 June 2011	151	142

Patient funds are held in a separate bank account. Any interest earned is allocated to the individual patient balances. Patient fund transactions during the year ended 30 June 2011 are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as at 30 June 2011, both as an asset and a liability.

Holiday homes funds	2011 Actual	2010 Actual
Balance at 1 July 2010	59	54
Monies received	14	13
Interest received	1	1
Payments made	(11)	(8)
Balance at 30 June 2011	63	59
Hutt Valley DHB Portion ¼ of holiday homes total	16	14
Total patient and Hutt Valley portion of restricted funds	167	156

The holiday homes were purchased for the benefit of staff from funds bequeathed for the purpose in 1993. The holiday homes are two units at Taupo, which are let to staff of the DHB, and Hutt Valley District Health Board, at a rate which will cover operating costs. The holiday homes transactions are recognised in the statement of comprehensive income, and in the statement of financial position.

In thousands of New Zealand Dollars

18 Operating leases

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2011 Actual	2010 Actual
Less than one year	2,407	2,210
Between one and five years	2,891	3,825
More than five years	-	37
	5,298	6,072

The DHB leases a number of buildings, vehicles and items of medical equipment under operating leases.

The leases are on normal commercial terms and include restrictions on sub-leasing. For leased buildings some leases have ratchet clauses, and most have rights of renewal.

No leases include contingent rentals.

Operating lease payments are recognised as an expense on a straight line basis over the term of the lease.

No leased properties are subleased by the DHB.

During the year ended 30 June 2011, $2.6m was recognised as an expense in the statement of comprehensive income in respect of operating leases (2010: $2.8m)

Leases as lessor

The DHB leases out various surplus properties under operating leases. The future minimum lease payments under non-cancellable leases are as follows:

	2011 Actual	2010 Actual
Less than one year	164	162
Between one and five years	524	514
More than five years	1,371	1,363
	2,059	2,039

During the year ended 30 June 2011, $3.4m was recognised as rental income in the statement comprehensive income (2010: $3.1m)

The DHB has:

- a long term agreement with the University of Otago for the provision of medical consultancy services and facilities from which they operate these services.
- long term ground leases in operation where the lessee owns all the improvements.
- medium term leases (consulting rooms) in two separate health centres.
- 43 short term commercial leases, all subject to 6 month termination notice.
- 2 residential leases all subject to the Residential Tenancies Act.

19 Financial instruments

Exposure to credit, interest rate and currency risks arise in the normal course of the DHB's operations. Derivative financial instruments are used to hedge exposure to fluctuations in foreign exchange rates and interest rates.

Credit risk

Financial instruments, which potentially subject the health board to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The DHB places its cash and short-term deposits with high-quality financial institutions and the health board has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 24% in 2011 (2010: 33%). It is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

At the balance sheet date there were no significant other concentrations of credit risk.

Interest rate risk

Cash flow interest rate risk is the risk that cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable rates expose the DHB to cash flow interest rate risk

The DHB adopts a policy of having a spread of interest rate repricing dates on borrowings to limit the exposure to short term interest rate movements. The DHB will from time to time utilise hedge instruments when term borrowings are to be renewed. The DHB borrowings are all fixed term and fixed interest rate, except for the overdraft facility for working capital, which is on a floating rate basis, and the bank loan which is also on a floating rate subject to an interest rate swap.

The net fair value of interest rate hedges swap at 30 June 2011 was $0.45m (2010: $nil)

Sensitivity analysis

If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $1m in 2011. (2010: $0.1m).

In managing interest rate and currency risks the DHB aims to reduce the impact of short-term fluctuations on the DHB's earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

At 30 June 2011, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $4.9m (2010: $5.1m). It is estimated that a general increase of one percentage point in the value of NZD against other foreign currencies to which the DHB had direct exposure would have decreased the DHB's surplus before tax by approximately $0.0005m for the year ended 30 June 2011 (2010: $4.3m).

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

19 Financial instruments (continued)

Effective interest rates and repricing analysis

In respect of interest-bearing financial liabilities, the following table indicates their effective interest rates at balance sheet date and the periods in which they reprice.

	2011 Actual							2010 Actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Secured bank loans:														
NZD fixed rate loan*	5.16	28,000				28,000		5.16	28,000					28,000
NZD fixed rate loan*	6.33	55,000	55,000					6.33	55,000			55,000		
NZD fixed rate loan*	6.84	25,000		25,000				6.84	25,000			25,000		
NZD fixed rate loan*	6.075	70,000			70,000			6.075	70,000				70,000	
NZD fixed rate loan*	6.37	62,000					62,000	6.37	62,000					62,000
NZD fixed rate loan*	6.295	20,000				20,000		6.295	20,000				20,000	
NZD fixed rate loan*	7.13	12,000				12,000		7.13	12,000				12,000	
NZD fixed rate loan*	6.57	11,000				11,000		6.57	11,000				11,000	
NZD fixed rate loan*	6.95	19,400				19,400		6.95	19,400				19,400	
NZD fixed rate loan*	6.39	8,600				8,600		6.39	8,600				8,600	
NZD fixed rate loan*	4.54	28,000	28,000					3.47	28,000	28,000				
Finance leases*	6.50	816	154	154	276	230	-	6.50	1,094	164	164	290	476	-
Bank overdrafts		-	-	-	-	-	-		-	-	-	-	-	-
		339,816	83,154	25,154	70,276	99,230	62,000		340,094	28,164	164	80,290	141,476	90,000

* These liabilities bear interest at fixed rates.

in thousands of New Zealand Dollars

19 Financial instruments (continued)

Contractual maturity analysis of financial liabilities

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

2011	Carrying Amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Creditors and other payables	65,130	65,130	65,130	-	-	-
Secured loans	339,000	399,030	125,230	83,496	123,381	66,923
Finance leases	816	921	329	313	279	-
Patient and restricted funds	167	167	167	-	-	-
Total	405,113	465,249	190,856	83,810	123,660	66,923

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

Contractual maturity analysis of financial assets

The table below analyses the DHB's financial assets into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date.

2011	Carrying Amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Cash and cash equivalents	13	13	13	-	-	-
Bank accounts	5,568	5,568	5,568	-	-	-
Debtors and other receivables	30,346	30,346	30,346	-	-	-
Trust and special funds - bank	266	266	266	-	-	-
Trust and special funds – term deposit	7,100	7,197	7,197	-	-	-
Trust and special funds – debtors	362	362	362	-	-	-
Total	43,655	43,752	43,752	-	-	-

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

in thousands of New Zealand Dollars

19 Financial instruments (continued)

Maximum exposure to credit risk

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

	2011 Actual	2010 Actual
Cash at bank and petty cash	13	14
Bank accounts	5,568	2,854
Debtors and other receivables	30,346	37,837
Trust and special funds – bank	266	670
Trust and special funds – term deposit	7,100	6,300
Trust and special funds – debtors	362	413
	43,655	48,088
Counterparties with credit ratings		
Cash at bank and term deposits	-	-
AA (Standard & Poors)	12,947	9,838
	12,947	9,838

Debtors and other receivables mainly arise from CCDHB's statutory functions, therefore there are no procedures in place to monitor or report the credit quality of debtors and other receivables to internal or external credit ratings.

Foreign currency risk

The DHB is exposed to foreign currency risk on purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily U.S. Dollars and AUD Dollars.

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

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2011 was $nil (2010: $nil), comprising assets of $nil (2010: $nil) and liabilities of $nil (2010: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive income. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as fair value through profit & loss". The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2011 was $nil (2010: $nil) recognised in fair value derivatives.

in thousands of New Zealand Dollars

19 Financial instruments (continued)

Fair values

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

	Note	2011		2010	
		Carrying amount	Fair value	Carrying amount	Fair value
Trade and other receivables	10	30,346	30,046	37,837	37,837
Cash and cash equivalents	11	13	13	14	14
Bank accounts	11	5,568	5,568	2,854	2,854
Secured loans including bank	13	(339,000)	(360,586)	(339,000)	(359,346)
Finance leases	13	(921)	(921)	(1,094)	(1,094)
Trade and other payables	16	(65,131)	(65,131)	(70,797)	(70,797)
Bank overdraft	11	-	-	-	-
		(369,125)	(390,710)	(370,186)	(390,532)
Unrecognised (losses)/gains			(21,585)		(20,346)

Estimation of fair values analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

Derivatives

Forward exchange contracts are either marked to market using listed market prices or by discounting the contractual forward price and deducting the current spot rate.

Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance sheet date. Where other pricing models are used, inputs are based on market related data at the balance sheet date.

Interest-bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Finance lease liabilities

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogeneous lease agreements. The estimated fair values reflect change in interest rates.

Trade and other receivables/payables

For receivables / payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables / payables are discounted to determine the fair value.

Interest rates used for determining fair value

The entity uses the government bond rate as of 30 June 2011 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2011 Actual %	2010 Actual %
Derivatives	N/A	N/A
Loans and borrowings	4.54, 5.16, 6.075, 6.295, 6.33, 6.37, 6.39, 6.50, 6.57, 6.84, 6.95, 7.13.	3.17, 5.16, 6.075, 6.295, 6.33, 6.37, 6.39, 6.50, 6.57, 6.84, 6.95, 7.13.

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel

Identity of related parties

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

The DHB has a related party relationship with its joint venture and with its board members and key management personnel.

In addition the following members of the board have related parties with the DHB customers and suppliers:

- Dr Virginia Hope is the Chairman of the Hutt Valley District Health Board. She was elected to the Board of CCDHB on 01 December 2010. She is also a Health Programme Leader in the Institute of Environmental Science and Research.
- Peter Glensor is a member of the Hutt Valley District Health Board. He is also the Deputy Chair of the Greater Wellington Regional Council. Peter Glensor was appointed to the Board of CCDHB on 01 December 2010.
- Dr Judith Aitken and Barbara Donaldson are both members of the Greater Wellington Regional Council.
- Peter Douglas is a member of the Hutt Valley District Health Board.
- Keith Hindle is a Board Member of the Hutt Valley District Health Board. He is also a Consultant for the Wellington Tenths Trust and a Director of Metlifecare Palmerston North.
- Helene Ritchie is a Councillor for Wellington City Council.
- Dr Donald Urquhart-Hay has an association with Wakefield Hospital and Mid Central Health.
- Debbie Chin is a Crown monitor for Hutt Valley DHB and CEO of Standards NZ.
- Sir John Anderson is the Director of the Commonwealth Bank of Australia who is the banker for the DHB. He is also the Commissioner of Hawkes Bay DHB. (Resigned as Chairman in November 2010)
- Dr Selwyn Katene is the Chairman of Te Roopu Awhina. Dr Selwyn Katene is also the Director of MANU AO Academy at Massey University. (Resigned in November 2010)
- Dr. Peter Roberts is a Senior Clinical Lecturer at The University Of Otago Wellington School of Medicine. He is the also the President of the New Zealand Medical Association and Member of the Royal Australian College of Physicians. (Resigned in November 2010)

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

- Cathy O'Malley is the CEO of the following suppliers, The Greater Wellington Health Trust, MATPRO Ltd, Compass Health Wellington Trust (which includes Capital PHO, Tumai mo te Iwi, Kapiti PHO) She is a director of MATPRO Ltd and is also a trustee of Wellington Free Ambulance.
- Dr Adrian Gilliland is a Clinical Tutor at The University Of Otago Wellington School of Medicine. He is also a member of the Clinical Advisory Group and a practicing GP at Ora Toa PHO.
- Dr Bryan Betty is a Board member of Porirua Health Plus and Porirua Union Health. He is also Clinical Tutor at The University Of Otago Wellington School of Medicine.
- Taima Fagaloa is a councillor at Porirua City Council.

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel (continued)

- Geoff Robinson is the Chair of The Medical Research Institute of New Zealand. He is also a trustee of the Wellington Hospitals and Health Foundation.
- Mary Bonner is a trustee of The Wellington Hospitals and Health Foundation.
- Vicky Noble is a Board Member of The College of Nurses Aotearoa.
- Ken Whelan is a trustee of The Wellington Hospitals and Health Foundation. (Left the DHB in September 2010)

Remuneration

The key management personnel remuneration is as follows:

	2011 Actual	2010 Actual
Short-term employee benefits	1,826	2,949
Post-employment benefits	15	7
Other long-term benefits	-	-
Termination benefits	-	-
	1,841	2,956
Executive team (as above)	1,841	2,956
Board members	387	415
	2,228	3,371

Key management personnel include all Board members, the Chief Executive, and the other 9 members of the management team.

The Board of the DHB as at 30 June 2011, and those who ceased to hold office during the year ended on that date, are set out below together with details of their remuneration (excluding expense reimbursement) received or receivable, for the year ended 30 June 2011.

The Board has taken insurance cover for Board members, Board Committee members, and employees for personal loss caused by wrongful acts in the course of their duties where indemnity is not available from the organisation. The Board has also taken insurance cover covering personal accident and travel risk for Board members, Board Committee members and employees where injury or loss occurs whilst on DHB business.

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel (continued)

Board members			Board Fees		Committee Fees	
Current board members as at 30 June 2011			**2011**	**2010**	**2011**	**2010**
Dr Virginia Hope	Elected	Board Chair from 1 Dec 2010 Chair HAC to 30 Nov 2010	43	29	7	5
Peter Glensor	Appointed	Deputy Chair from 1 Dec 2010 Deputy Chair HAC from 1 Dec 2010	15	-	1	-
Dr Judith Aitken	Elected	Chair DSAC to 30 Nov 2010 Deputy Chair CPHAC from 1 Dec 2010	25	26	5	3
David Choat	Elected	Member from 1 Dec 2010	15	-	2	-
Barbara Donaldson	Elected	Member from 1 Dec 2010	15	-	1	-
Peter Douglas	Appointed	Chair HAC from 1 Dec 2010	25	25	4	3
Margaret Faulkner	Elected	Chair DSAC from 1 Dec 2010 Deputy Chair FRAC until 30 Nov 2010	26	26	7	7
Keith Hindle	Appointed	Chair FRAC	24	14	4	1
Helene Ritchie	Elected		26	25	6	4
Darrin Sykes	Appointed	Member from 1 Dec 2010	15	-	3	-
Dr Donald Urquhart-Hay	Elected		25	25	2	3
Board members who resigned during the 2010/11 year						
Sir John Anderson	Appointed	Board Chair to 30 Nov 2010 Resigned 30 Nov 2010	21	50	-	-
Ken Douglas	Appointed	Deputy Chair, Chair (FRAC) to Nov 2009	-	14	-	-
Ruth Gotlieb	Elected	Resigned 30 Nov 2010	10	25	1	3
Selwyn Katene	Appointed	Resigned 30 Nov 2010 Chair CPHAC to 30 Nov 2010	10	25	1	3
Dr Peter Roberts	Elected	Resigned 30 Nov 2010	10	25	3	3
Crown monitors						
Ian Brown	Appointed	Crown monitor to Dec 2009	-	16	-	-
Debbie Chin	Appointed	Crown Monitor	35	20	-	-
			340	345	47	35

Legend:

DSAC – Disability Support Advisory Committee, HAC – Hospital Advisory Committee

CPHAC – Community and Public Health Advisory Committee, FRAC – Finance Risk & Audit Committee

Committee members' (other than Board members and employees)	**2011**	**2010**
Finance, Risk and Audit Committee		
Maureen Gillon (until May 2010)	-	1
Community and Public Health Advisory Committee		
Herani Demuth	1	3
Tavita Filemoni	1	1
Frances Hughes	-	1

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel (continued)	2011	2010
Kayleen Katene	1	-
Ken Patel	-	1
Stephen Palmer	2	1
Api Rongo-Raea	1	1
Disability Support Advisory Committee		
Nathan Bond	2	1
Margaret Guthrie (until May 2010)	-	1
Liz Mellish (until March 2010)	-	1
Judy Small	1	1
Hillary Stace	1	1
James Webber (from March 2010)	4	3
Hospital Advisory Committee		
Hilda Broadhurst	2	4
Malakai Jiko	2	3
Lynn McBain	2	2
Karen Coutts	4	1
	24	27

Sales to related parties	2011 Actual	2010 Actual
CRTAS (joint venture)	235	20
Wakefield Hospital	38	25
Capital PHO	-	93
Tumai mo te Iwi	7	28
Kapiti PHO	-	22
Ora Toa PHO	12	2
MATPRO LTD	-	1
Te Roopu Awhina	68	116
Wellington School of Medicine	825	1,545
Royal Australasian College of Physicians	8	2
Wellington Free Ambulance	79	74
Compass Health Wellington Trust	162	110
Porirua Health Plus Ltd	-	3
Mid Central District Health Board	581	21,913
Wellington Hospital and Health Foundation	33	20
Hawkes Bay District Health Board	283	18,325
Massey University	74	197
Hutt Valley District Health Board	4,702	61,558
Kapiti Community Health Group	1	-
Medical Research Institute of NZ	163	-
Otaki PHO	1	-
Victoria University of Wellington	135	-
Whitireia Community Polytechnic	177	-
Institute of Environment Science and Research	1	-
Work and Income	238	-
	7,823	104,054

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel (continued)

Purchases from related parties	2011 Actual	2010 Actual
CRTAS (joint venture)	979	898
Healthcare of New Zealand Ltd	-	719
Te Roopu Awhina	127	138
Wakefield Hospital	769	1,376
PowerHouse People Ltd	-	398
Compass Health Wellington Trust	6,990	8,449
Compass Health Care Network	42,284	19,760
MATPRO Ltd	128	128
Wellington City Council	965	1,180
Home of Compassion	1	-
Wellington Free Ambulance	211	-
Royal Australasian College of Physicians	27	10
Wellington Hospital & Health Foundation	10	82
Porirua Union Health	817	739
Porirua City Council	314	498
Massey University	49	133
Medical Research Institute of New Zealand	87	85
Wellington Tenths Trust	-	175
Metlife Care Palmerston North	-	1,104
Ora Toa PHO	3,595	2,102
Porirua Health Plus Limited	56	-
Wellington School of Medicine	3,314	10
New Zealand Medical Association	-	2
Mid Central District Health Board	95	2,720
Hutt Valley health	2,017	42,825
Hawkes Bay District Health Board	68	1,627
Victoria University of Wellington	57	-
Health Partners Consulting Group Limited	68	-
Institute of Environment Science and Research	10	-
Whitireia Community Polytechnic	59	-
	63,097	82,288

Outstanding balances to related parties	2011 Actual	2010 Actual
CRTAS (joint venture)	9	-
Te Roopu Awhina	-	11
Wakefield Hospital	-	53
Compass Health Wellington Trust	-	844
The Greater Wellington Health Trust	-	-
MATPRO Ltd	-	10
Capital PHO	-	153
Tumai mo te Iwi	-	89
Wellington City Council	-	17
Hawkes Bay District Health Board	10	3
Wellington School of Medicine	246	10

in thousands of New Zealand Dollars

20 Related parties transactions and key management personnel (continued)

	2011 Actual	2010 Actual
Hutt Valley District Health Board	156	1,740
Wellington Tenths Trust	-	27
Metlife Care Palmerston North	-	45
Kapiti PHO	-	-
Porirua City Council	-	21
Royal Australasian College of Physicians	-	-
Wellington Free Ambulance	-	-
Ora Toa PHO	-	223
Porirua Health Plus	-	55
	421	3,301

ASB Bank Ltd

ASB Bank Ltd is the DHB's banker and is a member of the Commonwealth Bank of Australia Group. During the year $0.7m of interest and bank fees were charged to the DHB and the DHB earned $0.2m of interest. The ASB Bank Ltd provides a working capital facility of $25m to the DHB. The facility Utilisation as at 30 June 2011 was $nil.

Outstanding balances from related parties	2011 Actual	2010 Actual
CRTAS (joint venture)	59	-
Massey University	112	8
The Royal Australasian College of Physicians	-	3
Hutt Valley District Health Board	1,144	578
Midcentral District Health Board	85	126
Wellington Hospital and Health Foundation	12	8
Porirua Union Health	-	1
Te Roopu Awhina	68	20
Wakefield Hospital	2	2
Compass Health Wellington Trust	89	4
Hawkes Bay District Health Board	69	91
Wellington Free Ambulance	14	-
Wellington School of Medicine	165	265
Medical Research Institute of NZ	24	-
Ora Toa Health Services	2	-
Whitireia Community Polytechnic	138	-
Victoria University of Wellington	44	-
Work and Income	321	-
	2,348	1,106

Transactions with associates and joint ventures are priced on an arm's length basis.

No provision has been required, nor any expense recognised for impairment of receivables from related parties (2010: $nil).

Ownership

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

Joint ventures

The DHB holds a 16.7% shareholding in Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial and financial policy decisions. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region. CRTAS has a total share capital of $600 of which the DHB's share is $100. At balance date all share capital remains uncalled.

Transactions with other entities controlled by the Crown

There have been transactions with other entities controlled by the Crown that have not been separately disclosed because the transactions have been carried out on the same terms as if the transactions had been carried out at arms length.

in thousands of New Zealand Dollars

21 Employee remuneration

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

	Number of Employees 2011	Number of Employees 2010
100 – 110	87	87
110 – 120	61	50
120 – 130	45	45
130 – 140	34	28
140 – 150	23	24
150 – 160	20	20
160 – 170	18	23
170 – 180	12	16
180 – 190	21	5
190 – 200	14	19
200 – 210	12	15
210 – 220	20	15
220 – 230	15	12
230 – 240	15	8
240 – 250	17	14
250 – 260	14	10
260 – 270	4	5
270 – 280	8	9
280 – 290	7	7
290 – 300	4	6
300 – 310	3	3
310 – 320	9	3
320 – 330	4	4
330 – 340	4	2
340 – 350	2	2
350 – 360	5	2
360 – 370	2	1
370 – 380	1	-
380 – 390	1	4
390 - 400	2	-
410 – 420	1	2
420 – 430	-	1
430 – 440	1	-
440 – 450	-	1
450 - 460	1	-
500 - 510	1	-
550 – 560	1	-
	489	443

Of the 489 employees shown above, 357 are or were medical or dental employees and 132 are or were neither medical nor dental employees. This represents an increase of 46 staff in total over the previous year.

If the remuneration of part-time employees were grossed-up to an FTE basis, the total number of employees with FTE salaries of $100,000 or more would be 716, compared with the actual total number of 489.

in thousands of New Zealand Dollars

22 Termination payments

During the year ended 30 June 2011, 20 (2010: 52) employees received compensation and other benefits in relation to cessation totalling $0.5m (2010: $1.1m).

No Board members received compensation or other benefits in relation to cessation (2010: nil).

23 Explanation of significant financial variances from budget

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2011 are provided below.

Statement of comprehensive income

The DHB recorded a deficit of $31.6m compared with the budgeted deficit of $40.1m.

Revenue was above budget mainly due to: the gain on the revaluation of buildings which was completed in June 2011; the devolution of Mental Health solutions contract to the DHB; additional electives revenue being earned and additional funding for Herceptin.

Expenditure was higher than budget for the reasons noted below:

- Clinical supply costs were above budget due to higher levels of activity than what was budgeted for and delays in the implementation of targeted savings initiatives.
- More outsourced services were contracted to cover for industrial action in laboratories and radiology, as well as covering for nursing vacancies.
- Personnel costs were higher than budget due to significant savings targets not being fully achieved.
- These cost increases were partially offset by savings in payments to non-health providers as targeted savings in this area came to fruition, and financing charges were lower than budget due to delays in the timing of equity funding received and historically low interest rates.

Statement of financial position

Major variances were:

- Trade and other receivables are under budget due to intensive collection activity and a change to processes leading to more timely invoicing and collection.
- The favourable bank balance is mainly due to capital expenditure being lower than budgeted in 2010/11.
- Trade and other payables reflect additional accruals.

Statement of changes in cash flow

The net cash flow was favourable to the budget. The major reasons were:

- Operating cash flows were better than budget, due to increased funding receipts which more than offset the increased payments to suppliers.
- Investing cash flow is adverse to budget due to receipt of proceeds from sale of Porirua land being budgeted to be received in 2010/11 when actual proceeds were received in 2009/10. This was partially offset by capital expenditure being lower than budget.
- Financing cash flows were adverse to budget due to a one-off payment to Ministry of Health.

24 Capital management

The DHB's capital is its equity, which is comprised of equity contribution, accumulated funds and other reserves. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

25 Summary revenues and expenses by output class

	Public Health Services			Primary and Community Services			Hospital Services			Support Services			Total DHB		
	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual
Revenue															
Crown	11,516	12,501	7,997	199,626	192,393	206,490	510,146	504,117	499,837	113,598	108,595	89,759	834,886	816,707	804,083
Other	-	-	223	65	-	5,664	51,461	10,757	28,965	-	9,519	2,511	51,526	20,276	37,363
Total revenue	11,516	12,501	8,220	199,691	192,393	212,154	561,607	514,874	528,802	113,598	118,114	92,270	886,412	837,883	841,446
Expenditure															
Personnel	-	-	97	-	-	2,449	347,448	336,844	346,936	3,581	3,664	1,083	351,029	340,508	350,565
Depreciation	-	-	-	2	-	3	43,148	35,922	37,980	-	3	-	43,150	35,926	37,983
Capital charge	-	-	-	-	-	-	8,807	11,350	6,763	-	-	-	8,807	11,350	6,763
Provider payments	11,063	12,675	7,893	163,145	171,595	184,687	35,739	32,492	32,892	100,848	100,034	78,713	310,795	316,796	304,184
Other	469	-	255	36,734	23,474	25,642	157,695	135,086	150,785	9,320	14,875	12,752	204,218	173,435	189,434
Total expenditure	11,532	12,675	8,245	199,881	195,069	212,781	592,837	551,693	575,356	113,749	118,577	92,548	917,999	878,014	888,929
Net surplus/ (deficit)	(16)	(174)	(25)	(190)	(2,675)	(627)	(31,230)	(36,819)	(46,554)	(151)	(463)	(277)	(31,587)	(40,131)	(47,483)

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid from the Funder Arm is matched to a purchase unit code, and then mapped to the relevant output class. This is done at a detailed transactional level and accounts for the majority of the DHB's revenue and expenditure.

The DHB's remaining activity is within the Provider arm, and as a result has been assumed to come under the Hospital Services output class.

There has been some reclassification between Primary & Community and Support services from 2010 to 2011 which accounts for most of the movement in these output classes from year to year.

The following table shows the consolidation of service statements for each output class.

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual	2011 Actual	2011 Budget	2010 Actual
Opening balance	(246,287)	(235,966)	(200,525)	(18,950)	(19,559)	(20,091)	4,313	1,561	7,175	(260,924)	(253,964)	(213,441)
Surplus/(deficit) for the year	(28,355)	(30,500)	(45,762)	612	(13)	1,141	(3,844)	(9,619)	(2,862)	(31,587)	(40,132)	(47,483)
Closing balance	(276,442)	(266,466)	(246,287)	(18,338)	(19,572)	(18,950)	469	(8,058)	4,313	(292,511)	(294,096)	(260,924)

26 Statement of going concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2010/11 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of comfort

The Board has received a letter of comfort, dated 4 October 2011 from the Ministers of Health and Finance.

Operating and cash flow forecasts

The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent. The Board is confident that the equity injections in the 2011/12 and 2012/13 years related to operating cash flows will eventuate.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next 3 years prepared by the Board show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of the DHB to continue as a going concern if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern.

If the DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.