CCDHB ANNUAL REPORT **2011/2012**

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Contents

The CCDHB Annual Report 2011/2012 is published online at www.ccdhb.org.nz/about us

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Wellington Regional Hospital, Riddiford St, Newtown, Wellington 6021.
Phone (04) 385-5999

A Day in the Life

11
babies are born

140
people present to Wellington Hospital Emergency Department

742
patients are seen by a nurse in general practice

1140
outpatients are seen

1900
meals are prepared and distributed (1150 at Wellington Regional Hospital, and 750 at Kenepuru Community Hospital)

155
patients are admitted to our hospitals. 48 of these are 'day patients' receiving treatment or surgery which is not expected to require an overnight stay.

38
infants are cared for in Wellington Regional Hospital's neonatal unit

6100
prescriptions are filled by community pharmacies

6000
community laboratory tests performed

2546
patients seen by a GP

96
people present to Kenepuru Accident & Medical Centre

2100
clean sheets are sent out from the hospital's laundry

1500
Around 1500 people are cared for in subsidised aged residential care

300
about 300 patients are examined in radiology

7
patients are flown to, or from Wellington Regional Hospital

55
about 55 patients undergo surgery

75
people a day have their eyes checked

Message from the Chair and CEO

Mary Bonner, CEO and Dr Virginia Hope, Board Chair

The 2011/12 year has seen Capital & Coast District Health Board arrive on budget, with a strong focus on achieving the government's health targets. CCDHB continues to actively seek more innovative ways to provide better health services as we further develop links with our community health partners and our neighbouring DHBs.

While there are still challenges ahead to meet the government's Quarterly Health Targets we would like to acknowledge the work done on the increasing access to cancer treatment, improvements to elective surgery times, and the flow of acute patients through the hospital. In the past year we moved from seeing 74% of patients who presented to the Emergency Department within the six hour time frame to almost 90%. This work has been a major focus for all hospital staff. By working together we have shown what is possible and we feel confident we can hit the 95% target soon.

A priority in 2011/12 was improving health outcomes for children. We are proud of our increased immunisation rates which are unparalleled in the region in recent decades. In the latest quarter, to 30 June, 94% of two year olds were fully immunised in our region. Of particular note are the results achieved for Māori and Pacific at 96% and 97% respectively. This achievement reflects effective collaboration between PHOs, primary health care and general practices, Plunket, Well Child Tamariki Ora providers, and Regional Public Health as well as local Lead Maternity Carer and Midwife teams. This achievement is an important investment in the future health of our children.

Rheumatic fever was identified as an issue for our children and we have been pleased with the implementation of the new throat swabbing services put in place in Porirua East. In the first three months of the programme 643 children were swabbed with 54 requiring treatment This is another example of this DHB working with local providers and other agencies (local schools in this case) to improve the health of our children.

Warmer, drier homes bring health benefits, especially for those with respiratory illness or other conditions derived from living in cold and damp houses and we have been pleased with our collaborative efforts with City Councils, Hutt Mana Charitable Trust, Sustainability Trust and Autix that have seen 351 houses (in Porirua) insulated in the last year.

At a regional and sub-regional level the past year has seen a greater trend toward establishing regional clinical networks that will ultimately provide a better service for all of our communities. One of the principles behind this work is that it is being led by senior clinicians and frontline staff, with support from management. This philosophy of new initiatives and service changes being led by clinical staff is now well embedded in Capital & Coast's work culture and continues to attract support from staff and external stakeholders. Collaborative work continues to progress across several areas including ENT services, diabetes, child health, and gastroenterology which will

result in improvements in service provision over coming years.

The Mental Health Directorate has had an especially busy year that began and ended with two significant openings. On July 25, 2011, Te Aruhe, New Zealand's first inpatient unit for youth with mental health and intellectual disabilities, was blessed and officially opened at Ratonga Rua O Porirua. With a strong emphasis on rehabilitation, this highly specialised service fills a unique need for a small number of young people who would otherwise have to be seen in adult facilities.

The opening of Te Whare o Matairangi at Wellington Hospital in July 2012 will be another achievement the Mental Health team can be extremely proud of. This $7.8 million refurbishment has taken 14 months to complete and involved extensive consultation with consumers, community groups and clinical staff. It will provide a state of the art facility for people dealing with acute mental health issues, providing a new model of care to help people return to their lives in the community.

In 2011 our radiation oncology service upgraded one of its radiotherapy linear accelerators with the first model of its kind in Australasia. The $5 million project marked the beginning of a new era in the radiotherapy treatment of cancers for Capital & Coast and the wider population it serves. Approximately 20,000 radiation treatments are provided to more than 1,300 patients each year at CCDHB so this new "linac" will help future proof the DHB, allowing staff to provide more focussed, and effective treatments with reduced toxicity for patients.

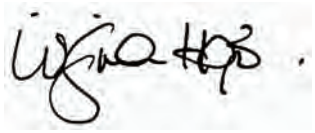
CCDHB continues to successfully work toward achieving its financial recovery. For the fourth year in a row we have met our financial targets, reducing our deficit by $20 million in the 2011/12 financial year. This is a success that we can all be proud of in a financially challenging environment felt across both the public and private sector. A great deal of our achievement comes down to the success of the strong clinical partnership model focused on improving our overall capacity to meet the needs of our community whilst improving the quality of care. We have looked at a variety of initiatives including better purchasing and management of our stock and a standardisation of products, in addition to looking for savings through improved contract negotiations.

Alongside this we continue to monitor and enhance our patient safety culture with new initiatives including a campaign to look at best practice for taking blood samples, a new vital signs chart, an improved feedback process and better information available for patients and their families. During the past year our simulation suite has been upgraded so that, as the main tertiary hospital for the region, our staff can continue to develop their skills through simulation training.

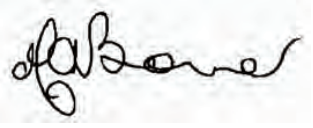
In the past year we have deliberately taken a more multi-disciplinary approach to caring for our patients that has doctors, nurses and other health professionals from the hospital and community planning health care together to ensure people get the right care as close to home as possible. This focus will continue in the coming year as we continue to look at smarter use of modern technology to provide more pro-active, community-based, individualised health care.

In March we celebrated the centenary of Wellington Children's Hospital, which first opened its doors in 1912 under the name of the King Edward VII Memorial Hospital for Children. It provided a wonderful opportunity for us all to look back on the clinical innovation and medical advances we have seen in the past 100 years as we continue to care for and support the most vulnerable members of our society. We would like to take this opportunity to recognise the work of the Hospital and Health Foundation and its volunteers. The Foundation, supported by our community and donors, organised many of the centenary celebrations as well as many other events over the course of the year.

Finally, we would like to thank the Board and the staff for their continued support and commitment to the people of this region. We believe that we are on track and focused on delivering first-rate health services to our community.



Dr Virginia Hope,
Chair



Mary Bonner,
CEO

Message from the Clinical Leaders

Vicky Noble, Director of Nursing, Primary Health & Integrated Care,
Kerrie Hayes, Director of Nursing & Midwifery,
Dr Geoff Robinson, Chief Medical Officer and
Christine Epps, Executive Director of Allied Health, Technical & Scientific.

This message has been written together by the Professional Heads as part of our vision of inter-professional collaboration, and drive for continuous quality improvement for the people and families that we work with. We are passionate about improving and leading the way we deliver healthcare as the needs of our communities change.

Over the last year, there have been many new and exciting clinical developments across the District, and indeed the sub-region, and region. All clinical and support staff are expected to meet the challenge of providing "Better, Sooner, and More Convenient" services within the health dollars that we have.

We see the development of a service improvement strategy for the DHB as an important step forward. This will enable us to shift the organisation's focus from the completion of various ad hoc projects and service improvements, to a more co-ordinated approach so that the improvements we all make are not only sustained, but are also seen to make a difference for the people we care for. Many clinicians have taken part in training to further develop their skills so that they can better understand and implement fundamental elements of improvement.

Another key strategy that is being undertaken with our primary health and community partners is the Integrated Care Collaborative programme. One of the main purposes of this programme is to improve the quality, safety and experience of care for the people and families that we look after. Groups of experienced clinical staff from across the health sector are coming together to break down some of the traditional barriers within healthcare that our patients and families experience. Work has already begun within many areas. Examples so far include:

- Health of Older People
- Acute Demand and After Hours
- Living Well with Long term Conditions
- Enablers – Communication/Information and Workforce Development

Child Health and the Mental Health Commissioning Group is currently being incorporated into the programme. It is very exciting to see that over 170 clinical staff across the system are involved so far. This indicates a real commitment to forming effective partnerships that are aimed at improving health outcomes for the population we serve. Fundamental to this partnership is a belief that high levels of constructive engagement will positively impact on the quality, safety and cost of the health and disability services we all provide.

As Professional Leaders, we continue to work hard to be accessible and available to hear clinician and consumer feedback, as well as to guide and

demonstrate strong clinical leadership. We value and appreciate the array of involvement from clinical staff at all levels across the DHB to ensure that we all practice safe, high quality, and effective healthcare. Together we are contributing to, implementing, and in some cases driving international best practice for healthcare.

Clinical Governance and improving standards of healthcare is at the forefront of our work. Within New Zealand, this is measured using a number of indicators and targets. This year our quality indicators are showing improvements in all the areas that we measured:

- Falls
- Pressure areas
- Continence
- Nutrition
- Hospital acquired infections

There are also a number of Clinical Governance structures that are supporting clinical excellence as well as integration of the patient journey across primary and community to tertiary services.

As a teaching hospital, our commitment to training a wealth of undergraduate and postgraduate students is well established. We have many links across the organisation into each of the four universities in and around Wellington, as well as across New Zealand. The ongoing commitment to the training of our workforce; both present and future remains a key driver to our success.

Vicky Noble,
Director of Nursing, Primary Health & Integrated Care

Kerrie Hayes,
Director of Nursing & Midwifery

Dr Geoff Robinson,
Chief Medical Officer

Christine Epps,
Executive Director of Allied Health, Technical & Scientific

About CCDHB

CCDHB 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 and Coast district, with two thirds of the population in Wellington City, 18% in Porirua and 14% on the Kapiti Coast.

CCDHB 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.

CCDHB is the leading provider of specialist tertiary services for the upper South and lower North Islands, covering 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, oncology, 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 drug services.

CCDHB operates two hospitals; Wellington and Kenepuru, supported by the Kapiti Health Centre, a large Mental Health campus at Porirua 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, a total of about approximately 5200 people.

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 experience poorer health outcomes. Māori and Pacific people are more likely to live in a deprived neighbourhood and have significantly higher rates of avoidable morbidity and mortality than other ethnic groups.

The district population is predicted to increase 15% 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 expected 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 the 15% of the district population estimated to have a disability.

For more detail on the health needs of our population see the 2011/2012 Annual Plan.

About our Annual Report

This report presents Capital and Coast District Health Board's (CCDHB) performance for the year 1 July 2011 to 30 June 2012. 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) 2011/12, and provides a detailed account of how the health funding received by CCDHB 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 CCDHB.

The Board's long-term strategic objectives (over 10 years) are outlined in its District Strategic Plan and each year the Board reviews how it has performed according to those objectives in its District Annual Plan.

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 health care 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 our local and regional provider partners.

Governance of CCDHB

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.

The Board of Capital & Coast DHB is responsible for the governance of the organisation and is accountable to the Minister of Health. The governance structure for DHBs is set out in the New Zealand Public Health and Disability Act 2000. The Capital & Coast DHB Board consists of 11 members who have overall responsibility for the organisation's performance. Seven Board members are elected as part of the three-yearly local body election process (being held again in October 2013) and four are appointed by the Minister of Health. A Crown Monitor was appointed in the 2007/08 year and replaced by a new Crown Monitor in November 2009.

Our Objectives as a District Health Board

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

- To reduce health disparities by improving health outcomes for Māori and other population groups.
- To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.
- To improve, promote, and protect the health of people and communities.
- To promote the integration of health services, especially primary and secondary health services.
- To promote effective care or support for those in need of personal health services or disability support services.
- To promote the inclusion and participation in society and independence of people with disabilities.
- To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services.
- To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.
- To be a good employer.

Board Profiles

Dr Virginia Hope BOARD CHAIR

Dr Hope is also Chair of Hutt Valley District Health Board and has been an elected Board member at Capital and Coast District Health Board since 2007. She was previously an elected member of the Auckland District Health Board. Dr Hope is a graduate of Auckland School of Medicine, the Wellington School of Medicine, and the Auckland Business School and a Specialist both in Public Health Medicine and in Medical Administration (FAFPHM, FNZCPHM, FRACMA). She was previously Deputy Chair of the Ministerial Review Group and the National Health Board prior to becoming Chair of CCDHB.

Peter Glensor DEPUTY CHAIR

Peter is an appointed member of the Board and also an elected member of Hutt Valley DHB. Previously he chaired HVDHB for seven years until 2010. He is a member of all the statutory sub-committees of the Board, including being Deputy Chair of CCDHB's Hospital Advisory Committee and Chair of HVDHB's Hospital Advisory Committee. Peter was Chair of the national network of DHBs and a member of the Capital Investment Committee, which advises the Minister on capital spending in health. Peter's interest is in strengthening the regional collaboration of the DHB, and maintaining a culture of excellence. He also represents Lower Hutt on the Greater Wellington Regional Council, where he is the Deputy Chair, and chairs the committee responsible for public transport and economic development.

Judith Aitken

Dr Aitken has served continuously as an elected member of the Board since 2001. For the past three years her focus has been on the prevention of childhood disease like rheumatic fever, alcohol harm reduction, increasing disabled peoples' confidence, and improving support for home carers. She would also like foster better relationships between hospitals and communities. Previously Dr Aitken was Chief Executive of the Education Review Office, and Women's Affairs. She is a member of the Disability Support Advisory Committee, and is deputy chair of the Community and Public Health Advisory Committee.

David Choat

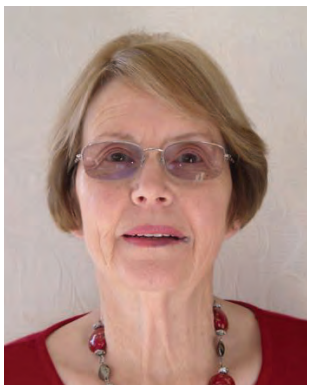
David is a public policy professional with experience across a range of areas including education, social development, and health. He was elected onto the Board in 2010 and is a member of the Community and Public Health Advisory Committee. He advocates against cuts to the health sector and for greater accountability and transparency in Board decisions. David also works at Parliament as a Director of Policy for the Leader of the Opposition's Office. He lives in Island Bay with his partner and two preschool children.

Barbara Donaldson JP

Barbara is an elected Board member and a member of the Hospital Advisory Committee. She is also a Greater Wellington Regional Councillor where she is Chair of the Environmental Wellbeing Committee. She has an MA (Psychology) from Victoria and a BBS from Massey. Barbara has an extensive background in the health sector as a senior hospital manager, Chief Executive of Quality Health New Zealand and International Accreditation Manager of the International Society for Quality in Health Care. She consults internationally on health quality development.

Peter Douglas

Peter Te Matakahere Douglas is married to Hera and has two teenage sons. He is Chief Executive of Te Ohu Kaimoana Trustee Ltd, the Māori Fisheries Trust. He has a background in policy advice and analysis in a range of areas and has worked in a number of government departments; including the Ministries of Social Development and Economic Development; the Department of Child Youth and Family and the Department of Prime Minister and Cabinet. He holds degrees in Social Sciences from Waikato University and Public Administration from Harvard University. A Board member since 2007, he is a member of the Financial Risk and Audit Committee, and chairs the Hospital Advisory Committee.



Margaret Faulkner QSM, JP

Margaret comes from a nursing background and has lived in Porirua for many years. Her nursing and management career covers work in many health areas including elder care, community care as a district nurse and a practice nurse and in the care of War Veterans'. Margaret has served as Chair of the Whitireia Polytechnic and in other nursing and carer workforce areas and has had a lifetime commitment to her community, including involvement as a volunteer in many health, education and youth organisations. Margaret is an elected member of the Board since 2000. She is a member of the Hospital Advisory Committee, the Financial Risk and Audit Committee, and chairs the Disability Support Advisory Committee.

Keith Hindle

Keith Hindle is an appointed member of the CCDHB Board. He is Chair of the CCDHB statutory Finance, Risk and Audit committee. He is also an appointed member of the Hutt Valley DHB Board and Chair of their Finance, Risk and Audit Committee and is also a member of both the CC and HV DHB Hospital Advisory Committees.

Keith has extensive senior level financial and managerial experience within the New Zealand business community. He is a director and shareholder of a number of private companies. He brings a wealth of financial expertise to CCDHB and is interested in strengthening relationships across the regional DHBs.

Helene Ritchie

Helene is an elected member of the Board, and a member of the Community and Public Health Advisory Committee, as well as the Disability Support Advisory Committee. She has extensive experience in democratic governance, and leadership in the public sector. Helene was the first female deputy mayor in Wellington, and maintains a comprehensive understanding of government process built from 35 years in public office, and professional experience as a registered psychologist and mediator. As an elected member, her focus is on mental health, child, elderly, and public health issues. She is also a Wellington City Councillor, holding the Natural Environment portfolio.

Darrin Sykes JP

Darrin is Chief Executive for the Crown Forest Rental Trust (CFRT). CFRT was set up under the Crown Forest Assets Act 1990 after the New Zealand Māori Council and Federation of Māori Authorities took court action to protect Māori interests in the Crown's commercial interests. Darrin was Director of the Waitangi Tribunal from 2004 to 2010. He was appointed by the Government in 2010 to the Capital & Coast Board and his Board roles include Deputy Chair of the Finance, Risk and Audit Committee; Member of Joint Capital & Coast/Hutt Valley DHB Community & Public Health Committee 2010-2011; and from February 2012 on the Hospital Advisory Committee. He was appointed to the Sport Wellington Board in April 2011 and has been a long term Director of the National Sports Organisation for touch rugby since 1991, serving as Chair (1994-1996, and 2003-2005) and Deputy Chair (2007-2012). Darrin's tribal affiliations are Ngāti Rangitihi and Ngatiawa.

Attendance at Board and Committee meetings

CAPITAL AND COAST DHB ATTENDANCE AT BOARD AND COMMITTEE MEETINGS:

JULY 2011 – JUNE 2012

Board member	Board 10 meetings	CPHAC 10 meetings	DSAC 4 meetings	HAC 10 meetings	FRAC 10 meetings
Dr Virginia Hope	10	7	3	9	9
Peter Glensor	9	9	4	10	x
Keith Hindle	9	x	x	10	10
Margaret Faulkner	10	x	4	10	10
Helene Ritchie	10	9	4	x	x
Darrin Sykes	9	3*	x	4*	8
Barbara Donaldson	9	x	x	10	x
Judith Aitken	9	9	4	x	x
David Choat	8	9	x	x	x
Peter Douglas	10	x	x	9	9

Note: Attendance at committee meetings is shown only for members of the committees. Additionally, some Board members attend some meetings of committees of which they are not members

Donald Urquhart-Hay was elected in 2010 and attended meetings throughout the 2010-2011 year. Sadly, he passed away early in the 2011-12 year in August 2011.

x = not a committee member

* = not a member of the Committee for the full year

CCDHB Committees

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

Hospital Advisory Committee (HAC)

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

Community and Public Health Advisory Committee (CPHAC)

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

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

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).

Where the money went

2011/2012 SPENDING ($M)

(Figures shown are for funder arm only)

198.71
Hospital - Medicine, Cancer & Community

75.38
Hospital - Mental Health Services

240.59
Hospital - Surgery Women's & Children

0.94
Hospital - Clinical and Corporate Support

12.73
Other Hospital Services

52.33
Primary Health Organisations & GP Services

15.78
Community Laboratories

(Paid to Hutt DHB)

27.33
Mental Health Services

(Including inter-district)

17.06
Care Co-ordination and Home Based Services for the Elderly

64.28
Community Pharmaceuticals

45.70
Inter-District Outflows

55.63
Aged Residential Care

2011/2012 REVENUE ($M)

667.12
Ministry of Health

178.62
Other DHBs

0.58
Other Revenue

846.32
TOTAL

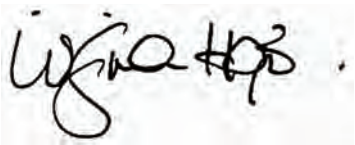
13.63
Other Elderley and Disability Support Services

36.15
Other Services

Statement of Responsibility

For the year ended 30 June 2012:

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 2012, fairly reflect the financial position and operations of Capital & Coast District Health Board.



Virginia Hope
Chair
29 October 2012

Peter Glensor
Deputy Chair
29 October 2012

Mary Bonner
Chief Executive Officer
29 October 2012

Theo Koenders
Chief Financial Officer
29 October 2012

Collaboration - Highlights

While Capital & Coast has always shared a close working relationship with its neighbouring DHBs (particularly Hutt Valley and Wairarapa DHBs), the past few years has seen a number of new clinical workstreams created as we seek to provide a better health experience for our community.

Collaborative efforts are the product of our commitment to work together across the health spectrum to improve our patient and population outcomes while improving quality and safety of care, and ensuring we are operating in a cost and clinically effective way.

This initiative is about joining up and leveraging the infrastructure across the system to improve the outcomes for our population, ensuring the sustainability of our services and providers while providing easy access for our patients and population. As a health system we are moving our focus from a reactive to a proactive system, which results in less acute illness and better quality of life for our communities.

This approach is a win-win for patients, DHBs, and Primary Care as we provide better, sooner, more convenient health care. Initiatives that have been developed include:

EAR, NOSE AND THROAT: Capital & Coast, Hutt Valley and Wairarapa DHBs have been working closely together to develop a sub-regional Ear, Nose and Throat (ENT) service. Work on shared clinical pathways is nearing completion with further work required to ensure consistent prioritisation. With the anticipated permanent return of two ENT surgeons in February 2013, the DHBs have been identifying where they would be best placed to provide services to the sub-region.

DENTAL: CCDHB and HVDHB developed a documented agreement for on-call maxillofacial cover.

The service has converted two junior doctor positions to senior FTE to increase quality and efficiency of services, participated in the CCDHB reduction in non-attendances to outpatient clinics project, and completed the feasibility study for digital imagery, which will be part of a national project.

Genetics

GENETIC HEALTH SERVICE NEW ZEALAND

Under the guidance of the National Health Board, Clinical Genetics commenced the transitioning to a national service on July 1, 2011. 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 CCDHB that they would support a two DHB provider hosted national service.

The new national clinical genetics service, Genetic Health Service NZ, was officially launched on May 2, 2012, following approval by the Minister of Health, with the expectation of increased activity and enhancements in quality, safety and service access for people nationwide.

Auckland and Capital & Coast DHBs are partnering in the provision of this service, delivered from three main hubs (Auckland, Wellington and Christchurch) known as Northern, Central and South Island. There will also be an extensive outreach clinic programme provided to all DHBs.

National Genetic Health Service team

Pain Management Services (APMS / CPMS)

The Pain Management Service incorporates both Acute and Chronic Pain Management teams. The past year has seen both arms of the service working on greater collaboration within and across both the organisation and the wider region. The CPMS has met a number of times with providers in the Hutt Valley with a view to delivering a more cohesive service across the region. Support for clinics and clinicians in Hawke's Bay has continued with the Clinical Lead attending clinics in Hawke's Bay for two days every month. With his ongoing support and guidance the local service has developed to the point where his input can be reduced to one day every other month.

Shared Care Paediatric Oncology

The past year has seen Wellington paediatric oncology service develop into a well functioning shared care centre. Clinical leadership and commitment in medicine, nursing and allied health as well as the support and brokerage of the newly formed National Child Cancer Network (NCCN) has strengthened this service.

The NCCN has been charged with developing national shared care guidelines and as part of the process met with DHB clinical and operational staff nationally. These face to face meetings in Wellington did much to support consensus on issues that have previously been contentious (diagnostic testing and surgery).

This process has also impacted on the confidence the Wellington Shared Care Centre and Christchurch as the Specialist Centre have in one another and, this together with the development in both medical and nursing capacity, will lead to a further one day reduction later this year in the visits by paediatric oncologists from Christchurch.

Laboratory Services

A focus for the laboratory this year was sub-regional collaboration and several projects were completed or are in progress in conjunction with Hutt Valley DHB.

HVDHB and CCDHB replaced their Point of Care Glucose Meters this year. This was this done through a joint procurement and implementation process. It is also operated through a joint IT process with a server hosted at CCDHB that connects the devices at both DHBs.

A joint procurement process is underway between the laboratories of HVDHB and CCDHB for a Laboratory Information System (LIS) with a single collaborative implementation planned for 2012/13.

There have been significant and exciting changes in diagnostic genetic testing during the past year. High resolution chromosome microarray technology is now considered a first-tier genetic test, replacing standard chromosome analysis in the assessment of patients with unexplained developmental disabilities or congenital anomalies.

Our accredited microarray service has expanded to provide testing for the Bay of Plenty, Waikato and Southern regions of New Zealand and we have successfully transitioned the majority of our neonatal and paediatric referrals on to this platform.

Keeping Well – Skin Infection Protocols

The Keeping Well, Healthy Skin in Greater Wellington (HSGW) project was established in 2011 to address the high rates of avoidable hospital admissions from serious skin infections amongst children in the Greater Wellington region.

The project is a collaborative effort combining Regional Public Health, Hutt Valley, Capital & Coast and Wairarapa DHBs, Compass Primary Health Care Network, and Valley Primary Health Organisation. The project produced a document of protocols on skin infections entitled, Protocols for the Management of Skin Infections in Children and Young People, in Community and Primary Health Care Settings, Wellington Sub-Region, which was released in May 2012.

It is expected that these protocols will form the basis for the management of skin infections for children and young people, in the community and Primary Health Care settings in the Wellington sub-region. The protocols include prevention measures and the management of some skin conditions that can lead to skin infections and bacterial skin infections, both with and without the use of antibiotics or other prescription medication. For the purposes of these protocols the most common bacterial skin infections covered are impetigo boils, cellulitis, human and animal bites. Other

minor skin conditions included which are problematic in the community and are known to lead to serious bacterial skin infection are insect bites, scabies, and headlice.

The aim of these protocols is to promote evidence-based practice for the prevention, assessment, management and treatment of skin infections in children from one year to 25 years of age and therefore to reduce the burden of skin infections in our communities and progression to serious skin infections requiring hospitalisation.

Integrated Care Collaborative

In the middle of 2011, CCDHB met with key Primary Care partners to talk about how we all could work strategically to provide seamless care across the health continuum.

Key drivers of this meeting were:

- Clinical and financial sustainability of the CCDHB health system.
- Improvement in outcomes for our patients and population.
- Improvement in the quality and safety of care for our patients.

It was agreed that significant improvements could be made through better integration of services between the hospital and primary care. At this and subsequent meetings agreement was reached about how all providers should work together, promoting openness, collaboration and honesty to build trust, reduce bureaucracy and increase innovation.

The group identified key areas for improvement, and over the next six months worked on developing relationships and the key issues for improvement. This work culminated in over 100 opportunities for improvement. The process had input from 170 clinical and management staff across the continuum. These ideas were refined to four workstreams, and clinical champions from the hospital and Primary Care were identified for each. We have since added two more workstreams in a federated approach, which ensures a collective view of priorities and opportunities.

The workstreams are:

- Health of Older Persons
- Living Well with Long Term Conditions
- Child Health
- Te Kahui (Mental Health Commissioning Group)
- Acute Demand and After Hours

There is also a workstream which is tasked with identifying and implementing system-wide improvements to infrastructure, workforce, information and communication.

By the end of the 2011/12 financial year the programme had agreed a leadership group, with terms of reference, a programme plan and programme framework.

We had also made significant progress in completing a business case for implementing the Shared Care Record in CCDHB, which will let GPs safely share primary care patient information in emergencies and when patients visit the hospital.

We had also identified an opportunity within CCDHB to work in a new way for patients with diabetes, focussing on:

- Measuring outcomes rather than outputs for patients with diabetes.
- Giving primary care more flexibility to target resources to those who need it.
- Refocussing our specialist resources on supporting primary care to deliver services.
- Using information we gather to better target our resources.

The Enablers workstream had also identified an opportunity to look at providing advice to GPs as well as and instead of outpatient appointments. This has the

potential to significantly reduce the time from referral to treatment, and will lead to better patient outcomes.

At the end of the financial year the Acute Demand and After Hours workstream had identified some ideas for improving the CCDHB systems response when our patients are acutely unwell. This work led to the implementation of free primary care for under-sixes on July 1 2012 at all practices and at all times.

Renal

Continued active involvement in Central Region Renal Network (CRRN) with CCDHB holding Clinical Lead role. CCDHB Renal service staff participation in CRRN working groups to increase the number of live donor transplants and to increase the number of patients on home based dialysis treatments. Other achievements included:

- Lower North Island regional collaboration with Peritoneal Dialysis tender process, with successful outcome of Baxter joint agreement with Hawke's Bay DHB.
- Regional agreement for development of satellite dialysis services, with planning underway for new 24 station satellite unit located on Kenepuru campus.

Radiology

Sub-regional, regional and national collaboration has continued to be a key focus for radiology management in 2011/12. The development of regional Key Performance Indicators will ensure more useful comparisons can be made across DHB's. Collaboration within the region has been excellent with support from HVDHB for MR Imaging as well as providing support when our MR scanner was not operational. Links have also been made with Palmerston North who has supported CCDHB with the review of Nuclear Medicine imaging during periods of annual leave.

ICU

With support from CCDHB ICU, Wairarapa DHB adopted the Early Warning System that was successfully rolled out across CCDHB in June 2011. With both DHB's using the same system it is expected that communication between the teams about the deteriorating patient will occur earlier leading to improved outcomes for this at risk patient group.

Gastroenterology

Achievement of contracted volumes for endoscopy along with sharing of endoscopic retrograde cholangiopancreatography (ERCP), and General Anaesthetic endoscopy lists with Hutt Valley DHB, thereby maximising the use of resources and reducing the wait time for patients.

Active participation in 3DHB sub-regional planning and short, medium and long term target setting, with a continued focus on maximising the use of resources to provide options to the patient.

Integration of a Wellington branch of the previously Christchurch and Auckland based New Zealand Familial Gastrointestinal Cancer Registry, giving Wellington District a closer to home option for patients with a family history of Gastrointestinal Cancer.

ICT

Information and Communication Technology (ICT) continues to make a significant contribution to regionally based projects. Contribution includes resources, demonstrated leadership and collaboration. A number of ICT staff are actively engaged on specific Advisory Groups and/or provide consultancy services. This demonstrated positive engagement also ensures that the projects are kept on track within the signed off resourcing.

Health Passport Programme

This year the Health & Disability Commissioner's Health Passport programme was trialled by CCDHB and HVDHB hospitals and communities in their respective regions. The passports are designed to assist healthcare professionals by allowing patients to provide their own personal information with regard to their conditions and needs.

Health passports are the first joint endeavour to address the safety and quality of care for patients who experience disability. Over 10,000 have been taken up within the CCDHB and HVDHB regions since the trial began on 1 April, 2011.

They are particularly useful for patients who require regular contact with doctors, and those with a range of needs relating to older age, disabilities, English as a second language, or other difficulties in communicating verbally.

The project is expected to launch into primary care during the third quarter of 2012/2013.

A joint appointment with Wellington City Council and CCDHB will see Rosie Macleod and Margot Beale produce a community directory, that includes health and support services, for the region.

Community Directory Accessibility

Wellington City Council and CCDHB have begun working closely together on a project that aims to produce one single accessible community directory for the region. The two-year project has been undertaken in order to fulfil the need identified by GPs, families, and specialists to improve the accessibility of community activities and services.

The Council's community directory is consistently popular, attracting about 17,000 visits a month, but information on a range of health, recreational and support services has been highly fragmented, making it difficult for people with high support needs to access these services. Young people leaving paediatric care are also particularly disadvantaged when it comes to seeking support from adult services.

The expanded directory will have a wider regional focus and include information links to health, disability and support services as well as recreational and leisure groups.

The aim is to have a comprehensive, usable and accessible directory of community activities and services – from arts, sports and hobbies to health and housing to disability support and childcare – acting as a valuable 'one stop shop' to anyone looking for such information.

Occupational Health and Safety (OH&S)

A major focus of activity for OH&S has been the establishment of a co-operative model for Occupational Health & Safety services for the Hutt Valley and Capital & Coast DHBs. This saw a joint Manager of Occupational Health & Safety appointed and an alignment of policies and processes across both DHBs and participation in sub-regional, regional and national health and safety projects. OH&S has been working with staff across both DHBs which has provided opportunities to observe different approaches to health and safety in action. This included aligning key health and safety policies associated with staff pre-employment screening, workplace rehabilitation, the prevention and management of risk to staff from infectious disease, hazardous substances, manual handling, violence and working in isolation.

We have achieved agreement across the two DHBs on the alignment of workplace incident reporting data. This will provide an opportunity for benchmarking and the comparison of data to benefit injury prevention and early intervention programmes in future.

OH&S has continued to monitor all aspects of CCDHB health and safety management systems throughout the year to ensure they operate effectively. This has once again resulted in us retaining tertiary level accreditation on the ACC Partnership Programme.

The OH&S service led a very successful staff flu prevention programme which resulted in the percentage of staff immunised this year increasing to 58%. Building on previous campaigns this was achieved with the help of an effective publicity campaign, increasing the length of time the vaccination was offered for and increasing the number of staff available to administer the vaccine to their colleagues in specific work areas.

In acknowledgement of the key role workplace OH&S representatives occupy in hazard management and injury prevention programmes, we have increased the amount of formal and informal health and safety training offered throughout the year. Monthly communications sent by email and in-person health and safety forums are organised and led by OH&S to provide opportunities for staff representatives to share ideas between services, communicate emerging risks and attend training. The same format and content for meetings, training and monthly communications is now used across both DHBs, which makes sharing resources to produce effective programmes much easier.

Human Resources Group

A major focus of activity in 2011/12 has been implementation of the report on developing a co-operative model for human resources for Hutt Valley and Capital & Coast DHBs, including:

- Recruitment is underway of GMHR to work jointly for both DHBs.

CEO Mary Bonner, WHHF Chair Bill Day and Brian Robinson from the Centre for Simulation & Skills Education with their new mannequin which will be used for staff training.

- Ensuring consistency of employment related advice provision, including MECA interpretations, across the two DHBs by way of weekly phone conferences.
- Looking at opportunities to pilot joint recruitment exercises and at the logistics of sharing information on vacancies (e.g. hard to fill roles). CCDHB and Hutt Valley DHB have worked collaboratively on two recruitment initiatives this year.
- Having investigated similar recruitment systems in use by other DHB's, the Phoenix Recruitment Candidate Management System was procured and implemented. In addition, a joint Request for Proposal process was initiated and presented to market through the Government Electronic Tendering System (GETS), and the two DHB's have developed a consistent approach to joint appointments.

Centralised recruitment processes have been continually developed throughout the year, with previous work in this area consolidated to enhance the recruitment services received by the organisation.

Development of strong collaborative relationships with Unions has continued to be a feature and focus of the year, at a local level and through participation in a range of national collaborative forums facilitated by District Health Board Shared Services (DHBSS).

RMO Unit

A new RMO manager has been appointed and this has lead to improved processes being developed for the recruitment and ongoing supervision of RMOs. Close ties have been built with the RMO units in Hutt Valley and Wairarapa. Regular Local Engagement Group meetings have been established with local RDA representatives and this has greatly enhanced good relationships with the RMO workforce, as evidenced by continued excellent recruitment.

Other highlights include:

- The Service Level agreements with Hutt Valley and Wairarapa DHB for RMO unit services were signed in early 2012. This ensures continuity of service and support for our RMOs across the sub-region.
- Policy and process development continues to progress well, aligning across the sub-region where possible. As a result recruitment for 2013 has been highly successful.
- Training and funding contracts have been agreed with Health Workforce NZ for the next year. This required extensive co-ordination across the region.
- A balanced scorecard approach has been adopted to improve monitoring and tracking of key projects supporting RMOs. This new tool has increased visibility and support where required, for example, 80% of surgical runs with a single named supervisor.

Skills and Simulation Centre

New technology has been funded by the Wellington Hospitals & Health Foundation (WHHF). This has all been installed and integrated into the suite of simulation tools provided by the centre. Other highlights include:

- A Users Group forum is in the process of being re-established to continue with the development of a regional clinical skills and simulation network and aligning with key work streams from the Central Region Training Hub.
- Accreditation by the Australian and New Zealand College of Anaesthetists has been received to continue to deliver the Effective Management of Anaesthetic Crises course for the next 7 years.

Central Region Training Hub (CRTH)

The hub became operational on January 1, 2012 with the objective to provided integration and co-ordination of pre-vocational medical training.

Positive progress is being made with the work streams specifically around RMO standardisation of training, with RMO and intern surveys being drafted.

A learning management system stock take across DHBs continues across the region. A proposal for CCDHB to take a lead role was approved in the development of a regional wide platform with Health Workforce NZ recognising an opportunity to work with MoH and Health Benefits Limited to align nationality. Further actions are ongoing.

Community - Highlights

Free after-hours care for children aged under six years

On July 1 2012, CCDHB implemented a new initiative from the Ministry of Health introducing free after-hours primary health care for children under the age of six years.

With services provided in Kapiti, Porirua and Wellington, the DHB easily met the Ministry of Health's requirement for free after-hours services to be available for most children under six years within 60 minutes travel time. CCDHB was the only DHB to achieve 100% right from the start.

As a result of this initiative, those general practices and medical centres that were charging children under six during the daytime, moved on to the Government's Zero Fees for Under-6s Funding Scheme. This scheme, which is available to Primary Health Organisation (PHO) providers, was designed to support more practices to provide free primary health care to children under six. All 62 general practices within the Capital & Coast District now provide free care to all eligible children under six.

The successful implementation of this service was due to a number of factors, most importantly the integral involvement of key stakeholders (PHOs and After-Hours Accident and Medical providers), in the planning and decision-making process. All those involved worked together in partnership and adhered to the agreed principles to deliver this service across the District.

A communications plan was jointly developed and key messages focussed on continuity of care with primary care providers, after-hours services providing urgent care, and the use of Healthline.

Creekfest Porirua

Creekfest 2012 was a huge success with 40,000 plus people attending and 96 providers and organisations having information stalls at the event in Cannons Creek. Regional Public Health (RPH) was well represented at Creekfest and was popular with the local communities.

Emergency Preparedness was this year's main topic. There were water container giveaways for each visitor to the Regional Public Health tent, an example of a "bucket toilet", and a competition for a ready to go survival kit containing all the contents you would need in a civil defence emergency.

Creekfest 2012

Lives Free from harm due to alcohol and other drugs

From January 1, 2012 to June 21, 2012, RPH objected to, or supported off license objections, on six occasions. Four were in CCDHB's area, including the Newtown Bottle Store and Fantame Liquor store in Cannon's Creek. The DHB provided supporting submissions objecting to these licensing applications.

A significant decision in the Capital & Coast DHB region was the Liquor Licensing Authority hearing ruling on the Fantame/Thirsty Liquor case.

The Judge ruled that a bottle store in a residential area should 'aim to serve the area in which it is situated and not the wider public'. The presentation of public health information combining Wellington Hospital Emergency Department data with local demographics and regulatory data was significant in informing the decision. The ruling is a real victory for the community with hours of operation having been dramatically restricted.

The decision in the case of the Newtown Bottle Store being refused a license and the backers of a proposed liquor store in Mungavin Avenue listening to the community and halting developments, were both further examples of positive collective action.

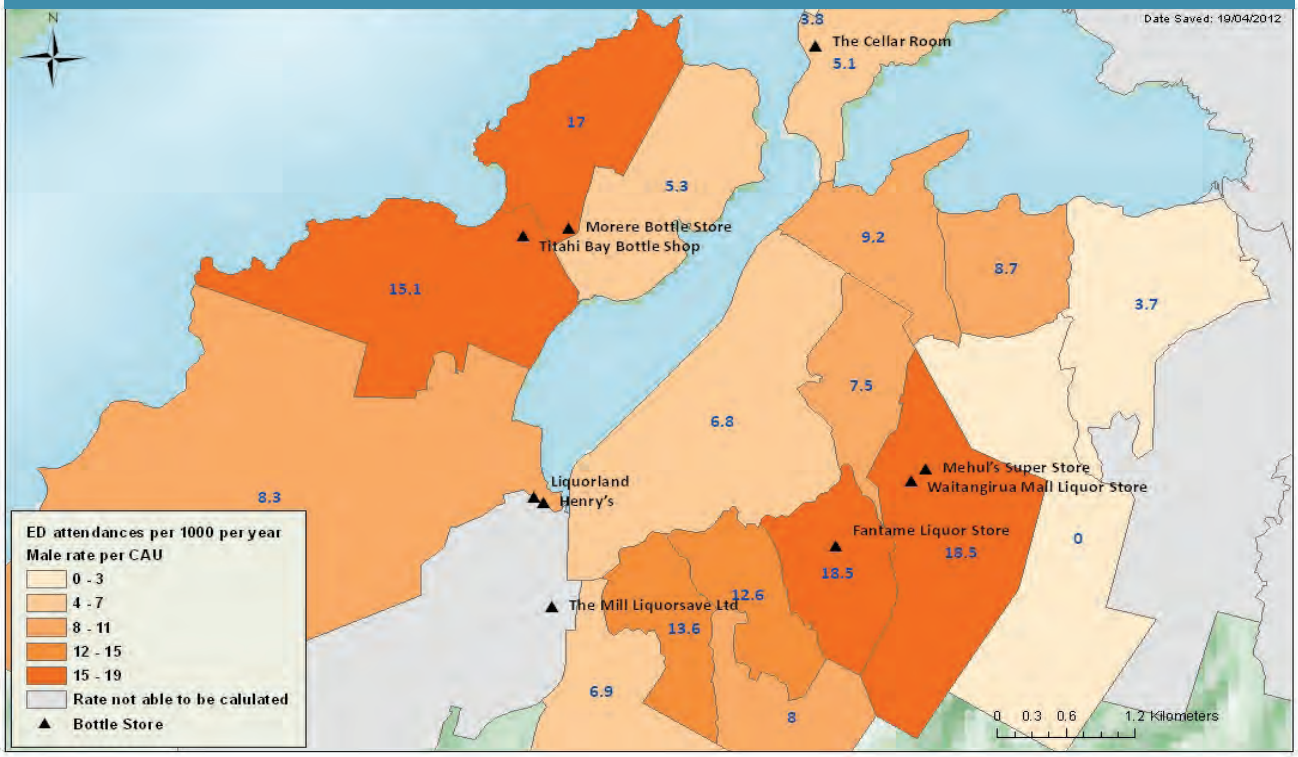
Rheumatic Fever - Porirua Kids Project

Regional Public Health and Compass PHO are jointly running the rheumatic fever sore throat swabbing programme in nine Porirua schools.

Rheumatic fever is the leading cause of childhood heart disease in New Zealand, contributing to poor child health outcomes. Māori and Pacific children are disproportionately represented in terms of disease incidence and rheumatic fever outcomes in New Zealand.

Rheumatic fever mostly affects children and adolescents and is a consequence of a throat infection caused by streptococcus bacteria. It can result in chronic heart disease with reduced life expectancy. In New Zealand it is linked to poorer housing conditions, overcrowding, and lack of recognition and treatment of streptococcus throat infections.

WELLINGTON HOSPITAL EMERGENCY DEPARTMENT PRESENTATION RELATING TO ALCOHOL FOR MALES AGED15-34 YEARS, RESIDING IN PORIRUA CITY.



From April 1 2012, the school-based throat swabbing service was successfully implemented within nine schools in Porirua East by a collaboration of school health nurses and primary care kaiāwhina working together. Over 1,200 swabs have been taken at schools since then. Whānau family members who live with children that require treatment are also eligible for throat swabbing and antibiotic treatment, and families are followed up by kaiāwhina to ensure that the children finish their course of antibiotics.

In the first three months of the programme 643 children were swabbed with 54 requiring treatment. This initiative is a positive example of multidisciplinary primary care providers working together to help improve the health of children in our district.

THE SCHOOL-BASED THROAT SWABBING SERVICE:

- Provides throat swabbing services in the school and/or home for school children aged 5-14 years that present with sore throats in high-risk areas, and for eligible whānau family members living with these children;
- Promotes awareness of rheumatic fever risk among children and their whānau and families in high risk areas;
- Develops and maintains relationships with other health and social service providers (including whānau ora providers) to facilitate referral and support as appropriate.

THE GOALS OF THE RHEUMATIC FEVER PREVENTION PROGRAMME ARE:

- To achieve equity of incidence and outcomes of rheumatic fever between Māori and Pacific children, and other New Zealand children;
- To contribute to the reduction of the rate of rheumatic fever among Māori and Pacific peoples;
- To contribute to the reduction of rheumatic fever recurrence in New Zealand.

Chris Campbell, who works for the Regional Public Health School Health and Immunisation Group, received an award for her outstanding contribution as a Public Health Nurse Leader in bringing the school-based throat swabbing and treatment programme to Porirua children.

Regional Public Health Nurse Annie Highet swabs a Cannons Creek School pupil as she explains the throat swabbing service to Prime Minister John Key and Education Minister Hekia Parata.

Chris says that she is 'chuffed to receive the award' and sees it as being as much for her colleagues and the staff at the four schools in the pilot. "I'm delighted to hear more kids say their mum or dad took them to the doctor for a sore throat – the message about early detection is really getting through."

Tobacco – Te Wananga o Raukawa

Te Wanaga o Raukawa has established a Tupeka Kore (tobacco-free) kaupapa for its new hauora facility (includes gym, stadium). The first tertiary institution to do so. Te Wanaga o Raukawa is determined to phase this in over the whole campus.

Te Roopu Āramuka Whāroaroa
(Opening the pathway for others to follow)

Homelessness Initiative

Te Roopu Āramuka Wharoaroa (Āramuka) was implemented in November 2010 to improve the health and wellbeing of people with complex needs who are homeless. Āramuka consists of a partnership approach which supports an integrated, collaborative service for a small group of priority people who are homeless and furthest from having their needs met across secondary and primary care. The partnership organisations are:

- Downtown Community Ministry (DCM), a social service organisation;
- Te Aro Health Centre, a primary health service;
- CCDHB, particularly including:
  - CCDHB Addiction service
  - Team for Assertive Community Treatment mental health assertive follow up team
  - Aramuka staff.

Each priority person is supported to identify their needs and enable them to have these needs met using:

- a navigator role to support access to services
- using strengths based practice, and
- a holistic framework based on Te Whare Tapa Wha (Durie, 1998).

This initiative is a testament to the power of collaboration, communication and initiative using the skills and resources of all the key stakeholders.

SERVICE SUCCESSES

SYSTEM IMPROVEMENT

Collaboration brings the agencies together to use what works best to support each other in the holistic delivery of services. This has achieved:

- better co-ordination of care and services
- improved follow up
- improved admission and discharge planning
- reduced Emergency Department admissions
- reduced duplication and fragmentation; and
- targeted, more appropriate and cost effective service provision.

Two further agencies have requested a partnership MOU arrangement, while another wants to work much more closely together.

PEOPLE

Āramuka is seeing those people sleeping on the street and often not associated with other services such as the night shelter, soup kitchen or DCM. These people have multiple needs around primary and secondary health, social services, housing and employment. This includes primary health, deaf with mental health needs, mental health, personality disorder, dementia and alcohol and other drug addictions.

In the past year nine people have been contacted, of which seven were discharged successfully into more appropriate services, including mental health and addiction services.

SPECIAL CIRCUMSTANCE COURT

Early this year a Special Circumstance Court was established in Wellington. This has been developed by the commitment of Judge Susan Thomas in response to a hui lead by Āramuka, CCDHB and psychiatric court liaison.

The Court's aim is to support the co-ordinated service delivery of multiple Government and non-Government agencies by creating rehabilitation plans for offenders appearing before it.

Low-level offenders are better able to address their own behaviour and lifestyle via rehabilitation plans, which address their health needs, identify the resources required, and establish the best practice for dealing with these offenders.

CCDHB EMERGENCY DEPARTMENT

An evaluation of this pilot service will be finalised in November 2012. Initial findings have seen a decrease in Emergency Department presentations in the past 12 months by this group.

Prior to being accepted by Āramuka, 12 of the priority people were generating more than 30 visits in a year. This has been reduced to around 19 visits since engagement with Āramuka per year.

Whānau Ora

In 2010, 25 provider collectives were announced in the first wave of the Whānau Ora roll out. These collectives, involving more than 150 health and social service providers, have begun work to develop and deliver Whānau Ora.

CCDHB have two provider collectives within the district; Te Runanga O Toa Rangatira and Taeaomanino & Pacific Health Wellington Collective. These collectives are currently finalising their 'Programmes of Action' business cases for implementation.

In conjunction with Compass Primary Health Care Network, the Māori Health Development Group have scoped the inclusion of Whānau Ora within the ICC framework. This move will be included in the Enablers workstream.

Capability development

HEALTH LITERACY

The Māori Health Development Group have been working with Workbase, a leading workforce literacy agency based in Auckland, to see how the DHB can improve its responsiveness to patients and the community through an improved health literacy framework.

The Māori Health Development Group hosted American health literacy expert, Dr Rima Rudd, in April, brought to New Zealand by Workbase, and funded by MoH. Dr Rudd presented to a wide range of clinical staff and management from across the sub-region on the importance of health literacy in improving population health outcomes.

MĀORI AND PACIFIC WORKFORCE DEVELOPMENT PROJECT

CCDHB has begun a comprehensive Māori and Pacific Workforce Development Project (Tu Pounamu) with the aspirational target of having a workforce which proportionately reflects the community it serves.

The focus of the group is to increase the composition of Māori and Pacific Health workforce.

WORKCHOICE: Through collaboration between the Māori Health Development Group, Kia Ora Hauora and Human Resources, CCDHB hosted 100 Year 12 students and their teachers, from seven schools across the Wellington Region for WorkChoice Day.

Students from the Wellington region enjoy Workchoice Day

The students were divided into 10 groups and met staff and experienced different aspects of working in the hospital. The day included 13 disciplines involving 30 staff and 11 tour guides.

From paramedics and CPR, to transit nursing and radiology, the students got to experience firsthand the truly multi-disciplinary nature of working in the hospital. Workshops provided practical information and hands on experience about the different professions, coupled with a Human Resource presentation on career planning.

Regional involvement

KIA ORA HAUORA - MĀORI HEALTH WORKFORCE PROGRAMME (KOH)

Kia Ora Hauora is a national Māori health workforce development programme aimed at building Māori workforce capacity and capability. CCDHB are leading and hosting the Central Region's Co-ordination Centre of this programme with the intention of enrolling and retaining 250 Māori on health-related career pathways. To date, the Central Region has a total 1095 total registered enrolments, of which 827 registrations are Māori.

Key regional initiatives undertaken in 2011/12 have been:

- Engagement with secondary schools;
- Career Educator breakfasts to support the development of stronger intersectoral relationships between health, secondary schools and tertiary institutions;
- Involvement with Career Expos;
- 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 Co-ordination 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.

"I found all nurses to be professional, efficient and very supportive and informative about my problem. I was surprised to see them visit my home the day after I returned from hospital Saturday morning. An extremely worthwhile service to the community. Thank you."

District Nurses - 80 year old female

Better Help for Smokers to Quit Health Target – Primary Care

Primary Care in the Capital and Coast district has undertaken a number of initiatives around the Better Help for Smokers to Quit Health Target, with a big push to identify smokers in December 2011.

Currently 82% of patients enrolled in a CCDHB PHO have a smoking status listed, an increase of 22% from 2010/11. This improved identification of smokers has enabled the PHOs to provide brief advice to quit and cessation support. By 30 June 2012, CCDHB PHOs reached 54% of identified smokers being provided brief advice to quit, a 24% increase in performance. Due to the work of primary care partners, CCDHB is second nationally for this measure.

Compass Primary HealthCare Network is working with practices to increase the number of patients to be given brief advice regarding their smoking. A centralised call centre was established to contact enrolled patients, identified as current smokers within the last 15 months, and offering brief advice over the phone. This group have also been sent a letter outlining the available resources to help them to quit.

A face to face smoking cessation service through Ora Toa PHO has been available for clients since September 2011. Two staff provide the service by visiting clients in their home, and providing follow up support by visits, telephone, email and text contacts. The service has delivered support to 260 clients in 2011/12.

There is an ABC Facilitator based at Ora Toa PHO. ABC prompts health professionals to Ask about smoking status, to give brief advice to all smokers to stop smoking and to provide evidence-based Cessation support for those who wish to stop smoking. In 2011/12, 706 health professionals were trained in ABC of which 461 are Quitcard providers, enabling them to provide patients with a voucher for Nicotine Replacement Therapy (NRT). Regular training sessions have been held with all PHOs to improve the provision of brief advice and quality of data capture.

Work will continue in this area in 2012/13 to provide brief advice to quit and cessation support to more smokers in the Capital & Coast district.

Cardiovascular Disease Health Target- PHOs' community initiatives

A new Cardiovascular Risk Assessment measure has been implemented from January 1, 2012 by the Ministry of Health for the More Heart and Diabetes Checks Health Target. Between January 1, 2012 and June 30, 2012, CCDHB performance improved 4.6% for Māori, 4.2% for Pacific, and 4.9% for the total eligible population. CCDHB end of year performance was 58.4% for Māori, 60.4% for Pacific and 53% for the total eligible population. CCDHB is proud to have achieved the 60% target for Pacific and to have higher rates for Māori and Pacific than the total, showing efforts to reduce disparities.

These positive results are a reflection of the efforts of primary care to support systematic risk assessments of targeted populations. Activities within PHOs have included the extension of nursing resource to carry out the assessments, promotion events focused on Māori and Pacific males, outreach services targeted to Māori and Pacific, and ensuring linkages with diabetes annual reviews.

A cardiovascular disease risk screening week at Cannons Creek hosted by Ora Toa PHO was very successful with 97 clients attending over four days. Many men who do not usually visit their GP were screened, and some clients were also followed up for overdue diabetic annual reviews. This screening also identified many smokers and prompted some of them to attempt to quit.

PHOs have been utilising Service to Improve Access

Kemp Home and Hospital residents with staff

funding to provide additional Cardiovascular Disease Risk Asessement clinics, including at high need clinics with high proportions of Māori and Pacific patients. Focus on this measure will be continued in 2012/13, with the target increasing to 75%.

Aged Residential Care Quality Project

Work has been underway since 2009 to improve the relationship of aged residential care providers and the quality of service they provide. In 2011/2012 the outcomes of these efforts have been seen.

The Health of Older Persons team in Planning and Funding has had a particular focus on quality improvement to strengthen relationships with the 33 providers and the Aged Residential Care facilities conforming to the National Health and Disability Service Standards.

CCDHB can be confident that this audit outcome is a true reflection of compliance against the Health & Disability Service Sector Standards. CCDHB has worked with physically checking and viewing the operational improvements in facilities as they have been developed and implemented. It is often through a collaborative approach and ongoing mentoring that this compliance is achieved.

- 84% of facilities have now achieved a 3-year Certification Period. It is anticipated that all facilities will move to three year periods during next audit cycle.
- Complaints to Planning & Funding related to Aged Residential Care have dropped from one to two a week in 2009/10 down to five for the 10/11 year to two in the 11/12 year.
- 35 nurses from a range of ARC facilities are currently participating in CCDHB Professional Development and Recognition Programme (PDRP), including the first at expert level. One large Aged Residential Care facility aims to have all its registered nurses on CCDHB's PDRP by the end of 2012 and is well on its way to achieving this ambitious goal.
- Whilst the Yellow Envelope project is in its infancy, when used appropriately it reduces the length of stay in the Emergency Department and facilitates a smooth transition of vital clinical information between secondary care and ARC admission/discharges. ED, Ambulance and ARC staff report high rates of satisfaction when used.
- The Clinical Governance groups that have been established and held quarterly are well attended.

"I have found these nurses practical, helpful, cheerful and respectful. Their visits have been an enormous help in adjusting to life with an ileostomy. Thank you."

Stoma Nurses - 68 year old female

Pacific Health Directorate

The purpose of the Directorate of Pacific Health is to contribute to CCDHB's aims to improve health outcomes for Pacific people in the short, medium and long term.

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

PACIFIC NAVIGATION SERVICE

Over recent months the DHB has reconfigured the Pacific Health Service contracts. Delivery of this wrap-around service is now the responsibility of Compass

Health and Well Health PHOs. The new service employs nine Navigators who come from a variety of backgrounds, such as Registered Nursing and community support work. Between them they cover a number of Pacific nationalities and speak several Pacific languages. Staff are based in Porirua and Wellington, and also provide a mobile service.

BREASTSCREENING FOR PACIFIC WOMEN

The Pacifica Women's Newtown Branch Vahine Orama Breastscreening event successfully screened over 40 Pacific women from the Wellington Region. The event also coincides with National Breastscreening Month. Vahine Orama works closely with Regional Screening Services and Catalyst Pacific/Samoa Capital Radio CCDHB Pacific Radio programme to promote breastscreening. The event has been held at Pacific Island Presbyterian Church in Newtown, Wellington.

SUB-REGIONAL PACIFIC STRATEGIC HEALTH GROUP

The Sub-Regional Pacific Strategic Health Group was launched in October 2011. Providing DHBs with sound advice on Pacific issues is critical to successfully meeting the needs of the Pacific community. Chairperson Fa'amatuainu Tino Pereira leads a skills based group which highlights the need for such groups to be providing solutions to the DHBs to support the delivery of services.

PACIFIC COMMUNICATIONS PROGRAMME

Engaging Pacific people in a way that promotes behaviour change is necessary to ensure Pacific people can make well-informed decisions about their food intake, as well as taking responsibility to attend health appointments and maintain general health overall.

In 2011/2012, the weekly Pacific Radio health programme broadcast on Wellington Access Radio 783FM has been instrumental in providing Pacific communities with better information about health in

THE PACIFIC NAVIGATORS Clockwise, from left to right: Pat Sila, Lani Wills, Iuliano Tinielu, Esther Pereira-Saena, Tuaine Faleafaga, Folele Fai, Kupa Kupa, Rachel O'Brien.

The PACIFICA Women's Newtown branch celebrate the Vahine Orama Breastscreening event at the Pacific Island Presbyterian Church in Newtown.

seven Pacific languages (Samoa, Tonga, Niue, Cook Islands, Tuvalu, Fiji, Tokelau).

The programme is in its second year, and has been the subject of a formal evaluation undertaken by Victoria University Health Sciences Research Centre. The evaluation reinforced the importance of the Pacific Radio programme, confirming that programme aims and objectives have been and continue to be achieved.

Examples of successful initiatives include:

- Raising Cancer awareness (ongoing building on Understanding Cancer campaign)
- Pro-active response to meningococcal alert
- Diabetes Awareness week 15-21 November
- Home Insulation campaign – to help reduce rheumatic fever, skin infections, respiratory diseases
- Working with Wellington Pacific Health - Promoting SunSmart, water safety and food hygiene aid
- The Vahine Orama Breastscreening Awareness programme.

Healthy Housing initiatives

CCDHB contributes funding to Healthy Homes Porirua and Warm Up Wellington – Subsidised Home Insulation programmes. The primary objective of these projects is to provide people on low incomes with the means of improving their homes by providing good quality home insulation and other energy saving measures resulting in improvement of their health and quality of life.

Better insulation means homes are warmer, cosier, and easier to heat. Warmer, drier homes bring health benefits, especially for those with respiratory illness or other conditions derived from living in cold and damp houses.

SUSTAINABILITY TRUST RETRO-FITS JULY 2011 – JUNE 2012	
Porirua	109
Wellington	158
Kapiti Coast	84
TOTAL	**351**

CCDHB funding boosts the EECA subsidy from 60% to 75% or 80% to low income families with identified health needs.

The programme saw 351 homes insulated through the 2011-2012 year.

Warm Up Capital & Coast - Fully Funded Home Insulation Programme

An opportunity was presented to CCDHB by Autex New Zealand and Powershed early 2012 to work in partnership with the local health sector to fully fund the insulation of homes of eligible patients.

Whereas other schemes require some financial input into the cost of insulating their home, this mechanism is focussed on targeting a free retro-fit to homes of those families where health professionals have identified insulation as being a critical catalyst to improved health and well-being within the household.

The generosity of Autex New Zealand in funding this programme provides CCDHB with a huge opportunity for Primary Care professionals to identify up to 400 households in 2012 for assessment and retrofitting.

Hospitals - Highlights

Elective Services

We have maintained and achieved Elective Services Patient-Flow Indictors (ESPI) compliance against the recently changed threshold. First Specialist Assessment (FSA) volumes are in line with targets and significant improvements have been made in reducing the numbers of patients waiting for a First Specialist Assessment.

- Within the first quarter of 2012, there will be no patients waiting greater than six months for their first specialist assessment.
- We have successfully maintained ESPI compliance for those waiting for treatment or intervention.
- We have continued to exceed our elective surgery discharges target, improving access to elective surgery for our patients.

In addition we have further reduced the number of patients assigned an Active Review status. We recognise that this category is often confusing for patients and our aim is to discontinue the use of this category in the near future.

"I could not fault the service provided for me and my family. We were all kept informed all the time and information was given freely and regularly."

ICU and Cardiology - 55 year old female

Surgical Services

CARDIOTHORACIC: 608 patients received cardiothoracic surgery this year, an additional 78 compared with last year. The Ministry of Health increased the threshold for maximum number waiting for surgery to 65 patients. This number was not exceeded in the year and there were no patients waiting greater than six months.

GENERAL SURGERY: The Central Region Metabolic and Bariatric service was established in September 2011 and has successfully provided 33 patients with Bariatric surgery.

The service appointed a general surgery locum in September, this additional resource has assisted the service in achieving its Health Target and reducing waiting times for those waiting for surgery.

ORTHOPAEDICS: The service was successful in securing Ministry of Health Elective Services Productivity and Workforce Programme funding for an 18 month Orthopaedic Redesign Project that commenced in June 2012. The project will:

- Redesign the orthopaedic service from the point of referral, from primary care, to discharge and return to primary care.
- It will pick up the recommendations arising from the Orthopaedic Hip and Knee Referrals Clinical Pathways Collaborative which was completed during 2011/12.

The service has considerably reduced the number of patients waiting longer than six months for assessment and treatment. This has been achieved by a combination of contracting cases to private providers and introducing processes to ensure the number of patients accepted for assessment and treatment does not exceed the service's capacity.

VASCULAR: The service has worked hard to achieve the Health Target and reduce waiting times for those waiting for surgery. As of June 30 2012, there were no patients waiting greater than six months for surgery.

UROLOGY: A number of urology procedures were contracted to private providers in 2011/12 to ensure no patients waited more than six months. Further contracting will be required to maintain current intervention rates and wait times until a fifth urologist is recruited.

AUDIOLOGY: Sargunam Sivaraj, Team Leader of Audiology completed his PHD in 2011/12. As an

integral component of ENT services, Audiology is also participating in the ENT sub-regional work.

NEUROSURGERY: During 2011/12 a fifth Neurosurgeon was appointed and another Neurosurgeon took extended leave to complete a cerebrovascular fellowship in Melbourne.

Transphenoidal neurosurgical procedures were successfully transitioned from provision via a private provider to being performed in-house.

WARD 6 NORTH (ORTHOPAEDIC AND UROLOGY: As part of International Nurses Day awards, Fiona Houghton, Charge Nurse Manager received acknowledgment for contributions to her team and the wider organisation.

At the beginning of March Speech-Language Therapists, from left, Lai-Kin Wong, Libby French and Naomi Seow ran a Dysphagia Screen Awareness Week on Ward 7 South. The purpose was to raise awareness in acute areas that all patients admitted with stroke should have their swallowing screened prior to eating and drinking.

The ward continues to focus on pressure area prevention, including improving access to specialised mattresses and development of patient information resulting in a reduction of acquired pressure areas.

Pre-operative hip and knee classes have been implemented and the average length of stay for non-complicated hip and knee joint replacements is better than benchmark.

The ward has developed a patient information discharge booklet and a flow chart for prescribing anticoagulants for discharge patients.

WARD 7 SOUTH (NEUROSURGERY, OPHTHALMOLOGY AND STROKE): In addition to the ongoing provision of a predominantly acute regional neurosurgery service, Ward 7 South has focussed on maximising ACC revenue, and identifying opportunities to decrease the average length of stay within specific groups of patients.

"Brilliant staff in ward 5 South from the health professionals, through to orderlies and counter staff. Efficient and competent under difficult circumstances. Always attentive and sympathetic. Always friendly with a ready smile and a joke. They gave 110%. A BIG thank you."

5 South - 80 year old male

24 Hour Operations Service

Following an earlier review an evaluation of the service was completed this year. Included in the recommendations adopted was the appointment of a Registered Nurse to support the activities of the nursing bureau. This role will enhance recruitment and retention of clinical staff.

The service has been heavily involved in activities associated with reducing the time patients wait in the Emergency Department. The service has participated in a number of improvement workshops, which have seen an overall improvement in our performance against this Health Target.

"A wonderful moment just prior to the anaesthetic was when a kind nurse's face appeared close to mine. She took my hand, smiled and said she was the best hand holder in the world. Much of my anxiety dissipated. It was the last thing I remembered. I trust this lovely gesture is routine. It is a moment of gentle humanity I will never forget."

Operating Theatre - 78 year old female

Anaesthesia

The service has continued to grow and now offers regional support in pain management and a wide range of subspecialty services. Our cardiothoracic anaesthesists received a commendation from visiting representatives of the Royal Australasian College of Surgeons (RACS) and our paediatric anaesthesia surgery was one of the factors that resulted in RACS granting CCDHB recognition for its ability to train paediatric surgeons.

Nursing staff working in our Post Anaesthesia Care Unit have helped to develop techniques of vascular access so that they now form a key component in an organisational vascular access service. This year has seen the registration of New Zealand's anaesthetic technicians as health professionals. This is 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 programmes 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.

The Department has introduced multidisciplinary training in obstetric emergencies to New Zealand and launched a teaching programme to assist in the management of airway emergencies. 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 programme to renew and invigorate our workforce.

Newly registered as health professionals - Anaesthesia Technician Sadun Kithulagoda, Clinical Educator Marcel Waayer, Team Leader James Hesketh, and Senior Technician Lisa Richardson.

INFECTION CONTROL: The ICU team are recognised for their commitment to patient safety. From left, Stephen James (ICU CNM), Cheryl Davidson (ACNM, ICU), Carolyn Fuge (Quality Manager, SWC), Dr Shawn Sturland (Director ICU) and James Robertson (Clinical Nurse Specialist).

Improving Services for our Patients

A key quality improvement initiative has been the introduction of the Central Line Associated Bacteraemia (CLAB) National Collaborative (funded by the Health Quality and Safety Commission) within our ICU. The key objective of this collaborative is to reduce the rate of CLAB in New Zealand ICUs towards zero (<1 per 1000 line days by March 31, 2013).

ICU is heavily involved in leading the CLAB project introduced in January 2012. The ICU Clinical Leader is the National Clinical Lead and the Charge Nurse Manager is the Central Region Project Manager. This national initiative employs international protocols for the insertion, maintenance and surveillance of these lines in order to reduce the incidence of infection. Treating a systemic blood borne infection is estimated to cost anywhere between $24,000 - $55,000 so any efforts to reduce this, particularly in vulnerable patient populations, like in ICU, is worthwhile. At 30 June there have been no central line infections in the ICU for over 420 days.

This is an important landmark and demonstrates CCDHB Intensive Care Unit's commitment to patient safety, shorter stays in ICU and reducing costs.

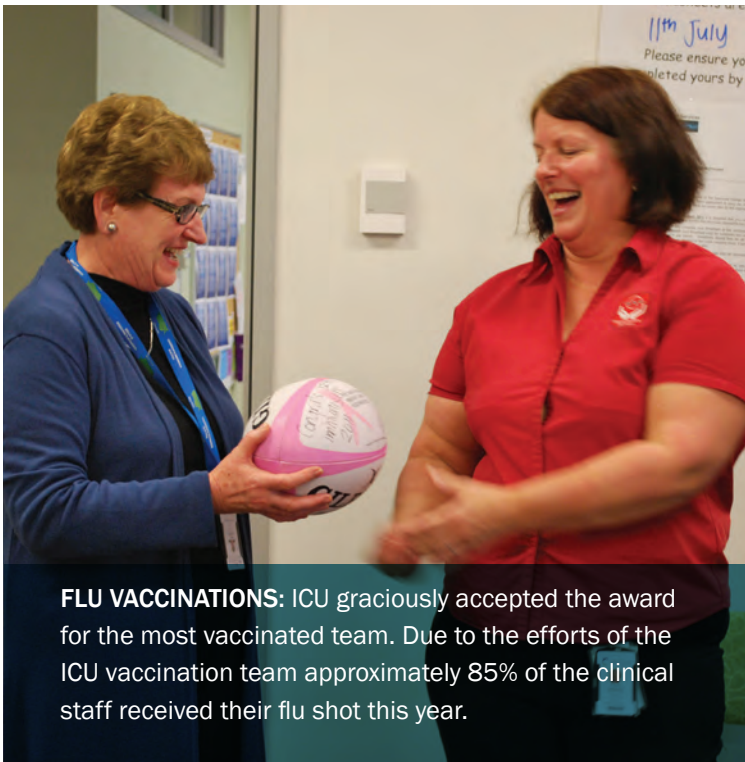
ICU

Intensive Care Services have had another busy year with increases in occupancy and elective surgery volumes.

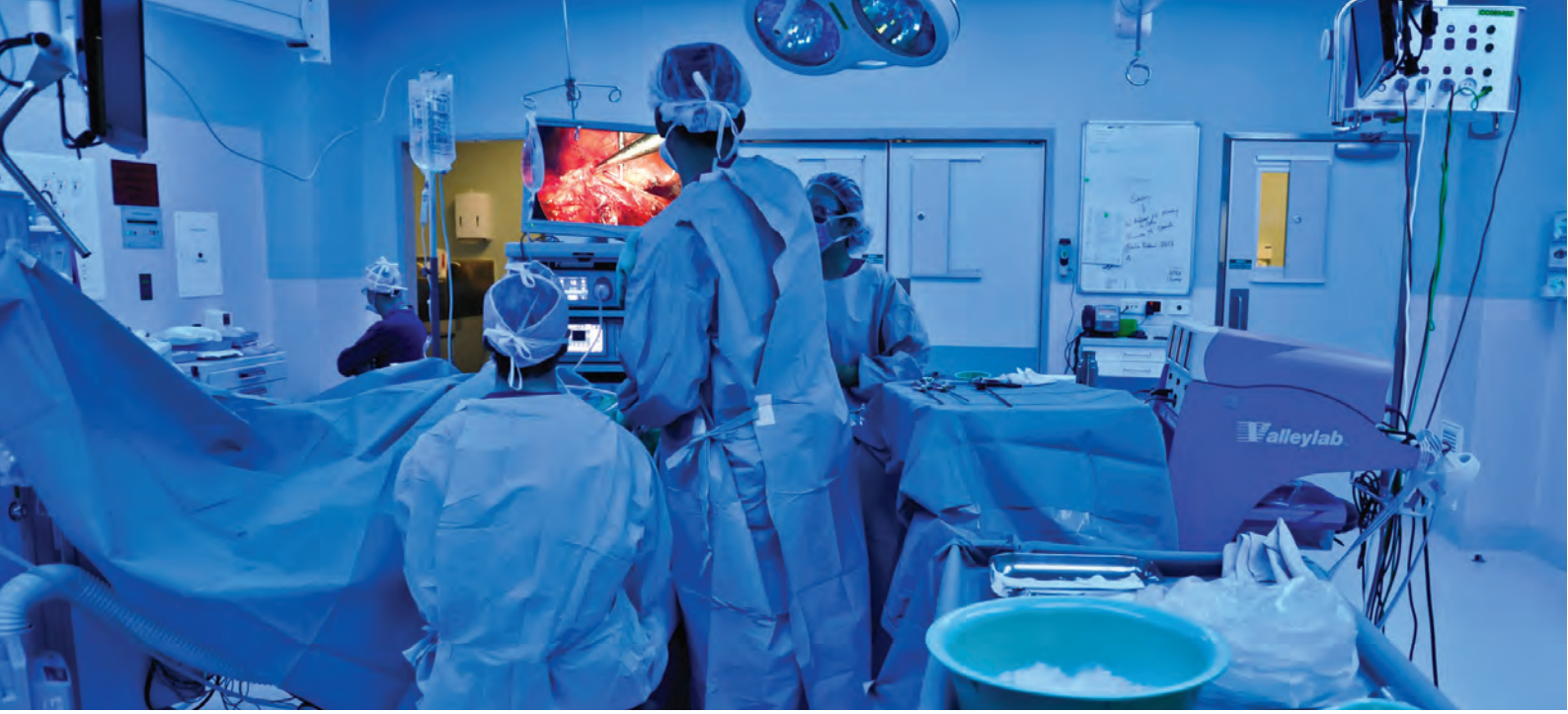
WORKFORCE DEVELOPMENT: ICU continues to actively foster and support ongoing training and development for both medical and nursing staff. The unit maintained its 100% pass rate for Registrars sitting specialist exams and 12 Registered Nurses achieved proficient or expert status on the Professional Development and Recognition Pathway. In addition four RN's graduated with Masters qualifications during the year.

IMPROVING PATIENT OUTCOMES: With support from CCDHB ICU, Wairarapa DHB adopted the Early Warning System that was successfully rolled out across CCDHB in June 2011. With both DHB's using the same system it is expected that communication between the teams about deteriorating patients will occur earlier, leading to improved outcomes for this at risk patient group.

Research involvement and capability continues to grow within the unit with the service contributing to 12 clinical trials. These include nine international trials and three national studies.



FLU VACCINATIONS: ICU graciously accepted the award for the most vaccinated team. Due to the efforts of the ICU vaccination team approximately 85% of the clinical staff received their flu shot this year.



Theatres

PERIOPERATIVE SERVICES: This year perioperative services have focussed on initiatives to enhance the flow of patients into and out of theatre. Within the theatre suite patient holding bays have been staffed, which has reduced bottlenecks that previously occurred within the Surgical Admission area and at theatre reception. Currently the extended recovery facility, which provides care for patients overnight, is operating at near capacity on a consistent basis. This enables beds to be available within ward areas for sicker patients and acute admissions.

In a joint initiative with the Acute Pain Management Service (APMS) nurses from the perioperative area are rostered to APMS on the weekend, thereby ensuring consistent availability of expertise to the surgical wards across seven days.

Demand for access to the PICC line service continues to grow with a recent audit indicating that most patients are now having their lines inserted by specifically trained staff, during normal working hours. The waiting time has also decreased, resulting in 80% of patients having their line inserted within 48 hours of referral. This has led to an overall reduction in the length of hospital stay for patients commencing chemotherapy treatments and for patients who are requiring long term antibiotic therapy.

THEATRES WELLINGTON AND KENEPURU: Theatre services continue to focus on supporting the delivery of surgery to both the local and wider population. This translated into:

- 7456 elective surgeries at Wellington Regional Hospital in 2011/12
- 2875 elective surgeries at Kenepuru Hospital in 2011/12.

In addition theatre staff supported 5751 acute operations and 1345 caesarean sections.

"Excellent service received. I was fully briefed before my procedure, I received a toasty warm blanket after changing into the hospital gown and my procedure was entirely painless. The lunch given afterwards was most welcome also. Top marks to all who dealt with me."

Kenepuru Hospital Perioperative Unit - 59 year old female

Throughout the year the theatre service has maintained its focus on reducing costs within the theatre suite. This has been led by a committed representative group and supported by the wider theatre staff. Without this level of buy in from staff the $2 million savings achieved would have not been possible.

In support of the ongoing increase in the delivery of elective surgery at Kenepuru Hospital the theatre service received a number of new pieces of equipment, including new towers for laparoscopic surgery, a new phaco machine to support ophthalmology and a new theatre table.

STERILE SERVICES: The service is undertaking an improvement project focussing primarily on raising overall productivity. Included in the project is a review of the standard operating processes between theatre and Sterile Services. This work has led to introducing new processes, realigning workstations, reducing activity duplication within the service and greater understanding and appreciation of the contribution sterile services makes to the overall delivery of surgery.

As the work continues we plan to redirect the flow of instruments through the unit. By installing more streamlined decontamination units, we will enhance the environment for staff and improve productivity.

Transit Lounge staff

Transit/Flight Retrieval

PATIENT TRANSFER SERVICE

This is a multifaceted area covering patient transfers within the hospital and transfers by road or air, to and from other hospitals within the wider region. Fixed wing or helicopter air transfers are primarily in conjunction with the Life Flight Trust. Road transfers are in conjunction with Wellington Free Ambulance (WFA). We are fortunate to have a dedicated WFA staff member on site during working hours to assist our relationship with the service.

THE TRANSIT LOUNGE

The Transit Lounge is in its third year of operation and continues to increase usage. Following a review of patient use of the lounge the operation hours were changed and it is now open longer in the evening. In another milestone for the area this year, two babies were delivered in the immediate vicinity with the assistance of the transit staff.

Children's Health Service

It has been an eventful and exciting year for Children's services at CCDHB with the highlight being celebrations to mark the centenary year of the Children's Hospital, which turned 100 on 13 March, 2012. To commemorate this service to the community a week of celebrations was opened by Hon Peter Dunne, Associate Minister of Health, in the atrium of Wellington Regional Hospital. There were static displays of our current and past practice at the children's hospital and nurses and medics musing on the past and commenting on the possible future. A highlight was the performances by children from the Cathedral Choir and the Kapa Haka group from Mount Cook School. Other events included the opening of the reconfigured Childrens' Wards by the Governor General, Lt General Rt Honourable Sir Jerry Mateparae, and an official all hospital staff birthday celebration.

CHILDREN'S HOSPITAL RECONFIGURATION:

The reconfiguration of the Children's Hospital, including a redesign of the Paediatric Oncology Day Ward and the Child Assessment Unit, began in November 2011 and was completed by the end of March 2012. This was a logistical challenge as the wards needed to decant twice into one ward. Ward staff worked tirelessly to ensure that there was as little disruption to the patient experience as possible during this period. The wards have now been renamed Ward 1 (previously Ward 19) and Ward 2 (previously Ward 18) to provide uniformity with the rest of the hospital.

The Children's Health Service owes a debt of gratitude to the public who, through the tireless efforts and support of the Wellington Hospitals & Health Foundation, have donated more than $800,000 to this project.

"My daughter was admitted yesterday. All of the staff I had contact with, from the gentleman who walked us from Emergency to the ward, the people in the Paediatric Acute Assessment Ward and the Children's Ward itself were absolutely brilliant. I had been dreading the admission but now would feel much more positive should we need to go back."

Paediatrics - Patient's mother

The Governor-General His Excellency Rt Hon Lt Gen Sir Jerry Mateparae talks with some young patients after officially opening the refurbished Children's Wards as part of the centenary year of Wellington Children's Hospital.

NICU staff Sandy Bryant and Hasu Patel performing the two person sterile change. In the past year there has been no longline infections thanks to this change in procedure.

PAEDIATRIC SURGERY: The Elective Health Target measuring the number of children receiving elective surgery, achieved 98% of the total plan to actual discharges. The demographic split between local and Inter District Flow (IDF) patient inflow remained at 50%, consistent with the previous year, however, the total number of patients treated was 3% lower overall.

The total number of acute patients was consistent with 2010/11, with an increase in patients from outside the district offset by the decrease in local patients treated.

NEONATAL INTENSIVE CARE UNIT: There are now five neonatal nurse specialists embedded in the RMO roster that has contributed substantially to continuity and safety of infant care.

All staff in NICU have worked towards decreasing infection in NICU with a sizable reduction in nosocomial infections evident. NICU has exceeded the international standard of Long Line Infections in their infant population by going for a year without any Long Line Infections.

The past year continues to show an increase in occupancy, with bed days increasing by approximately 1,000 - average occupancy at 36.5 compared with 35.7 the previous year. Local discharges from the unit increased 10% - 645 compared to 578 the previous year - and IDF inflow patients showed a 6% decrease - 256 and 272 respectively. Transfers to postnatal wards increased from 260 in 2010/11 to 302 in 2011/12. The overall performance to contract result was close to target, with local case weight over-performance offset by Inter District Flow inflow under-performance. Contract volumes for 2012/13 have been adjusted to reflect work performed during the past year.

DEVELOPMENT OF VIOLENCE INTERVENTION SERVICES: Analysis of the current work undertaken in child protection, together with redevelopment of the training structure and a national audit for the Violence Intervention Programme, has been completed. This work will provide a platform for the development of a sustainable service in the area of violence intervention at CCDHB.

Additionally, the new Gateway Assessment service as part of services for children in care, announced in the 2011 Budget, will augment these services. This assessment process gathers information from CYFS, health, and education services, to identify ways the three agencies can best work together to improve the overall health, education and wellbeing outcomes for the child or young person. CCDHB has employed a Gateway Coordinator who will also complete youth assessments, with a paediatrician completing child health assessments.

Children from the Cathedral Choir perform as part of celebrations marking the centenary of the Wellington Children's Hospital.

Women's Health Service

MATERNITY: In 2011/2012 3796 women give birth to 3875 babies, 3448 delivered at Wellington (3535 in 10/11), 232 at Kenepuru Birthing Unit (225 in 10/11) and 116 at Paraparaumu Birthing Unit (166 in 10/11).

There was no significant change in the mode of birth from 2010/2011 to 2011/2012.

We have seen an increase in the number of women referred to our Obstetric Diabetic Service with the care delivered by a multidisciplinary team from both the Women's Health and Diabetes services. There has been a high rate of non-attendance, especially from women living in the Porirua region who found it difficult to travel to Wellington for regular appointments. By working across the two services we have started a weekly clinic at Kenepuru Hospital, attendance rates have improved and we have had a lot of positive feedback. Women still need to travel to Wellington for ultrasound scans but in conjunction with Radiology we will be extending our ultrasound service to Kenepuru in the second quarter of the next financial year, initially focusing on providing scanning services for obstetric diabetic women.

We completed our strategic planning for the National Maternity Quality and Safety Programme and the final plan went to the MOH in June 2012. Our major focus is consumer and Lead Maternity Career engagement to improve the quality and safety of service provided. Two consumers and two LMC Midwives have been appointed and will be representative of their groups on the Maternity Quality & Safety Governance Committee.

We have finalised planning to introduce the Practical Obstetric Multi-Professional Training (PROMPT) course into the primary units at Kenepuru and Paraparaumu. The course consists of multiple interactive drills and workshops within the normal working environment and participants for the primary units will also include Wellington Free Ambulance Call Centre staff and at Kenepuru medical staff and duty managers who respond to emergency 777 calls.

GYNAECOLOGY: We are pleased with the progress and discussions, facilitated by Planning and Funding, to look at ways of improving gynaecology care in the community and better triage to secondary services. This will address unnecessary referrals and facilitate prioritisation and assessment of urgent cases.

DAY OF SURGERY ADMISSIONS (DOSA): After successfully admitting all non-cancer gynaecology day of surgery admissions directly to the Surgical Admissions Unit in 2010/2011, it was decided to follow the same process in 2011/2012 for all gynaecology cancer surgery admissions. The women are admitted directly to the Surgical Admissions Unit rather than being admitted to the inpatient ward (Ward 4 North). This facilitates good theatre throughput and allows the 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. Between 60-70 women are admitted via SAU per month.

> ***"Flawless, they made a really terrible situation into something beautiful. I will never forget my time here with our baby boy."***
>
> Maternity - Pohutukawa room

PROFESSIONAL DEVELOPMENT RECOGNITION PATHWAY FOR RNS (PDRP): In 2011/2012 on Ward 4 North Gynaecology, a further 3 RNs were successful in obtaining Proficient Level on the pathway. This brings the gynaecology nursing workforce up to almost 50% proficient RNs.

Quality Innovation: Reducing Length of Stay on the Gynaecology Ward

An initiative within the gynaecology ward has been to reduce the average length of stay for uro-gynaecology patients. In conjunction with the specialist uro-gynaecology SMOs, the Charge Nurse has led practice to move away from keeping women in as inpatients to carry out repeat trial of voids after surgery.

If the woman fails her trial of void on the first occasion, an indwelling catheter is reinserted and the woman is discharged home to return a week later where, as a day patient on Ward 4 North Gynaecology, the woman will have her catheter removed and her trial of void is supervised by the CNM. There has been a greater success rate for these women, with almost all passing successfully on their second attempt of trial of void.

There were two women who failed, they were taught intermittent self catheterisation and reported back via telephone, with a weekly visit to the ward to go over their results with the CNM. Both women were successful in returning to normal voiding within three weeks.

Quality Component

The Surgery, Women & Children's (SWC) Directorate initiated the organisation's review of the inpatient Patient Admission to Discharge Plan (PADP) in 2011, and the revised plan went live in April 2012. A post-implementation audit showed considerable improvement in compliance across the SWC Directorate inpatient areas. The Directorate has also developed a Paediatric Admission to Discharge Plan that will be trialled in late August 2012, and we are revising the Maternity Care Plan, which will be trialled late 2012.

With the introduction of the National Maternity Quality and Safety Programme (MQSP) the Women's Health Service have actively engaged consumers and the Primary Sector to work towards improving maternity services.

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

VASCULAR ACCESS TREATMENT COMMITTEE:

Over the past year the Vascular Access Treatment Committee (VATC) has been supporting several CCDHB initiatives including the CLAB national collaborative in ICU, the Hospital Admission, the Prevention Project, and the Cellulitis Pathway. The committee has been involved in the standardisation of IV consumables across the DHB resulting in significant cost savings to the organisation. VATC is supporting trials of new equipment including PICCs suitable for power injections and peripheral intravenous cannulae that utilise latest technology in cannula design.

VATC is also developing new policies and guidelines, and education, training and competency packages. These are to ensure that all patients receive the right venous access at the right time and that the venous access devices are inserted and managed according to best practise.

The Vascular Access Service, which was set up last year and reports to VATC, is enabling an increasing number of PICCs to be inserted, particularly in Oncology patients. A PICC continuation record has been developed which will soon be in use within CCDHB. A retrospective audit carried out last year, looking particularly at complication rates, compared favourably to international standards.
The Vascular Access Service at CCDHB is the only one of its kind in New Zealand, being a multi-disciplinary service using IV ECG guidance for tip placement in PICC insertion.

Cancer Services

The service has completed the framework for the ambulatory model of care in the cancer centre and is now progressing this work to implementation. It is focussed on ensuring pathways for patients are streamlined and patients have their treatment in the right place and at the right time.

The Multi Disciplinary Meeting (MDM) framework has now been implemented across seven of the ten Cancer MDMs. With support from the Central Cancer Network progress has been made towards using video conferencing that will allow clinicians from other DHBs to engage in the MDM process without having to travel.

The opening of the new radiotherapy linear accelerator. From left: CEO Mary Bonner, Dr Carol Johnson, Health Minister Hon Tony Ryall and Board Chair Dr Virginia Hope.

Radiation Oncology

Capital & Coast received the first Varian Truebeam radiotherapy linear accelerator in Australasia. The $5 million project marked the beginning of a new era in the radiotherapy treatment of cancers for Capital & Coast.

The new model Truebeam Linac was delivered to the radiation therapy department at Wellington Regional Hospital on July 31, 2011. It replaced a 14 year old machine that delivered more than 100,000 treatments during its lifetime. While the Linac was being installed, patients received treatment from the two other Linac machines, with staff working extended hours to ensure there was no disruption to patients.

The project was funded by CCDHB – the sole provider of radiation therapy in the Wellington region. Approximately 20,000 radiation treatments are provided to more than 1,300 patients each year. Radiation treatment rates have grown by 23% in the past four years.

The Radiation Oncology Service has continued to achieve its wait time target of four weeks from Decision to Treat to first Radiation Treatment. This is remarkable considering the reduced service capacity for 12 weeks during the installation of a the new Linear Accelerator.

Cancer Centre Clinical staff have been actively engaged in regional and national developments in relation to cancer. This includes membership of regional and national committees and participation in the newly developed Tumour Stream work programme and the National Medical Oncology Models of Care.

The Charge Nurse Manager for the Cancer Day Ward has been appointed as Nurse Director for the Central Cancer Network for one day per week. This role is focused (amongst other things) on developing a Cancer Nursing Strategy across the Central Cancer Network region.

HAEMATOLOGY: The haematology transplant unit celebrated 30 years of autologous bone marrow transplants this year. This is a wonderful milestone and the transplant unit continues to increase the number of autologous and allogeneic transplants for patients who require this treatment.

"I would like to record my most sincere thanks to the wonderful radiography team who administered my treatment over the last six weeks. An amazing group of caring, cheerful, attentive and professional young people. They are truly admirable. This helped make a difficult journey much easier for me. Also huge thanks to the supportive doctors, nurses and the welcoming front desk faces of the Radiation team."

Oncology Radiation - 59 year old female

MEDICAL ONCOLOGY: The Medical Oncology team appointed three new Senior Medical Officers during 2011/12. The appointments have been important in establishing and meeting the new MoH Wait Time targets for chemotherapy. This target requires patients to be receiving Chemotherapy within four weeks from the time the decision to treat is made. Both the Medical Oncology and Haematology service have achieved this target.

CANCER RESEARCH UNIT: The Wellington Blood and Cancer Centre (WBCC) Research Unit is a team of research nurses and co-ordinators who have been actively engaged over the past year to assist in providing Oncology and Haematology patients with the opportunity to have greater choice regarding treatment options, and access to treatments or treatment regimens otherwise unavailable,

should they be eligible and consent to participate.

There are more than 30 clinical trials currently open to patient recruitment in Medical and Radiation Oncology and Haematology. A similar number of trials are in the final process of trial closure for archiving for a number of years, or have patients with ongoing participation either with treatment or regular review as per Trial Protocol.

PALLIATIVE CARE: The Palliative Care service has implemented the Liverpool Care Pathway (LCP) across most inpatient areas within the hospital. This work has been led by the LCP Clinical Nurse Specialists. Each ward has identified a LCP champion to support the implementation of the LCP.

The team is progressing the role of a nurse practitioner for the team, this role will enhance the senior nursing resource available and enable changes to models of care for patients.

Emergency Department and Short Stay Unit

EMERGENCY DEPARTMENT: The Wellington Emergency Department was able to increase the number of Resident Medical Doctor and Senior Medical Doctors during the 11/12 year. This is part of a plan to improve medical staffing within ED to support the increasing number of patients presenting to the department.

The ED team have implemented a number of change processes that are focussed on improving the flow of patients through ED and to enhance the patient experience. This has focussed on improving the triage process and zoning the department into teams. Both projects have been successful and have been implemented with good support from staff. A third project has also commenced to evaluate the utilisation and processes within the Minor Care Zone.

A number of nursing staff are working towards achieving advanced practice roles, for example Clinical Nurse Specialists and Nurse Practitioners, and these roles will support the ongoing development of nurse-led services within ED.

Wellington ED has hosted a number of courses that are related to emergency nursing. These have been well attended by nursing staff from around New Zealand and feedback has been positive. These opportunities have raised the profile of Wellington ED as a tertiary emergency department.

Simulation exercise for ED staff

The Australasian College of Emergency Medicine has granted the Emergency Department accreditation for a further two years for the training of advanced trainees in Emergency Medicine within the department.

The College noted with approval:

- The support that the appointment of the current Director of Emergency Medicine has across the hospital.
- The commitment of the emergency staff to maintaining quality of care and training in the face of service demand pressures.
- The innovative practices and new models of care being introduced to assist with the service

"My father in law was treated in ED for renal failure. The RN who looked after us was outstanding in the professional manner in which she attended to my father in law and to this family. Despite ED being extremely busy, she gave us time, and explanations. She gave us confidence in her practice and we were all very appreciative."

Wellington ED - 59 year old female

SHORT STAY UNIT (SSU): SSU is a gateway for surgical and medical patients that assists with ED flow, and aids patients in transitioning home, or on to the correct hospital service. In keeping with its title, the unit aims to discharge patients within 24 hours of admission.

In the 2011/12 year, 4805 patients were admitted to the SSU, up from 4541 the previous year. Despite the increased number of admissions, this year saw a marked improvement for the SSU with 77% of patients discharged within 24 hours, up from 71% the previous year.

Renal

Service delivery and patient care are our main priority in the renal service and we have made a number of positive developments over 2011/12, including:

- 23% growth in patients on home based peritoneal dialysis.
- Successful transition to new haemodialysis machines (AK96) for home based patients, following a patient retraining programme.
- Successful transition to high flux haemodialysis for all home based patients.
- Successful transition to haemodiafiltration treatments for 10% of incentre dialysis treatments (across the Dialysis unit and Porirua Dialysis centre).
- Availability and transition to use of latest technology in high flux dialysers.
- Successful transition to Asceptic Non Touch Technique (ANTT) practice with central venous dialysis catheters.
- Home dialysis patient workshop based in the community, held July 2012, attended by 26 patients with a further one planned for late 2012.
- Ongoing participation in clinical trials involving transplant and home dialysis patients.

We are also focusing on developing our medical and nursing workforce using a number of different approaches. In November 2011 we held a Renal Focus Month on Ward 5 North which was a successful innovative approach to staff education with the main aim being: "Learning that will inspire, inform and motivate renal specialty nursing practise".

Alongside this we have also helped our senior nurses and registered nurses develop and achieve career progression through the Professional Development and Recognition Programme (PDRP). A Renal SMO undertook a sabbatical in palliative care with a view to facilitating closer cross specialty collaboration and held formal education days for nursing staff within the service and externally.

"Staff were extremely professional and courteous. They always introduced themselves initially and explained to me what they were doing, made me relaxed and anxiety free. Capital stuff."

Interventional Radiology Ward - 47 year old man

Gastroenterology

Achievements within Gastroenterology have included:

- Formal training of one Gastroenterologist in Endoscopic Ultrasound to an internationally recognised standard.
- Achievement of Expert level for one Gastroenterology nurse.
- A published article on the nursing role in bowel preparation in Kai Tiaki magazine by another Gastroenterology nurse.
- Purchase and installation of an Automated Endoscopic Reprocessor, enabling a consistant standard of high level disinfection, while minimising the health and safety risks associated with manual cleaning.

"Amazing treatment, care and respect over a very trivial matter. I felt humbled as there were so many needy people there. Keep up your good work, a privilege to be treated so well."

Eye Clinic - 72 year old female

ICT (Information and Communication Technology)

SOPRANO MEDICAL TEMPLATES: A number of Soprano Medical templates have been developed in-house facilitating easier clinical processes and improving the information available for clinicians. ICT are now in the position to create Soprano medical templates quickly and meet clinician's needs in a cost effective manner.

ELECTRONIC DISCHARGE SUMMARIES: Discharge summaries are now sent electronically to GPs rather than by fax. Reducing cost and effort and the potential risk of privacy breaches.

This major step forward includes the monitoring of electronic messages to GPs to identify sending errors or failures.

INFRASTRUCTURE UPGRADES: As a result of significant improvements and investment in back-office components CCDHB has maintained the benefits of a stable and reliable ICT infrastructure with minimal downtime.

A new network design is incrementally being deployed across the organisation which includes wireless technologies. Planning is underway to revitalise the desktop environment with upgrades to current technology, including Windows 7.

Patient Administrative Services

NON-ATTENDANCE RATES: Our non-attendance rate for outpatient clinics for 2011/12 was 6% overall. Māori patient rates were 13% and Pacific Island 15%. A number of strategies have been put in place over the last three years to improve attendance. The main focus has been in the Senior Medical Officer and Registrar groups but Allied Health groups have now been added.

A Did Not Attend (DNA) project was set up to address attendance rates specifically for Māori and Pacific Island patients as the rates for these groups have been historically higher. Reporting data was also reviewed to ensure consistency reporting. The group identified a number of innovations and improvements and these will be implemented in the 2012/13 year. Consumer and primary care focus groups and individual interviews were facilitated by a MCC project manager and Māori and Pacific managers to discuss barriers to attendance.

PATIENT FOCUSSED BOOKINGS: We have been working with Hutt Valley DHB with a view to using their "UBook" system. This will assist with automating the booking system for First Specialist Assessments and management of waiting lists. In the longer term there is potential for patients to book their own appointments on line. We are also investigating ways of setting up an electronic queue for subsequent appointments to avoid disruption to patients when clinics need to be cancelled.

EREFERRALS FROM GENERAL PRACTITIONERS: In July 2011, a process was set up for the Outpatient Booking Centre to receive eReferrals from primary care. There are now approximately 1800 referrals a month coming

Kenepuru Hospital orderly and Black Fern Moana Aiatu practices her scrum skills with colleagues Zoran Palijan and Trevor Moore.

through this system, using a referral template which has improved the quality of information. The system generates an automatic acknowledgement to the GP when the referral arrives.

Integrated Services

A new course for all Orderly and Security staff is focussing on customer service training. While orderlies are tasked with taking patients from point A to B, they present a human face of the organisation and are usually the only informal contact patients have with the hospital. The customer service training is a first of its kind initiative to give orderlies the tools to provide an outstanding customer service experience to patients.

Theme days in Vibe Café saw the staff café decorated and food prepared to reflect the theme; this provides a break for staff from the usual fare and something to look forward to in their hectic days at work.

"My husband is a regular patient at Wellington Hospital due to his respiratory failure. Yesterday he was assisted to the respiratory department by an orderly who ... actually talked to [him] like a friend, rather than just another sick person. He was friendly, chatty, cheerful, easygoing, relaxed and respectful. It was such a refreshing and enjoyable two minute journey and it put my husband in a good mood for the rest of the afternoon."

Security Orderlies - Patient's wife

Emergency Management

A strong focus of the Emergency Management Service's planning this year has been on incorporating the lessons from the Canterbury earthquakes into local planning – both within the DHB and in the wider emergency services and civil defence setting.

Work within the DHB has focused on three major areas:

- Primary Care: General Practices are being encouraged to participate in local emergency groups (LEGS) as a way of building mutual support relationships with other local health and emergency agencies. Compass Health has agreed to co-ordinate the primary health response to disasters, and is working closely with the DHB to establish procedures and resources for this key role.
- Aged Residential Care: Planning and Funding staff are working with Emergency Management to ensure arrangements are in place to provide post-disaster support for Aged Residential Care Facilities, and other vulnerable groups in the district.
- Resilience: Work is continuing with a number of DHB services to increase the resilience of critical utilities and key supplies in recognition that in a worst case scenario, it may be very difficult to obtain immediate outside assistance.

While the service dealt with the usual range of emergencies during the year, two operations were noteworthy:

- The storm and subsequent snow and lightning in August 2011 caused a cascading series of events ranging from difficulties transporting staff to and from work, through to a power cut at Wellington Regional Hospital, and a significant water leak in a clinical area. The support from both Wellington Free Ambulance and the Fire Service was greatly appreciated.
- When 11 people lost their lives in a hot air balloon accident in Carterton, the post-mortem examinations and DVI procedures were conducted at the Wellington Regional Hospital mortuary. While it is accepted that hospital

Lucy Goff operating the Haematology Department's state of the art Sysmex CS-2100i System.

mortuaries are not ideal settings for this type of operation, it was successfully completed within a week – due largely to the professionalism of the Pathology, Police, and DHB staff, and the fact that many of those involved had taken part in earlier exercises at the hospital.

Laboratory

Equipment was purchased for the automated extraction of HIV, Hepatitis B and Hepatitis C viral loads to enable a single point of testing in the Wellington region for these tests. The advantages gained from this new technology were further enhanced with IT3000 middleware, which eliminates the need for transcription of results. Hep B & C viral load testing is now performed at the Capital & Coast laboratory with expert clinical input into the comments and results. The results are delivered electronically to the requestors.

New coagulation analysers for the Haematology Department were introduced to replace the old equipment. The new Sysmex CS-2100i System minimises pre-analytical errors by using multi-wavelength scanning and sample liquid-sensing technologies to provide extra operator support – it identifies and automatically manages potentially problematic test samples prior to analysis.

IT 3000 auto validation software was installed for auto validation and filing of Biochemistry Cobas test results. This is middleware that sits between the analytical systems and the laboratory information system. The previous process required staff performing to view, validate and file every result individually.

An antibody to TSH receptors (A-TSHR) assay is now performed at CCDHB rather than being sent away to an external laboratory. This reduced the turnaround time for this testing by approximately two weeks. This test is used primarily to help diagnose an autoimmune thyroid disease and to separate it from other forms of thyroiditis.

The Molecular Department of the laboratory developed a Memorandum of Understanding between the CCDHB laboratory and ESR for the development of new assays. Both organisations benefit from this agreement.

Pharmacy

A new national medication chart was introduced into the DHB in September 2011. This is primarily an initiative of the Health Quality and Safety Commission to establish one standard format hospital prescription medication chart throughout all DHBs in NZ. Pharmacy was pivotal in the introduction of this chart by training clinical staff and organising the changeover from one chart to another in clinical areas. The process proceeded very smoothly.

Medicines reconciliation is another initiative of the Health Quality and Safety Commission to enhance patient safety and reduce harm associated with medications. Reconciliation is an evidence-based method to reduce discrepancies. The business case for additional resources to provide a programme of medicines reconciliation to patients on admission was approved in May 2012.

This project involves the reconciling of patient medications upon admission into hospital with those that were being taken by the patient in the community.

It is anticipated that this programme will be fully up and running in all hospitals by the middle of 2013.

During 2012 the Preferred Medicines List (PML) has been developed for use within both CCDHB and HVDHB. The PML is not only an electronic list of approved drugs that should be used within our DHBs but also a set of clinical guidelines intended to be used primarily by Registrars. It is expected that the PML will be officially launched at the end of August 2012.

The International Medication Safety Self Assessment for Oncology from the 2012 Institute for Safe Medication

Practise (ISMP) has been completed. This project was led by our oncology pharmacist. The assessment will help identify an international baseline for safe medication practices related to oncology as well as provide recommendations for improvement.

As a result of completing the assessment, CCDHB will obtain confidential aggregate results to compare our practice with demographically similar organisations and use that information for our own safety and quality improvement efforts.

Radiology

Radiology successfully outsourced a substantial number of Medical Resonance Imaging (MRI) to bring the waiting list back to acceptable levels. This places the department in a better position to comply with the Ministry's quality indicators for waiting times for CT and MR imaging.

Radiology successfully recruited three new radiologists, one of whom started in 2011/12 and the others are expected to start in August and October 2012.

The employment of a cardiologist who specialises in elective physiology increased the range of patients that are treated in the Interventional Recovery Ward (IRW.) Cardiology laboratory co-ordinators have been assigned and this has improved patient flow and turnaround time.

The successful International Accreditation New Zealand (IANZ) audit in May 2012 was a great achievement for the department. The accreditation team were very complementary and their final report following the audit contained no corrective actions and just three strong recommendations.

"I had two bookings, a mammogram and an ultrasound, and they were both on time. They were very polite and sensitive, not pushy and rushing things, especially the squeeze machine, and were considerate of my being anxious. Thank you."

Radiology - 47 year old female

Procurement

The permanent appointment of a therapies trained Clinical Advisor to work closely with Central Equipment Pool (CEP) staff has increased the relationship between CEP and Allied Health. This has highlighted areas for improvement and a greater awareness of processes and protocol around both internal and external based clinical services.

Through participation in developing national and regional initiatives CCDHB has shown a growth in annualised savings, which for 2011/2012 sat at $5.4m. This is a $3.1m increase on the previous year and is a reflection of the emphasis placed on stronger negotiation at a local level, and increased alignment to national and regional initiatives

Increased investment in CEP held medical devices such as syringe drivers, and roho cushions, has assisted in reducing costs associated with obtaining such items as rentals from outside agencies by $24k over the last quarter of 2011/2012. Further reductions are anticipated during the first half of the coming financial year.

KENEPURU CLINICAL SERVICES BLOCK AIR HANDLER UPGRADE: Old ventilation plant serving much of the Clinical Services Block including A&M, Radiology and Therapies was replaced with minimal disruption to building users. Additionally some humidity control function was added to the ventilation equipment serving two existing theatres. This work was completed directly above theatres where noise from installation work had the potential to cause disruption below. Despite the tight spaces and need to ensure ventilation, work was completed with very little impact on day to day operations.

MAIN SWITCHBOARD REPLACEMENT: Needing to replace the main switchboard and keep the Ward Support Block, especially kitchens and the call centre in operation, meant that some smart thinking was required to install new switchgear in the basement. By splitting the board into two identical parts half of the existing board could be removed and a new section installed. This method meant that any planned outages could be kept to a minimum and very little interruption to normal service delivery occurred.

Māori Health

MĀORI NURSES FORUM: The Māori Health Development Group and the Director of Nursing and Midwifery Office continue to work together on a joint approach to workforce development, as well as supporting the current workforce, both professionally and culturally.

The 2011 Māori Nurses & Midwives Professional Development Hui was a great success. Presentations were made by nurses who have completed Ngā Manukura training, as well as discussion on professional development that was culturally appropriate, and framed in a kaupapa Māori philosophy.

> ***"Awesome service. Staff are amazingly welcoming, atmosphere is just like being at home. If we didn't have a service like this, we wouldn't have been able to be here with our 82 year old father who underwent surgery. An enormous blessing to the 'Te pehi parata whanau whare'. A godsend."***
>
> Whanau Whare - Patient's family

An education session for staff on Tikanga guidelines.

MAORI AND PACIFIC WORKFORCE DEVELOPMENT PROJECT: CCDHB has begun a comprehensive Māori and Pacific Workforce Development Project (Tu Pounamu) with the aspirational target of having a workforce which proportionately reflects the community it serves.

The focus of the group is to increase the composition of Māori and Pacific Health workforce. In line with the CCDHB Strategic Workforce plan, the Māori Health Development Group are developing a specific Māori Workforce action plan to progress this.

TIKANGA GUIDELINES EDUCATION TRAINING: The Tikanga Guidelines education programme was developed to support all staff at CCDHB to help them understand the unique issues that Māori patients face in a hospital setting. The programme consists of an easy to access flipchart, face to face education sessions and a complimentary e-learning assessment.

Key achievements have seen;

- 3,728 staff in attend an education session.
- 2786 staff successfully complete the e-learning module.
- 769 staff successfully complete the e-learning module in 2011/12.

The success of the programme has been reflected in the number of requests to attend training from health provider organisations external to the CCDHB.

The University of Otago was contracted to evaluate the effectiveness of the Tikanga Māori Guidelines Programme for staff, Māori patients and their whānau. Recommendations to strengthen, embed, and expand the programme are currently being implemented. It was also noted that:

- CCDHB was commended on the successful development and implementation of this programme and the effort extended to reach a high number of staff.
- Capital & Coast senior management, the Clinical Governance Group and the Māori Partnership Board were commended for supporting the Tikanga programme and advancing efforts to be responsive to the needs of Māori.

Quality and Risk

RISK MANAGEMENT: Across the organisation senior management continues to develop risk management and training, provided via a dedicated in-house audiovisual training pack.

SERVICE HEALTH CHECK: CCDHB has moved away from a formal accreditation model and developed an internal system called service health check, for ensuring that our services are delivering high quality and safe care services. Over a three year period all services (clinical and corporate) will be evaluated using this model. It involves speaking to our workforce, consumers who use the hospital services and an on-site observation delivery of the care services. This process has been in place for just over a year and has heralded some valuable results and information which are helping our services to continue to deliver the best possible care to our patients.

CONSUMER EXPERIENCE AND ENGAGEMENT: In a targeted move, our complaints service has been rebranded and is now called the Consumer Experience Office focussing on improvement in service provision and consumer experience and outcomes. To date we have successfully improved our response times to patient complaints, achieving 100% compliance to acknowledging complaints received within a five day timeframe, and have taken an improved approach to managing concerns up front, enabling quicker resolution.

Where possible we engage consumers in projects that involve a redesign of such things as policy, patient information and letters, that directly impact or interface with our consumers and their families. Our focus is 'What matters to you?' as opposed to 'What's the matter?'

Clinical Governance

The Strategic Clinical Governance Committee meets monthly with good representation from all directorates and professional groups. Reporting lines from the various sub-committees have been strengthened and the clinical governance structure is now well embedded and is functioning well.

The HHS Executive reviews clinical governance activity every month. The clinical professional leaders and Executive Directors of Organisational Development & Patient Safety also attend monthly directorate performance meetings to ensure that clinical and operational governance is integrated.

Research Office and Clinical Trials Unit

The Research Office is now well established and is providing a high quality support service to researchers across the organisation. This includes providing advice on study design, assisting with grant and ethics applications, as well as frequently co-ordinating the running of research studies.

Regular symposia on research methodology, ethics and statistics continue to be offered to staff, including those at Hutt Valley DHB and other collaborative research groups. The Clinical Trials Unit (CTU) was officially opened in April 2011 and activity continues to increase, with a number of new studies likely to begin in early 2012/13.

Key research projects and trials include an influenza study, rheumatic fever, fractured hip, clostridium difficile study, an HRC funded PIPER trial investigating colorectal cancer outcomes and DCV melanoma studies.

Victoria University's School of Nursing, Biological Sciences laboratory, the Medical Research Institute of New Zealand, Massey University and Whitireia Polytechnic all have a presence on site and represent the vision for a collaborative partnership between academic, research and teaching organisations which will foster research, clinical trials, health education and training under an established 'hub'.

The Diploma of Clinical Research continues to be co-ordinated by Dr Jeremy Krebs (CCDHB Endocrinologist and Clinical Leader), with an intake of around 15 students annually, from various clinical disciplines. Development of the Masters and PhD programmes continues with a number of PhD students based in the new CCDHB research lab.

The inaugural Small Research Grants Application programme was offered in May 2012 and six small research projects received support valued at over $36,000. A second funding round is due in September 2012.

Patient Safety

The focus on strengthening and improving a culture of patient safety across the DHB continues, including the development and approval of an Employee Engagement and Patient Safety Culture strategy.

Achievements include:

- Standardised and improved adverse event management and reporting processes with particular emphasis on supporting and developing workforce skills, open communication with patients and families and sharing of learning across NZ.
- Co-ordination and delivery of a series of communication skills workshops and interactional competence development accessible to all DHB staff.
- Responsive expert analysis and activity in relation to emerging risks or issues related to patient safety.
- Advocacy of patient and family centred focused health services and care.

A Patient Safety initiative from the past year involved raising clinical awareness around Wrong Blood in Tube (WBIT) events where crossmatch blood samples have been mislabelled.
A successful campaign to make sure all labelling was done at the bedside, after asking the patient their full name and date of birth, has ensured we are not having these labelling errors.

Learning, Development & Research

LEARNING AND DEVELOPMENT STRATEGY: The Learning and Development Strategy has been approved with a clear direction and strategic objectives for the group over the next five years. Overwhelming support has been given towards a new model.

Key areas include:

- The management and administration of programmes.
- Educational and multi-media support for subject matter experts.
- Growing demand for eLearning.
- Increased governance and strategic guidance of organisational development.

GENERIC ORIENTATION: An improvement plan has been implemented to support the achievement of certification standards. The plan seeks to provide better assurance and record keeping ensuring all new staff receive appropriate organisation-wide and service-specific orientation.

PROGRAMME DELIVERY: Learning Development & Research's core services, such as CPR and IV therapies training, continue to receive positive feedback with new programmes being established.

- The Health Care Assistant (HCA) programme is completed with in excess of 180 HCAs now with a Level 3 qualification. Further support continues for new staff already enrolled into existing programmes.
- After piloting the Clinical Service Leadership Programme in 2010/11, two programmes have been run in 2011/12. The aim of the programme is to provide a collaborative leadership development opportunity whereby clinical leaders and operations managers/ service leaders come together to explore key leadership issues at a national and local level. The development of the programme is an integral part of CCDHB's approach to enabling the greater involvement of doctors in leadership and decision making.

The main lounge area of the refurbished Te Whare o Matairangi

Mental Health

In March 2012 Mental Health Services received a very positive Hospital Certification Surveillance Audit. All auditors reported back about how impressed they were with the respect shown to clients by staff involved in their care and the level of care being provided. They were also impressed with the Clinical Governance structure, data collecting systems and reporting processes Mental Health Services had in place. The overall comment was that the progress Mental Heath Services were making was very obvious and the teams were congratulated on this.

TE WHARE O MATAIRANGI REFURBISHMENT: The refurbishment of Te Whare o Matairangi was the biggest project completed this year and was the culmination of 10 years of planning by the Mental Health Directorate and 14 months of construction. This project required close liaison with a dedicated team from within the Mental Health directorate using information collected from their stakeholders and staff to help design the new ward.

Along with a major seismic strengthening programme, new electrical, plumbing and air conditioning systems were installed and combined with the architect's translation of the service needs. The result is a spacious, modern, and respectful facility, with bright courtyards and educational and rehabilitation tools. It is now the leading acute inpatient facility in the country and will help people recover so they can return to their lives in the community.

In July 25, 2012 the refurbished Te Whare O Matairangi was reopened, providing greatly improved facilities for service users and their whānau, staff, volunteers and staff of other agencies who assist in supporting recovery. The increased space comprises two physically distinct areas:

- **Te Taha Tauira:** An acute inpatient facility, with many design features that enhance the quality and care within a secure environment.
- **Te Taha Manaaki:** A more open facility with a stronger focus on transition into the community.

YOUTH ID: On July 25th 2011, Te Aruhe, New Zealand's first inpatient unit for youth with mental health and intellectual disabilities was opened, helping to fill a significant gap in the sector. It is a highly specialised service for a small number of people who have specialist needs, the emphasis being on rehabilitation and specialist care. This unit is the first stage of a national inpatient youth forensic mental health service.

REFERAL MANAGEMENT MODEL: The Electronic Referral Management Module implemented in April this year had a positive impact on the service in terms of improved efficiency and increased reporting capability.

The system is not only intuitive but has created a closer link with clinical practice and is used jointly by administrative and clinical staff. This has set the scene for the service to look at how the data that is collected can be used to improve outcomes for people who use the service.

FAMILY ADVISOR APPOINTMENT: Mental Health Directorate is proud to announce the appointment of two family advisors. This team will be responsible for the important link between clients, whānau and the service.

LEARNING AND DEVELOPMENT: The Directorate successfully implemented a fully integrated learning tool, "Totara", enabling the service to develop and run training online.

Unveiling the new name at Te Aruhe

I feel safe here. The doctors know what they're doing and all the nurses are really good. The support staff are amazing and their response times are excellent. My privacy is respected.

Mental health - 28 year old male

CONSUMER ACTIVITIES: Successful implementation of poetry workshops at Rangatahi will result in the publication of a poetry book "Smells like Sugar," which will be launched in October 2012.

This comes after the success of "What it Takes to Fly", the first book of client's poems which was a sellout and had to be reprinted.

Another highlight was the inclusion of a Wellness Plan template in consumer friendly language on the Electronic Health Record. This encourages collaborative preparation of plans that are meaningful and useful to the service user and are capable of being printed off, so hard copies can be kept for the consumers own use.

FAMILY COUNCIL: Te Korowai Whariki Whānau Council was established on November 22, 2011. The brief of this council is to improve family, whānau and consumer involvement and outcomes for people who use the Forensic and Rehabilitation Mental Health Services and Intellectual Disability Services in inpatient and community settings, from prison and other offender management areas.

VIOLENCE REDUCTION AND SUPPORT CO-ORDINATION GROUP: A joint union, staff and management committee has been recently established within the CCDHB mental health service. The committee consists of union delegates, management, staff representatives, and the consumer advisor. This committee is working towards improvements in CCDHB mental health workplace violence prevention programme. The group has taken a pro-active role in identifying and addressing clinical safety and quality issues at the team and service level. The joint committee has recently completed a staff survey relating to Health and Safety processes and the effectiveness of post management procedures after staff have been involved in aggressive events. The findings from this survey will be used to further assist the committee focussing on improving communication and procedures.

The Te Aruhe team in the new unit.

Statement of Service Performance

The Statement of Service Performance sets out Capital & Coast DHB's (CCDHB) key performance measures as described in the Statement of Intent for the period 1 July 2011 to 30 June 2012.

Highlights:

In 2011/12 CCDHB maintained high performance in areas of achievement and progressed work to improve the health of the CCDHB population. CCDHB made significant advances in reducing disparity and increasing access for vulnerable populations, such as the increases in cardiovascular risk assessments, mental health access, immunisation, and adolescent utilisation of dentists, in addition to the reduction in avoidable hospitalisations.

- CCDHB provided advice to help quit to 96% of people who smoke and were admitted to hospital in 2011/12.
- 7,866 elective surgeries were delivered to the DHB population in 2011/12; above what was planned and 196 more than in the previous year.
- CCDHB PHOs have increased the number of cardiovascular risk assessments provided to the target population. This is a new performance measure and good progress has been made towards the 60% target, particularly for Māori and Pacific people for whom the cardiovascular disease burden is higher.
- The DHB has made significant improvements to the length of time patients stay in the Emergency Department; despite greater numbers of people presenting to ED. The proportion of patients either discharged home or admitted to a ward within six hours has increased 13% to reach 87% at the end of 2011/12.
- 94% of two year olds had received the scheduled immunisations at the end of 2011/12. Immunisation rates were higher for Māori (95%), Pacific (97%) and children living in deprived areas (95%).
- More people accessed specialist mental health services. Three percent of the population are estimated to require specialist mental health services and CCDHB has achieved this target for 2011/12.
- People in CCDHB are less likely to be admitted to hospital for an avoidable condition compared with national rates. Avoidable hospitalisation rates have improved for some vulnerable population groups during 2011/12.
- 62% of adolescents received free dental care from a DHB funded community dentist. This is an increase of 11% over the previous year.

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.

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 2011/12 is measured. These performance measures, targets, and milestones are subject to annual audit by auditors appointed by the Office of Auditor General.

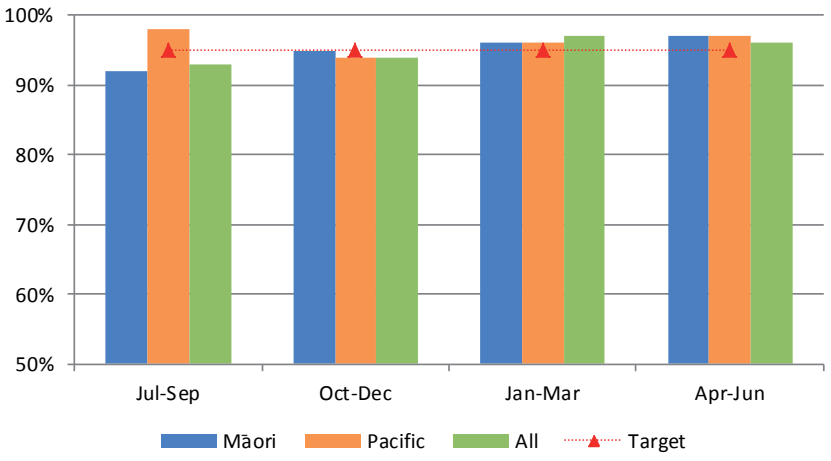
Output Class: Prevention Services

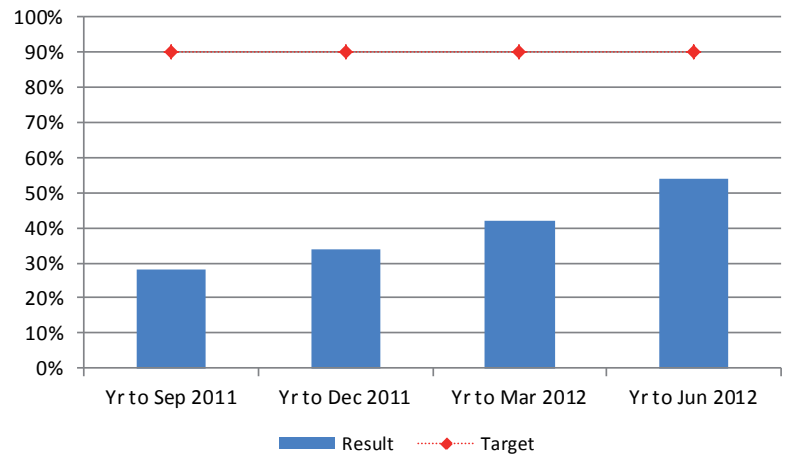
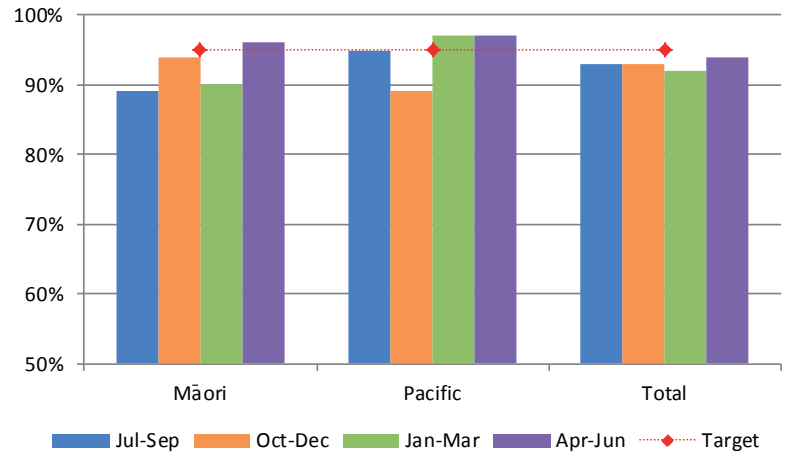
Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

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

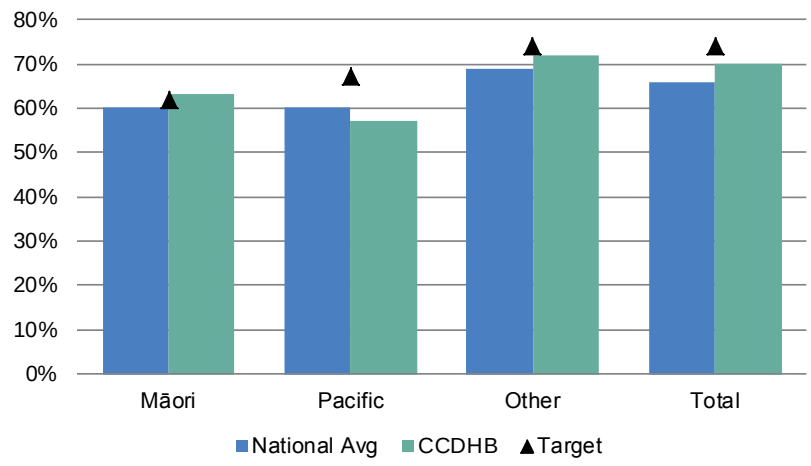
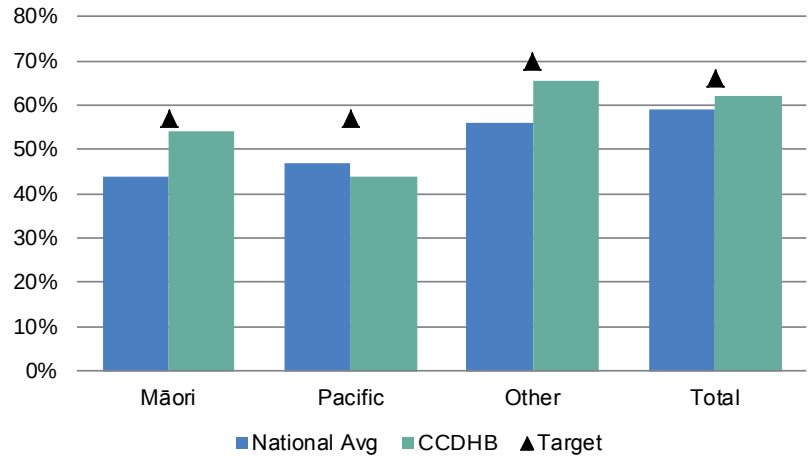
Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.

On a continuum of care these services are public wide preventative services.

Performance Measure	Performance Result	Target Achievement
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 are 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: 95%	**Percentage of Hospitalised Smokers Offered Advice to Quit**  CCDHB has maintained achievement of the Better Help for Smokers to Quit health target in 2011/12.	**Achieved** Māori: 97% Pacific: 97% Total: 96%

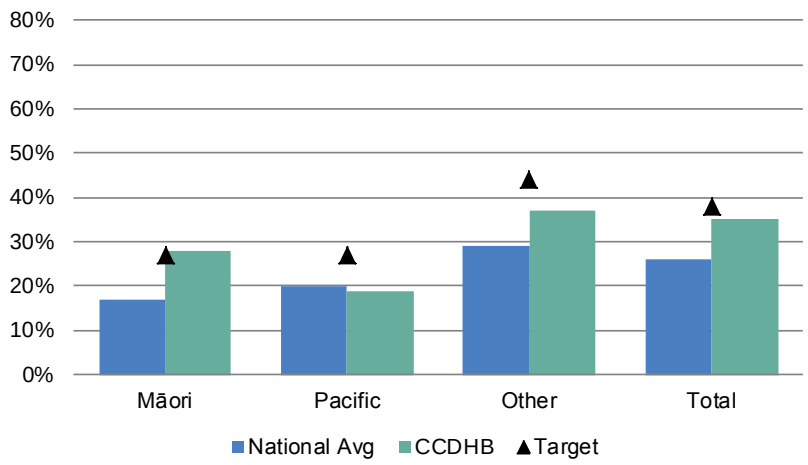
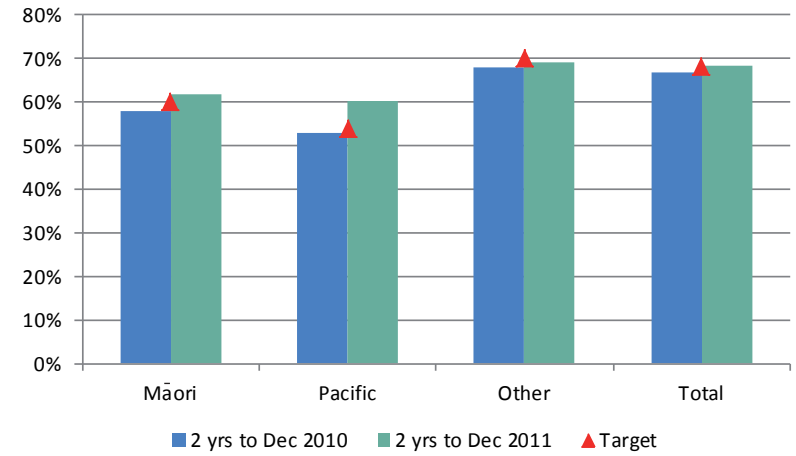
Performance Measure	Performance Result	Target Achievement
Percentage of smokers enrolled in PHOs who are offered advice to quit Target: 90%	**Percentage of Smokers Enrolled in PHOs Offered Advice to Quit**  This is a measure of the Government's health target for Better Help for Smokers to Quit. In 2011/12 there has been a steady increase in performance by PHOs, who are actively identifying smokers in their enrolled population to ensure brief advice to quit is being provided. By 30 June 2012, CCDHB PHOs achieved 54% of identified smokers being provided brief advice and support to quit. This places CCDHB second nationally for 2011/12. CCDHB is proud of the hard work by primary care to progress this measure over the 2011/12 year, increasing performance by 26%.	**Progress towards target** 54%
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: 95% Pacific: 95% Total: 95%	**Proportion of Two Year Olds Fully Immunised**  CCDHB is proud to have performed well for our Māori and Pacific populations. Performance for high need (Decile 9 & 10) was 95%, further contributing to reducing disparities. CCDHB missed the 95% target for the total population by only 14 children. CCDHB anticipates continued performance for this measure in 2012/13.	**Partially Achieved** *Achieved* Māori: 96% Pacific: 97% High need: 95% *Partially Achieved* Total: 94%

1 Ministry of Health DHB Performance Monitoring Framework 2010/11

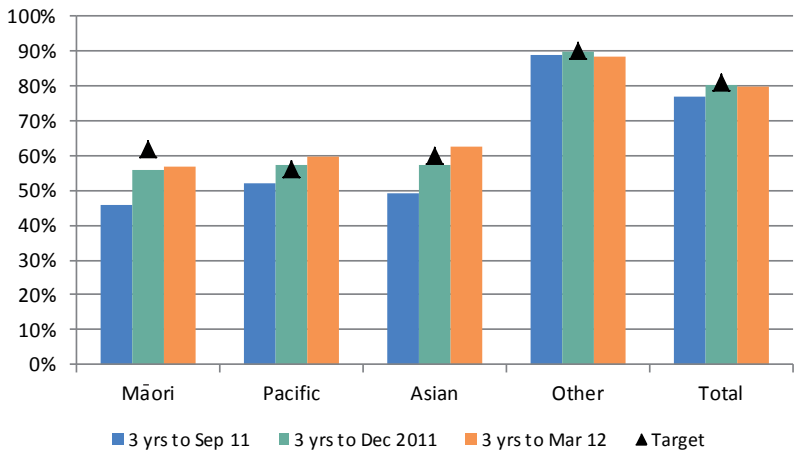
Performance Measure	Performance Result	Target Achievement
Improving breastfeeding rates – Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy 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] Target: Māori: 62% Pacific: 67% Other: 74% Total: 74%	**Full or Exclusive Breastfeeding at 6 Weeks**  CCDHB is above the national average for all groups but Pacific for the July – December 2011 period. Target was achieved for the Maori population.	**Partially Achieved** *Achieved* Māori: 63% *Not Achieved* Pacific: 57% Other: 72% Total: 70%
Proportion of infants fully or exclusively breastfed at 3 months. Target: Māori: 57% Pacific: 57% Other: 70% Total: 66%	**Full or Exclusive Breastfeeding at 3 Months**  While targets were not achieved, CCDHB is above the national average for all groups but Pacific for the July – December 2011 period.	**Not Achieved** Māori: 54% Pacific: 44% Other: 65% Total: 62%

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 for the breastfeeding measures is based on Plunket figures for the six months July – December 2011, as provided by the Ministry of Health.

Performance Measure	Performance Result	Target Achievement
Proportion of infants fully or exclusively breastfed at 6 months. Target: Māori: 27% Pacific: 27% Other: 44% Total: 38%	**Full or Exclusive Breastfeeding at 6 Months**  CCDHB achieved target for Māori. CCDHB is above the national average for all groups except the Pacific population; however Pacific rates are close to the national average.	**Partially Achieved** *Achieved* Māori: 28% *Not Achieved* Pacific: 19% Other: 37% Total: 35%
Percentage of eligible women (50-69 yrs) having breast screening in the last 2 years[4] Target: Māori: 60% Pacific: 54% Other: 70% Total: 68%	**Percentage of Eligible Women Having Breast Screening in the Last 2 Years**  Performance has improved for the percentage of women 50-69 years who have had breast screening in the past 24 months. Significant improvement has been seen for Pacific women, and Māori have also increased, showing the effect of efforts to reduce disparities.	**Achieved** Māori: 62% Pacific: 60% Other: 69% Total: 68%

4 Data provided by Ministry of Health for two years to December 2011.

Performance Measure	Performance Result	Target Achievement
Percentage of eligible women having cervical screening in the last 3 years[5] Target: Māori: 62% Pacific: 56% Asian: 60% Other: 90% Total: 81%	**Percentage of Eligible Women Having Cervical Screening in the Last 3 Years**  Targets were achieved for Pacific and Asian populations, and improvements seen for ethnic groups as well as the total population.	**Partially Achieved** *Achieved* Pacific: 60% Asian: 62% *Not Achieved* Māori: 57% Other: 88% Total: 80%

Measure	Target	Performance	Achievement	Comment
The number of house insulation installations for low income residents with long-term respiratory or circulatory conditions	200	351	Achieved	
Combined audit score for child protection and partner abuse	140/200	168/200	Achieved	
The number of visits by school health nurses	3,363	2,859	Not Achieved	
The number of Before School Checks	3,333	3,341	Achieved	
High Needs	553	555	Achieved	
The number of Year 7 children vaccinated in schools	3,450	2,379	Progress toward target	70% of the eligible population was immunised.
The number of Year 8 girls vaccinated against HPV	1,505	846	Progress toward target	52% of the eligible population was immunised.
The proportion of 'never smokers' among Year 10 students	73%	72%	Progress toward target	
The percentage of enrolled people over 65 years vaccinated against flu	68%	66%	Not Achieved	The performance was close to target and CCDHB will continue to work with primary care to increase immunisation for vulnerable populations.
The percentage of high needs enrolled people over 65 years vaccinated against flu	67%	65%	Not Achieved	
The percentage of adults consuming 2+ fruit daily	62%	The survey from which this information is obtained has not been repeated by the Ministry of Health in 2011/12		
The percentage of adults consuming 3+ vegetables daily	64%			

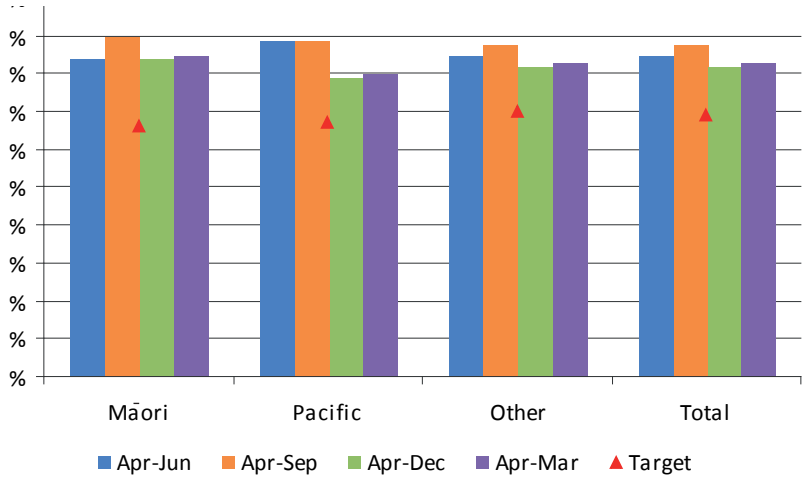
5 Data provided by the National Screening Unit.

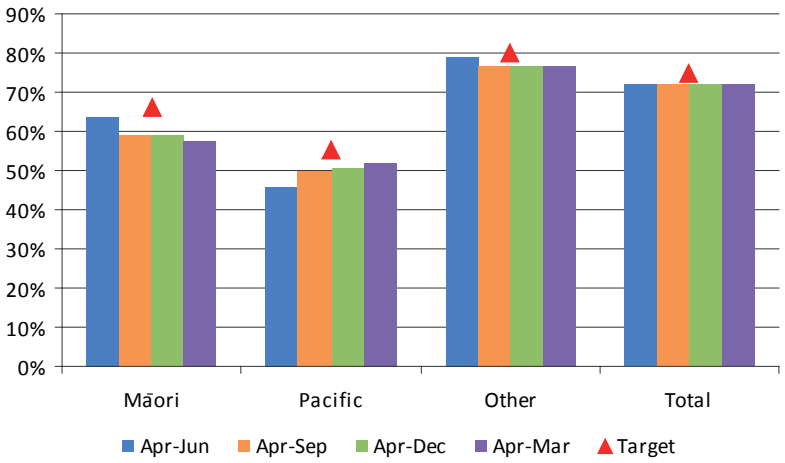
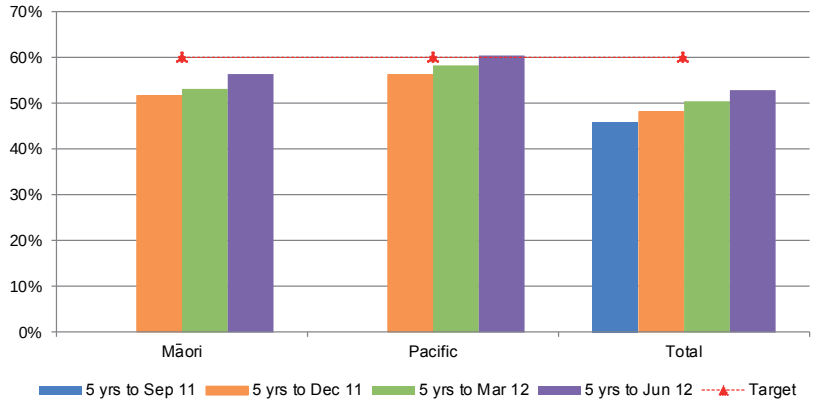
Output Class: Early Detection and Management Services

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

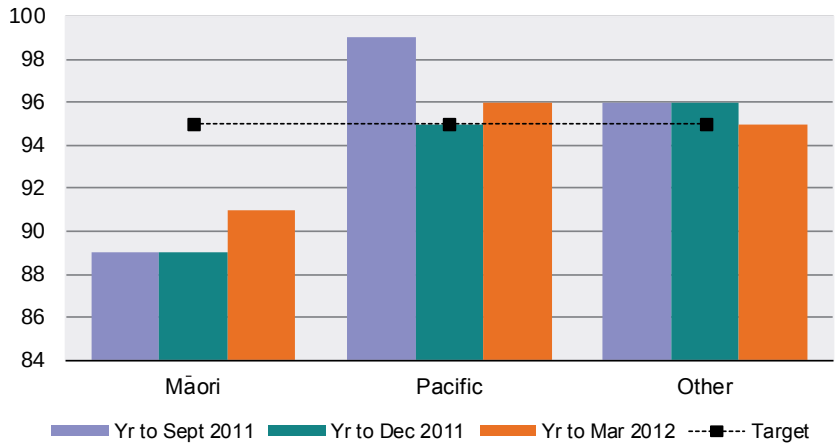
These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

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 Māori 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: 65.9% Pacific: 67.1% Other: 69.9% Total: 69.1%	**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.  CCDHB continues to perform well in the Diabetes Free Check measure. National changes in the Diabetes Get Checked programme may have led to variability of performance in the last year.	**Achieved** Māori: 85% Pacific: 80% Other: 83% Total: 83%

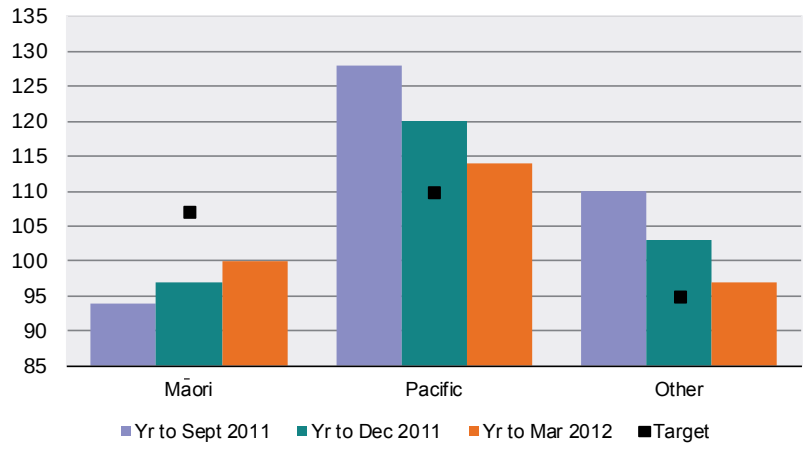
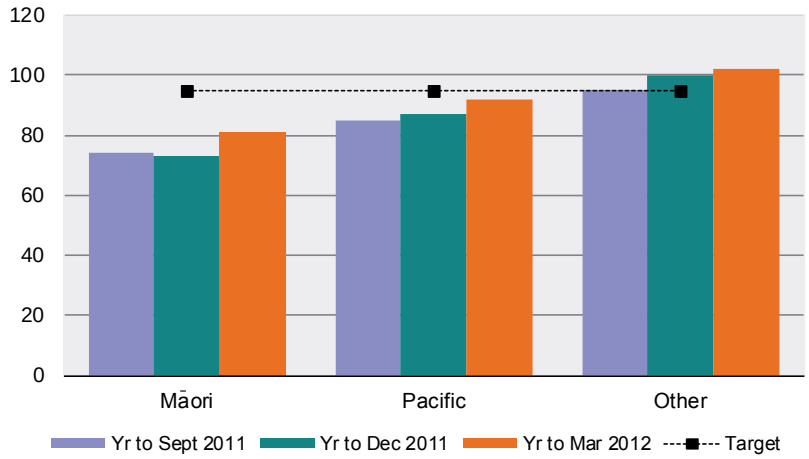
Performance Measure	Performance Result	Target Achievement
Proportion of diabetics checked with satisfactory blood glucose control (HbA1c less than or equal to 8) Target: Māori: 66% Pacific: 55% Other: 80% Total: 75%	**Percentage of Diabetics with Hb1Ac<=8** This is a portion of the measure of the Government's health target for Better Diabetes and Cardiovascular Services.  CCDHB's performance in the Diabetes management measure did not reach targets for 2011/12, however, rates for Pacific have increased across the 2011/12 year. Improvements in HbA1c are much more difficult and complex than completing an annual check. A Diabetes Improvement Care Plan is being developed to improve diabetes care through our Better Sooner More Convenient planning, and the CCDHB Integrated Care Collaborative process.	**Not Achieved** Māori: 58% Pacific: 52% Other: 77% Total: 72%
Percentage of people receiving a cardiovascular risk assessment in the last 5 years[6] Target: Māori: 60% Pacific: 60% Other: 60% Total: 60%	**Percentage of People Receiving a Cardiovascular Risk Assessment in the Last 5 Years**  This is the measure of the Government's health target for More Heart and Diabetes Checks, which came into effect on 1 January 2012. This measure is reflective of the work of primary care to assess the cardiovascular risk of eligible patients to ensure early detection and good management of long term conditions. CCDHB has achieved target for Pacific, and rates for Māori and Total have consistently increased during 2011/12. These positive results are a reflection of the efforts of primary care to support systematic risk assessments of targeted populations. Activities within PHOs have included the extension of nursing resource to carry out the assessments, promotion events focused on Māori and Pacific males, outreach services targeted to Māori and Pacific, and ensuring linkages with diabetes annual reviews.	**Partially Achieved** *Achieved* Pacific: 60.4% *Progress towards target* Māori: 56.4% Total: 53%

6 This measure changed as of 1 January 2012 to be aligned with the PHO Performance Programme measure as per Ministry requirements. The targets were changed to 60% as compared to the 90% target stated in the 2011/12 Annual Plan for the previous measure.

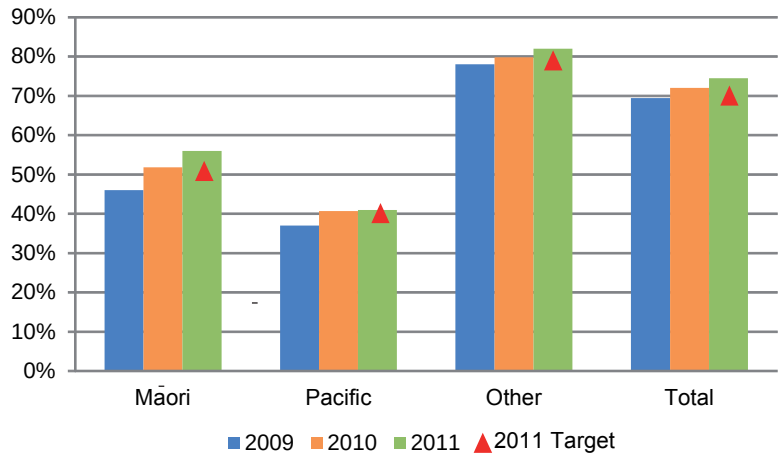
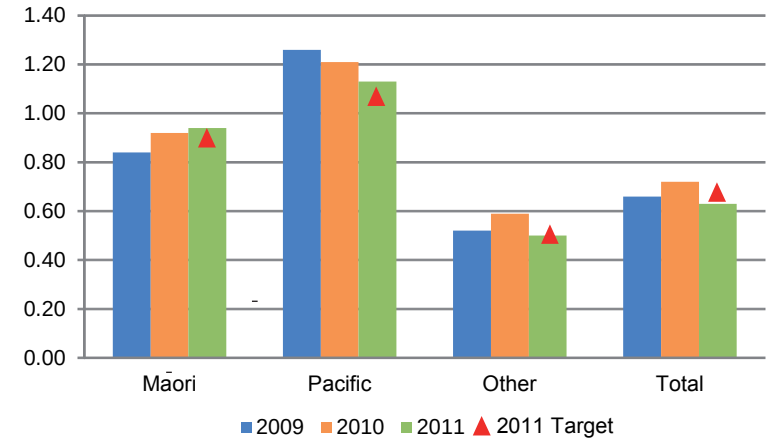
Performance Measure	Performance Result	Target Achievement
Ambulatory Sensitive Hospitalisations[7] (ASH) are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication 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[8] 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). For this measure, CCDHB is looking to reduce the standardised discharge ratio.  CCDHB is proud of its performance as there has been a decrease in ASH admissions for the 0-74 age group, led by decreases for the 0-4 population. Target was achieved for Māori and Other Populations, and progress was made in reducing Pacific ASH admissions. The condition with the most ASH admissions is Cellulitis, and a targeted cellulitis programme has recently begun which may assist in reducing admissions for this condition. Reductions have been seen over the past year in admissions for Upper Respiratory and Ear, Nose and Throat conditions, diabetes, stroke, and rheumatic fever/heart disease. The reduced admissions for upper respiratory and ear, nose and throat conditions are potentially a result of the insulation programmes that CCDHB supports. In 2011/12, a total of 452 homes were insulated through Sustainability Trust, the Pacific Healthier Homes Project, and Warm Up Capital & Coast.	**Partially Achieved** *Achieved* Māori: 91 Other: 95 *Not Achieved* Pacific: 96

7 ASH data is provided by the Ministry of Health for the 12 months to September, December, and March.

8 ASH data covers a 12 month period judged against national performance baselines from September 2010.

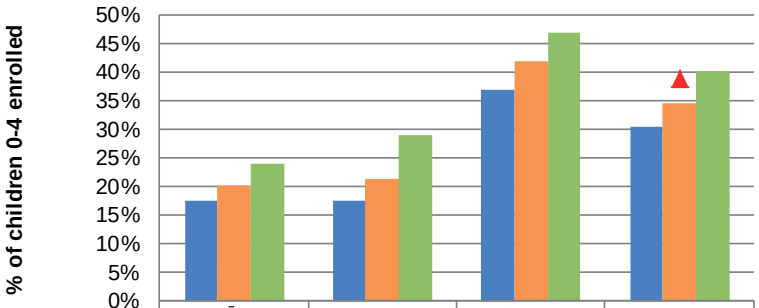
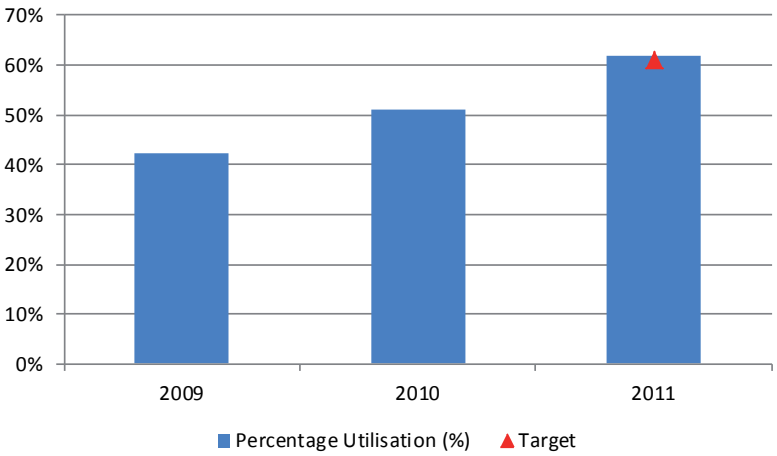
Performance Measure	Performance Result	Target Achievement
Ambulatory Sensitive Hospitalisation standardised discharge ratio for 0-4 years Targets: Māori: <107 Pacific: <110 Other: <95	**Ambulatory Sensitive Hospitalisations, 0-4 years**  There has been a substantial decrease in the number of ASH admissions for 0-4 year olds during the 2011/12 year. Target was achieved for Maori, and progress was made in reducing ASH admissions for Other and Pacific populations. The highest ASH admissions for 0-4 are for dental conditions, and it is anticipated with the work underway by the Regional Dental Service targeting this age group that this will be reduced in the 2012/13 year.	**Partially Achieved** *Achieved* Māori: 100 *Not Achieved* Pacific: 114 Other: 97
Ambulatory Sensitive Hospitalisation standardised discharge ratio for 45-64 years Targets: Māori: <95 Pacific: <95 Other: <95	**Ambulatory Sensitive Hospitalisations, 45-64 years**  Targets were achieved for Māori and Pacific Populations. There is an increasing trend of ASH admissions for this age group, however there is no single condition driving the increases. The highest numbers of ASH admissions for the 45-64 age group are for angina and chest pain, which may be reduced through improved performance for Cardiovascular Risk Assessments.	**Partially Achieved** *Achieved* Māori: 81 Pacific: 92 *Not Achieved* Other:102

Oral Health Services[9] 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.[10]

Performance Measure	Performance Result	Target Achievement
Percentage of children caries free at five years Target: Māori: 50% Pacific: 40% Other: 79% Total: 69%	**Percentage of Children Caries Free at 5 years**  Through this measure CCDHB is looking to increase the percentage of children age 5 that 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 2011; 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 focussed on Māori and Pacific children.	**Achieved** Māori: 56% Pacific: 41% Other: 82% Total: 75%
Mean number of Decayed, Missing or Filled Teeth (DMFT) at year 8 Target: Total: 0.67	**Mean Number of Decayed, Missing or Filled Teeth (DMFT) at Year 8**  Through this measure CCDHB is looking to reduce the mean DMFT in Year 8 students. There has been improvement for most groups in 2011, and the target has been achieved. 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.	**Achieved** 0.63

9 Ministry of Health Oral Health data covers calendar years; therefore the reportable period for the 2011/12 year pertains to the 2011 calendar year.

10 Nationwide Service Framework; Service Specifications; Child Oral Health, Ministry of Health 2010/11

Performance Measure	Performance Result	Target Achievement
Percentage of children under 5 years enrolled in DHB funded dental services Target: 39%	**Percentage of children under 5 years enrolled in DHB funded dental services**  The percentage of children under 5 who are enrolled with the Regional Dental Service has increased for all groups in 2011/12. Work is underway to improve enrolment for this age group in order to positively impact on oral health outcomes for preschoolers.	**Achieved** 40%
The percentage of adolescents using DHB funded oral health services Target: 61%	**Percentage utilisation of DHB funded dental services by adolescents**  CCDHB has made significant gains in adolescent utilisation over the past few years. CCDHB improved performance by 11% in the 2011 year. Increased utilisation of DHB oral health services will improve the oral health of adolescents in addition to reducing the incidence of dental conditions.	**Achieved** 62%

	Māori	Pacific	Other	Total
2009	18%	18%	37%	31%
2010	20%	21%	42%	35%
2011	24%	29%	47%	40%
2011 Target				39%

Measure	Target	Performance	Achievement	Comment
The percentage of projected population enrolled with a local PHO	89%	93%	Achieved	
Māori	80%	85%	Achieved	
Pacific	95%	100%	Achieved	
The percentage of eligible people enrolled in Care Plus	92%	98%	Achieved	
The percentage of children 0-12 years not examined by the School Dental Service according to their planned recall period	7%	18%	Not Achieved	
The number of community pharmaceutical items dispensed	3,300,000	3,300,858[11]	Achieved	
The number of community laboratory tests performed	2,100,000	2,209,554[12]	Achieved	

Output Class: Intensive Assessment and Treatment Services

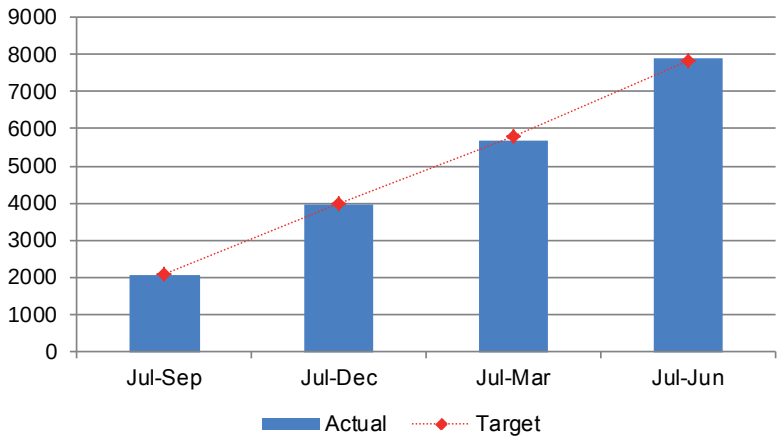
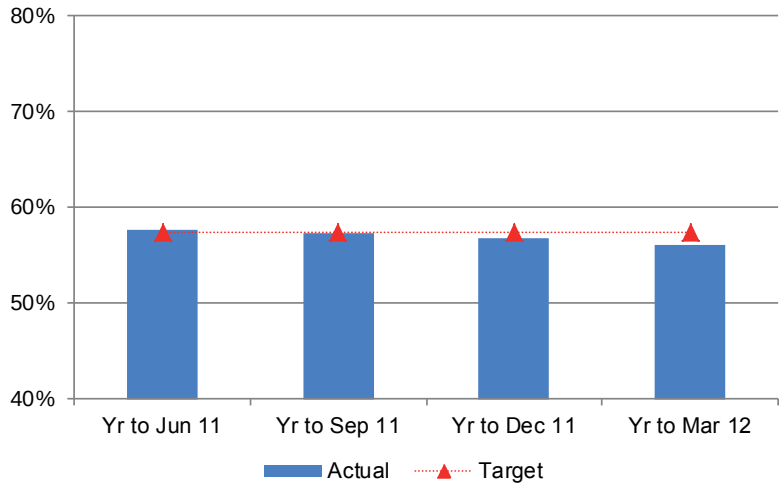
Intensive assessment and treatment services are delivered by a range of secondary and tertiary providers. These services are usually provided out of hospitals or other facilities that enable co-location of clinical expertise and specialized equipment. These services are generally complex and provided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

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, 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.

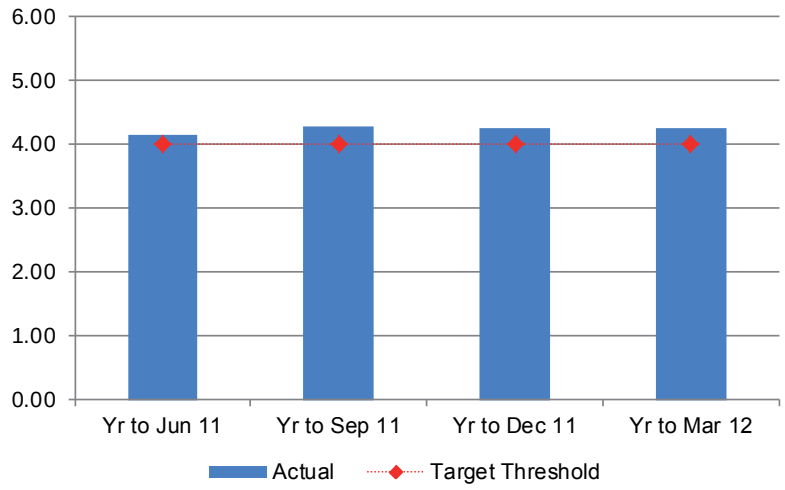
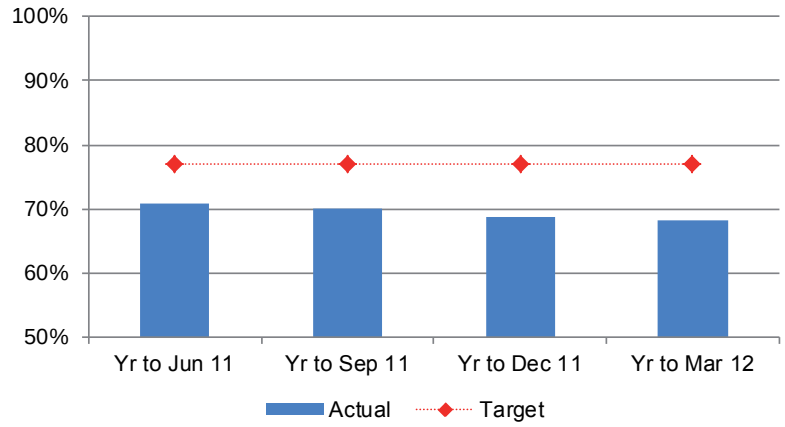
On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

11 Results for the year to April 2012.

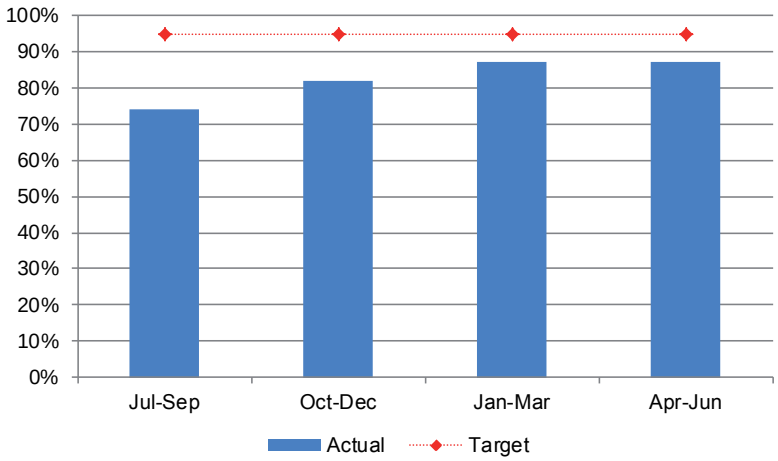
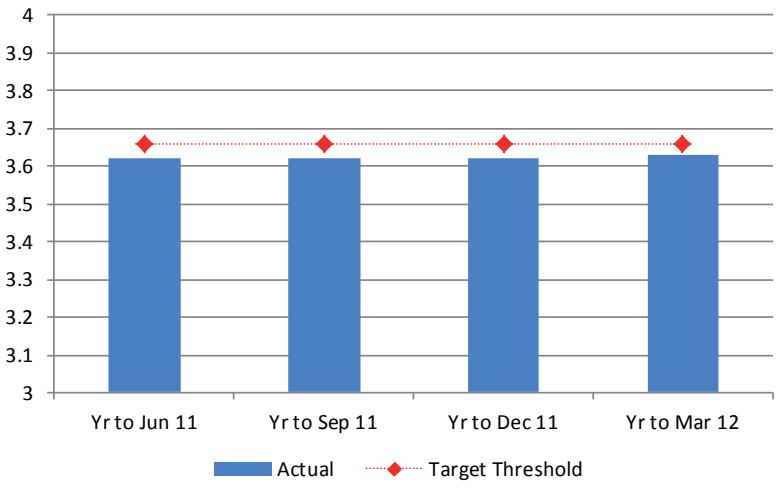
12 Results for the year to May 2012.

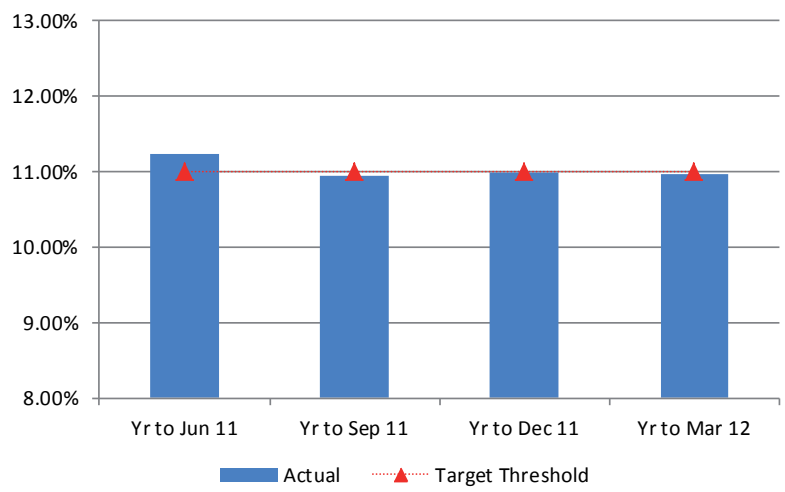
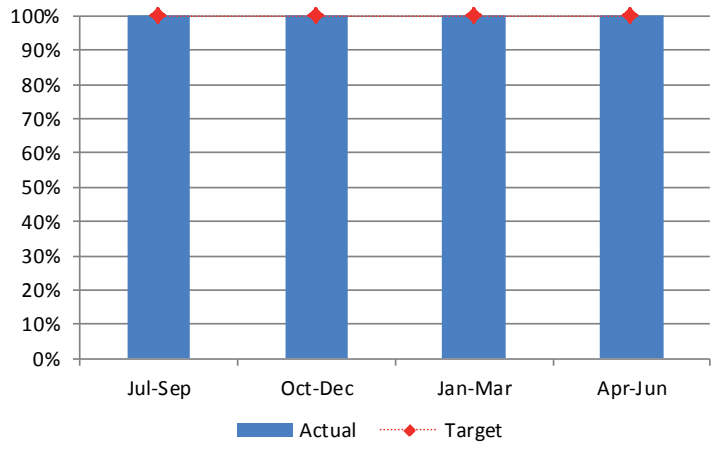
Performance Measure	Performance Result	Target Achievement
Elective (Inpatient and Outpatient) Services: Includes: Services provide by the DHB's hospital services to the population and services provided by other DHBs for the CCDHB population. The Minister has set an expectation that the national annual 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: 7,828	**Number of Surgical Elective Discharges**  This is a measure of the Government's health target for Improving Elective Services, calculated cumulatively through the year. An increased focus on elective surgery throughput and productivity has resulted in CCDHB exceeding the elective surgery health target by 38 discharges.	**Achieved** 7,866
Percentage of elective and arranged day surgery performed as day cases (standardised) Target: 57.4%[13]	**Elective and Arranged Day Surgery**  CCDHB did not achieve the elective and arranged day surgery target for 2011/12. While areas for improvement are under investigation, it is noted that CCDHB is a leader among tertiary providers for this measure.	**Not Achieved** 56%

13 This target was revised by the Ministry of Health due to a change in methodology for calculating the measure.

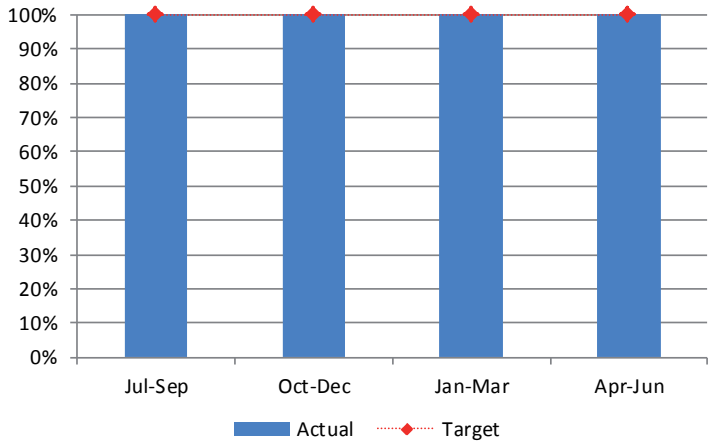
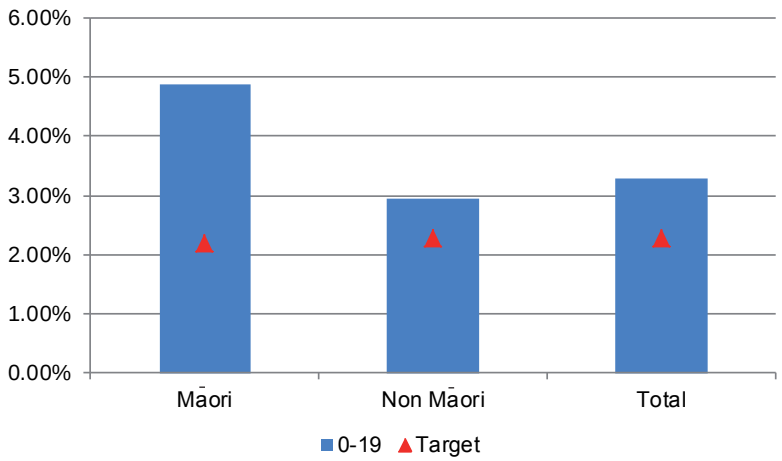
Performance Measure	Performance Result	Target Achievement
Standardised average length of stay for elective and arranged inpatients Target: <4 days	**Elective and Arranged Length of Stay**  CCDHB did not achieve target for elective and arranged length of stay. The results are distorted due to the CCDHB model of care, and CCDHB anticipates actual length of stay will be better reflected when the measure is changed in 2012/13 to overall length of stay rather than split into 'elective and arranged' and 'acute'.	**Not Achieved** 4.25 days
Percentage of elective and arranged surgery occurring on the day of admission (standardised) Target: 77%	**Elective and Arranged Day of Surgery Admission**  CCDHB did not achieve target for elective and arranged day of surgery admissions. This is due to low rates for arranged cases, and a detailed analysis is underway to determine where improvements can be made for 2012/13.	**Not Achieved** 68%

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; serious injury; and 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.

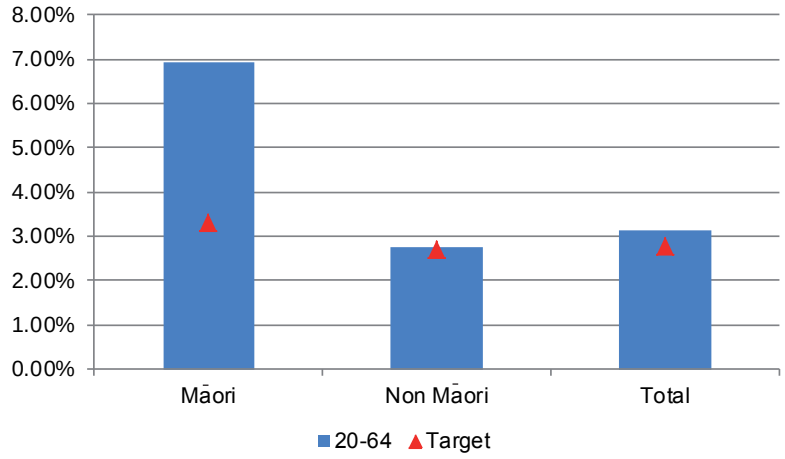
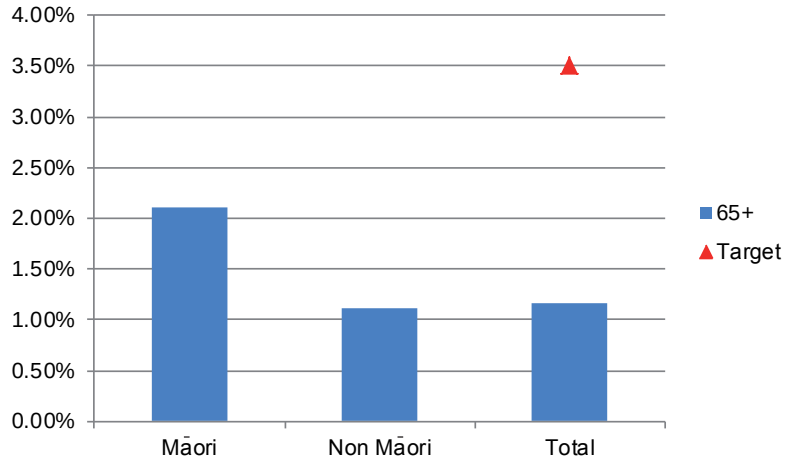
Performance Measure	Performance Result	Target Achievement
Percentage of patients admitted, discharged or transferred from ED within six hours Target: 95%	**Percentage of Patients Admitted, Discharged or Transferred from ED within Six Hours**  This is a measure of the Government's health target for Shorter Stays in Emergency Departments. CCDHB has implemented new strategies with the aim to improve performance for the percentage of patients admitted, discharged or transferred from ED within six hours. While CCDHB did not achieve the national target, CCDHB has seen a 13% increase over the 2011/12 year. CCDHB is continuing with improvement strategies with the aim to meet the target by December 2013.	**Progress towards target** 87%
Standardised average length of stay for acute inpatients (days) Target: 3.66 days	**Average Acute Inpatient Length of Stay**  CCDHB 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 flexibility of capacity that improves acute flow.	**Achieved** 3.63 days

Performance Measure	Performance Result	Target Achievement
Percentage of acute hospital readmission within 30 days of discharge Target: 11%	**Percentage of Acute Readmissions to Hospital**  CCDHB has reduced the percentage of acute hospital readmission within 30 days of discharge, showing the quality improvements that have been undertaken in 2011/12.	**Achieved** 10.98%
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 who start radiation therapy within four weeks of decision to treat[14] 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 CCDHB patients requiring radiotherapy in 2011/12 received this within 4 weeks of decision to treat.	**Achieved** 100%

14 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).

Performance Measure	Performance Result	Target Achievement
Percentage of patients who start radiation therapy within four weeks of decision to treat[15] Target: 100%	**Patients Starting Chemotherapy within Four Weeks**  All CCDHB patients requiring chemotherapy in 2011/12 received this within 4 weeks of decision to treat.	**Achieved** 100%
Mental Health – This measure targets improved access to services, which is expected to 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% Non Māori: 2.29% Total: 2.27%	**Percentage of the 0-19 population accessing secondary mental health services**  	**Achieved** Māori: 4.89% Non Māori: 2. 95% Total: 3.29%

15 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).

Performance Measure	Performance Result	Target Achievement
Age 20-64 Target: Māori: 3.3% Non Māori 2.7% Total: 2.76%	**Percentage of the 20-64 population accessing secondary mental health services**  CCDHB continues to work towards improving access to mental health services.	**Achieved** Māori: 6.94% Non Māori: 2. 74% Total: 3.14%
Age 65+ Target: Total: 3.5%	**Percentage of the 65+ population accessing secondary mental health services**  The result for this age group is not comparable to the target that was set in the Statement of Service Performance, as the target was set based on the inclusion of psychogeriatrics while the result does not include this group. CCDHB aims to provide accessible mental health services for the over 65 population and is working to improve the access rates of this group. It should be noted that psychogeriatrics data is not provided to the national mental health database (PRIMHD) and is therefore not included in the Ministry of Health's calculation of performance for the 65+ population.	Total: 1.16%

Performance Measure	Performance Result	Target Achievement
National Total Population Target: 3%	There has continued to be an increase in the access rates for Mental Health services, resulting in CCDHB's achievement of the national target of 3% access for the total population. This has been reached through the re-organisation of service delivery, including the introduction of Te Haika, the single point of access and triage for local mental health services and through improved data capture. Non-Government Organisations providing Mental Health services to the CCDHB population have succeeded in making improvements in the quality of the data being provided to PRIMHD. Most organisations now have data reflecting the complete 12 month period in PRIMHD. In particular those providing Alcohol and Drug, Kaupapa Māori and Pacific services are making a significant contribution to access rates for youth and priority populations in the CCDHB region. The introduction by CCDHB of an electronic Referral Management System in April 2012 is expected to enable further improvement in 2012/13 of access rates through more efficient data capture.	**Achieved** Total: 3%

Measure	Target	Performance	Achievement	Comment
The number of first specialist assessments (FSAs)	15,223	15,476	Achieved	
The standardised intervention rate for elective services	308	302[16]	Achieved	The rate is not significantly different to target due to confidence intervals.
The percentage of "DNA" (did not attend) patients Māori	14%	12%	Achieved	
Pacific	17%	12%	Achieved	
The percentage of births in primary maternity facilities[17]	>9.3%	9.6%	Achieved	
The percentage of births by caesarean section	<30%	31.1%	Not achieved	Progress on reduction on the caeserean section rate has been slower than desirable, and work is underway to target improvement in this area. CCDHB's performance is consistent with peer DHBs.
The percentage of mothers exclusively breastfeeding on discharge	75%	79.3%	Achieved	
The median postnatal length of stay for primiparous women discharged home after normal delivery	> 1 day 17.4 hours	1 day 20.5 hours	Achieved	
The percentage of long term mental health clients who have up-to-date relapse prevention plans	95%	84%	Progress towards target	Progress has been made on this measure in 2011/12, increasing 14% from the 2010/11 result of 70%.

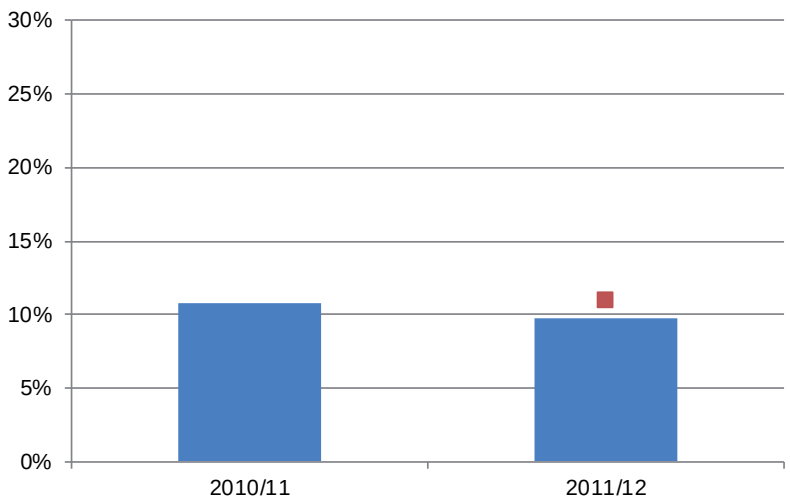
16 Data is for the year to December 2011. The lower confidence interval is 295 and the upper confidence interval is 309.

17 Data for maternity measures is for the 2011 calendar year, aligned with the Women's Health Service Annual Clinical report.

Output Class: Rehabilitation and Support Services

Rehabilitation and 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 CCDHB is three fold, 1) to work cross-sectorally to ensure that disability needs are met as part of CCDHB health (business as usual) services 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 3) To better understand from a population health perspective the specific health needs linked to impairment to inform a population health strategy to improve the health of disabled people particularly those under 65.		
Number of CCDHB staff receiving disability awareness training sessions Target: 1000	The number of staff who received first stage disability responsiveness training was 870. The target of 1000 was not achieved because: -The educator role was vacant for 9 months -Emphasis is being placed on integration of disability responsiveness into clinical areas which reduces the number of staff included in the result. Future targets are focussed in numbers of disciplines including disability as an optional or mandatory core competency.	Progress towards target 870
Percentage of DHB workforce identifying as having a disability Target: >2.5%	The percentage of DHB workforce identifying as having a disability as at 30 June 2012 was 1.3%. The current measure is difficult to use for determining the actual number of workforce having a disability as many staff do not wish to identify. The disability question has now been framed in a supportive way and a disability clause has been implemented into all HR policies. In order to encourage safe disclosure of disability, plans are in place to allow anonymous reporting to measure the work force more accurately.	Not Achieved 1.3%
Number of GP practice accessibility audits Target: 12	CCDHB 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 2011/12 shifted to mental health service providers. 24 mental health services 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 24

Performance Measure	Performance Result	Target Achievement
Health and Support Services for Older People – In 2003 responsibility was devolved to CCDHB 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. CCDHB 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. CCDHB 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 Māori 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		
The proportion of people over 65 who are supported to remain in their own homes and communities Target: >11%	 The new model and contracts for Home & Community Support Services were implemented during the 2011/12 year. This change has resulted in improvements such as timely reviews and reassessments of client supports in their homes and had lead to a decrease in overall numbers of clients receiving services. This approach is in line with CCDHB's intention to provide services and resources to people in the community with more complex support requirements, allowing those people to remain safely in their own homes for as long as possible, with appropriate support.	**Not Achieved** 10%

Measure	Target	Performance	Achievement	Comment
Rate per 100 of hospitalisation for falls for people aged 65+ years	<5.8	3.84	Achieved	Data sources have changed since the target was set for this measure; the data is now run by the DHB as it was removed as a performance measure to the Ministry of Health.
The number of needs assessments completed	5,000	4,342	Not Achieved	Data sources for reporting on assessments have changed since the target was set for this measure. All clients are assessed using the interRAI assessment tools; data for which is now reported via the national interRAI datawarehouse. The development of the datawarehouse means there is a consistent national data source for analysing and reporting interRAI data.
The number of clients receiving community package of care services	>3,805	3,275	Not Achieved	Improved allocation of resources to clients was introduced in 2011/12, better targeting those with complex needs.
The number of respite days	6,500	6,048	Progress towards target	This has increased from 5,104 in 2010/11.
The number of rest home level bed days	<135,000	132,528	Achieved	
The percentage of residential care providers meeting three year certification standards	80%	84%	Achieved	

Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of the Capital and Coast District Health Board's financial statements and statement of service performance for the year ended 30 June 2012.

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 80 to 120, that comprise the statement of financial position as at 30 June 2012, 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 55 to 77.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 80 to 120:
  - comply with generally accepted accounting practice in New Zealand; and
  - fairly reflect the Health Board's:
    - financial position as at 30 June 2012; 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 55 to 77:
  - complies with generally accepted accounting practice in New Zealand; and
  - fairly reflects the Health Board's service performance for the year ended 30 June 2012, 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 29 October 2012. 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

Matters relating to the electronic presentation of the audited financial statements and statement of service performance.

This audit report relates to the financial statements and statement of service performance of the Capital and Coast District Health Board (the Health Board) for the year ended 30 June 2012 included on the Health Board's website. The Board is responsible for the maintenance and integrity of the Health Board's website. We have not been engaged to report on the integrity of the Health Board's website. We accept no responsibility for any changes that may have occurred to the financial statements and statement of service performance since they were initially presented on the website.

The audit report refers only to the financial statements and statement of service performance named above. It does not provide an opinion on any other information which may have been hyperlinked to or from these financial statements and statement of service performance. If readers of this report are concerned with the inherent risks arising from electronic data communication they should refer to the published hard copy of the audited financial statements and statement of service performance and related audit report dated 29 October 2012 to confirm the information included in the audited financial statements and statement of service performance presented on this website.

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

Financial Statements

STATEMENT OF COMPREHENSIVE INCOME
For the year ended 30 June 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Revenue	1	919,322	893,880	885,332
Total income		**919,322**	**893,880**	**885,332**
Clinical supplies		104,089	87,817	98,406
Employee benefit costs	2	369,785	368,689	351,029
Infrastructure and non-clinical expenses		48,032	48,409	48,368
Other operating expenses	3	4,306	6,402	13,212
Outsourced services		23,386	16,262	22,330
Payments to non-health board providers		318,636	314,232	310,795
Capital charge	4	9,629	9,464	8,807
Finance costs	5	19,763	22,566	20,821
Depreciation and amortisation expense	6,7	41,642	40,068	43,151
Total expenses		**939,268**	**913,909**	**916,919**
Surplus/(deficit) for the year		**(19,944)**	**(20,029)**	**(31,587)**
Other comprehensive income				
Revaluation reserve movement		-	-	**(4,756)**
Other comprehensive income for the year		**-**	**-**	**(4,756)**
Total comprehensive income for the year		**(19,944)**	**(20,029)**	**(36,343)**

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 2012
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 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 of the year	-	(2,248)	(2,508)	(31,587)	(36,343)
Balance at 30 June 2011	**424,716**	**22,021**	**-**	**(292,511)**	**154,226**
Balance at 1 July 2011	424,716	22,021	-	(292,511)	154,226
Contribution from the Crown	423	-	-	-	423
Repayment of equity	(3,484)	-	-	-	(3,484)
Restatement plant & equipment, furniture & fittings	-	-	-	-	-
Total comprehensive income for the year	-	-	-	(19,944)	(19,944)
Balance at 30 June 2012	**421,655**	**22,021**	**-**	**(312,455)**	**131,221**

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 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Assets				
Current assets				
Cash and cash equivalents	11	252	6,930	14,881
Trade and other receivables	10	39,789	36,112	30,346
Inventories	8	6,775	6,751	6,339
Trust and special funds	12	7,634	7,933	7,728
Total current assets		**54,450**	**57,726**	**59,294**
Non-current assets				
Property, plant and equipment	6	534,291	545,642	547,835
Intangible assets	7	12,391	21,024	11,121
Investments in joint ventures	9	700	-	-
Total non-current assets		**547,382**	**566,666**	**558,956**
Total assets		**601,832**	**624,392**	**618,250**
Equity				
Crown equity		421,655	449,748	424,716
Revaluation reserve		22,021	24,595	22,021
Retained earnings/(losses)		(312,455)	(328,627)	(292,511)
Total equity		**131,221**	**145,716**	**154,226**
Liabilities				
Current liabilities				
Trade and other payables	16	69,210	72,706	65,130
Borrowings	13	153,278	28,045	108,276
Employee entitlements	14	54,451	57,188	51,434
Provisions	15	323	3,148	1,007
Patient and restricted funds	17	161	-	167
Total current liabilities		**277,423**	**161,087**	**226,014**
Non-current liabilities				
Borrowings	13	186,261	311,816	231,540
Employee entitlements	14	6,658	5,773	6,116
Provisions	15	269	-	354
Total non-current liabilities		**193,188**	**317,589**	**238,010**
Total liabilities		**470,611**	**478,676**	**464,024**
Total equity and liabilities		**601,832**	**624,392**	**618,250**

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 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2012 Budget	2011 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		874,469	866,883	841,578
Other receipts		36,814	30,498	24,674
Cash paid to suppliers		(501,824)	(476,931)	(488,222)
Cash paid to employees		(366,226)	(362,975)	(348,568)
Cash *generated from operations*		**43,233**	**57,475**	**29,492**
Goods and Services Tax &and other taxes (a)		4,146	(500)	(2,388)
Capital charge paid		(10,605)	(10,865)	(9,057)
Net cash flows from operating activities	11	**36,774**	**46,110**	**18,047**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		-	-	3,300
Interest received		1,729	911	1,115
Acquisition of property, plant and equipment		(23,297)	(32,237)	(31,173)
Acquisition of intangible assets		(6,124)	(11,227)	(264)
Investment in joint venture		(700)	-	-
Appropriation from trust and special funds (b)		89	-	(334)
Net cash flows from investing activities		**(28,303)**	**(42,553)**	**(27,356)**
Cash flows from financing activities				
Proceeds from equity injection		423	20,029	45,908
Borrowings raised		-	-	-
Repayment of equity		(3,484)	(3,484)	(3,484)
Repayment of finance leases		(276)	-	(279)
Interest paid		(19,763)	(20,891)	(20,823)
Net cash flows from financing activities		**(23,100)**	**(4,346)**	**21,322**
Net increase/(decrease) in cash and cash equivalents		(14,629)	(789)	12,013
Cash and cash equivalents at beginning of year		14,881	15,652	2,868
Cash and cash equivalents at end of year	11	**252**	**14,863**	**14,881**

(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 and special funds in investing activities reflects the net of trust and 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 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2011 Actual
Legal proceedings against the DHB		425	1,603
Other contractual matters		885	649
		1,310	**2,252**

The DHB has been notified of 6 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2012 (2011: 4).

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 (2011: $nil).

STATEMENT OF COMMITMENTS
As at 30 June 2012
in thousands of New Zealand dollars

	Note	2012 Actual	2011 Actual
Capital commitments		**1,642**	**12,839**
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,766	2,407
One to two years		1,148	1,905
Two to five years		426	986
Over five years		-	-
		4,340	**5,298**

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

Statement of Accounting Policies

Reporting entity

Capital & Coast District Health Board (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

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

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

Basis of preparation

The financial statements for the year ended 30 June 2012 were approved by the Board on 28 October 2012.

The financial statements have been prepared for the period 1 July 2011 to 30 June 2012. Comparative figures and balances relate to the period 1 July 2010 to 30 June 2011.

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.

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.

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 and resulting rates 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 2012, indirect costs accounted for 1.48% of the DHB's total costs (2011: 1.47%).

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.

in thousands of New Zealand dollars

1 Revenue

	Note	2012 Actual	2011 Actual
Ministry of Health contract funding		690,688	650,277
Other government		16,129	15,709
Inter district flows (other DHBs)		182,784	168,899
Non government & crown agency sourced		27,992	26,990
Reversal of impairment previously recognised		-	17,433
Restatement plant & equipment, furniture & fittings		-	4,909
Interest income		1,729	1,115
		919,322	885,332

2 Employee benefit costs

	2012 Actual	2011 Actual
Direct staff costs (excluding increases in employee benefit provisions)	345,094	330,951
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	13,776	11,993
Contributions to defined contribution plans	7,493	7,042
Increase/(decrease) in employee benefit provisions	3,422	1,043
	369,785	351,029

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

3 Other operating expenses

		2012 Actual	2011 Actual
Impairment of trade receivables (bad debts)		1,404	2,682
Increase /(decrease) in provision of trade receivables (doubtful debts)	10	(768)	(713)
(Gain)/loss on disposal of property, plant and equipment		52	7,990
Audit fees for financial statement audit		194	190
Board member fees	20	371	387
Rental and other operating expenses		3,053	2,676
		4,306	13,212

4 Capital charge

	2012 Actual	2011 Actual
The DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance. The capital charge rate for the period ended 30 June 2012 was 8 per cent (2011: 8 per cent)	9,629	8,807

5 Finance costs

	2012 Actual	2011 Actual
Interest on bank overdraft	2	31
Interest on bank loan	1,275	1,171
Interest on term borrowings	18,433	19,548
Interest on finance leases	53	71
	19,763	20,821

in thousands of New Zealand dollars

6 Property, plant and equipment

	Freehold land	Freehold buildings	Lease improvements	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Cost							
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
Balance at 1 July 2011	24,114	446,151	2,694	66,433	34,407	14,449	588,248
Additions	-	4,797	-	9,208	4,061	28,440	46,506
Disposals	-	-	-	(479)	(90)	-	(569)
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(23,400)	(23,400)
Restatement plant & equipment, furniture & fittings	-	-	(2,324)	(5,726)	(3,691)	-	(11,741)
Transfer between categories	6	828	-	(47)	16	(828)	(25)
Balance at 30 June 2012	24,120	451,776	370	69,389	34,703	18,661	599,019
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	-	-	-	-	-	-	-
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

in thousands of New Zealand dollars

6 Property, plant and equipment (continued)

	Freehold land	Freehold buildings	Lease Improve-ments	Plant & Equip-ment	Furniture & Fittings	Work in progress	Total
Depreciation and impairment losses							
Balance at 1 July 2011	-	(1,980)	(2,335)	(20,099)	(15,971)	(28)	(40,413)
Depreciation charge for the year	-	(21,976)	(128)	(9,185)	(5,119)	-	(36,408)
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	277	71	-	348
Revaluations	-	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	3	2,325	5,726	3,691	-	11,745
Transfer between categories	-	(28)	-	(1,016)	1,016	28	-
Balance at 30 June 2012	-	(23,982)	(138)	(24,297)	(16,312)	-	(64,728)
Carrying amounts							
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
At 1 July 2011	24,114	444,171	359	46,334	18,436	14,421	547,835
At 30 June 2012	24,120	427,795	232	45,092	18,391	18,661	534,291

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 to be 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 2012 net revaluation losses of $20.4m are is to be carried forward to future years.

Borrowing Costs

The total amount of borrowing costs capitalised during the year ended 30 June 2012 was $nil (2011: $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 $0.5m (2011:$0.8m).

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $18.7m (2011: $14.4m) which includes $14.3m (2011:$3.2m) of refurbishment of existing buildings.

in thousands of New Zealand dollars

7 Intangible assets

	Software	Licences	Total
Cost			
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
Balance at 1 July 2011	18,901	1,986	20,887
Additions	5,596	873	6,469
Disposals	-	(26)	(26)
PP&E restatement	(70)	(324)	(394)
RevaluationsTransfer between categories	25	-	25
Balance at 30 June 2012	24,452	2,509	26,961
Amortisation and impairment losses			
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)
Balance at 1 July 2011	(8,498)	(1,269)	(9,767)
Amortisation charge for the year	(5,017)	(216)	(5,234)
Impairment losses	-	-	-
Disposals	-	24	24
PP&E restatement	82	324	406
Transfer between categories	-	-	-
Balance at 30 June 2012	(13,433)	(1,137)	(14,570)
Carrying amounts			
At 1 July 2010	15,609	312	15,921
At 30 June 2011	10,404	717	11,121
At 1 July 2011	10,404	717	11,121
At 30 June 2012	11,018	1,373	12,391

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

	2012 Actual	2011 Actual
Pharmaceuticals	1,435	1,206
Surgical & medical supplies	5,111	4,983
Other supplies	229	150
	6,775	6,339

The amount of inventories recognised as an expense during the year ended 30 June 2012 was $52.2m (2011: $50.8m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2011: $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

Carrying amount of investments in joint ventures

	2012 Actual	2011 Actual
Uncalled ordinary share capital	-	-
Advance on redeemable preference shares	700	-
	700	-

Central Region Technical Advisory Services (CRTAS) has a total ordinary share capital of $600 of which the DHB share is $100. At balance date all ordinary share capital remains uncalled.

As at 30 June 2012, a further investment in CRTAS includes an advance, for the acquisition of Class B Redeemable Preference Shares. The advance will convert to Redeemable Preference Shares after all terms of the issue, compliance with the applicable law and any requirements of the Ministry of Health are complied with.

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

	2012 Actual	2011 Actual
Non-current assets	238	30
Current assets	1,149	146
Non-current liabilities	-	-
Current liabilities	1,212	52
Net assets/(liabilities)	175	124
Income	1,934	696
Expense	1,882	676
	52	20

Owing to the minor nature of the joint venture, no results are recorded in the DHB's financial statements.

The DHB's share in contingent liabilities
Central Region TAS has no contingent liabilities. (2011: $nil)

The DHB's share in commitments
The DHB share of Capital Commitments for CRTAS is $nil1 (2011: $nil).

in thousands of New Zealand dollars

10 Trade and other receivables

	2012 Actual	2011 Actual
Trade receivables from non-related parties	4,030	7,036
Ministry of Health receivables	19,731	10,941
	23,761	17,977
Accrued income	12,072	10,552
Prepayments	3,956	1,817
	39,789	30,346

Trade receivables are shown net of a provision for doubtful debts amounting to $0.9m (2011: $1.7m)

The carrying value of receivables approximates their fair value.

As at 30 June 2012, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2012			2011		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	22,153	-	22,153	16,577	-	16,577
Past due 1-30 days	914	-	914	342	-	342
Past due 31-60 days	150	-	150	291	-	291
Past due 61-90 days	302	-	302	116	-	116
Past due > 91 days	1,124	882	242	2,301	1,650	651
Total	24,642	882	23,761	19,627	1,650	17,977

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:

	2012 Actual	2011 Actual
Balance at 1 July 2011	1,650	2,363
Additional provisions made during the year	372	777
Provisions reversed during the year	-	-
Receivables written-off during period	(1,140)	(1,490)
Balance at 30 June 2012	882	1,650

in thousands of New Zealand dollars

11 Cash and cash equivalents

	2012 Actual	2011 Actual
Petty cash	13	13
Bank accounts	102	5,568
Call deposits	137	9,300
	252	14,881

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. The funds are not included in the above balances.

Bank facility

Capital & Coast DHB is party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts daily and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum working capital facility limit for CCDHB is $40.2m.

The DHB previously had a working capital facility supplied by ASB Bank Limited, which was established in October 2004. The facility consisted of a bank overdraft with a limit of $25m. The ASB working capital facility was secured by a negative pledge. This facility was cancelled in April 2012.

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

	2012 Actual	2011 Actual
Surplus/(deficit) for the year	(19,944)	(31,587)
Add back non-cash items:		
Depreciation & amortisation	41,641	43,151
Revaluation gain	-	(17,433)
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	52	3,081
Interest income on financial assets	(1,729)	(1,115)
Add back items classified as financing activity:		
Interest expense on financial liabilities	19,763	20,821
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(9,443)	4,191
(Incvrease)/decrease in trust and special funds	94	(345)
(Increase)/decrease in inventories	(436)	67
Increase/(decrease) in trade and other payables	3,986	(5,321)
Increase/(decrease) in employee benefits	3,559	2,461
Increase/(decrease) in provisions	(769)	76
Net movement in working capital	6,434	1,129
Net cash inflow/(outflow) from operating activities	36,774	18,047

in thousands of New Zealand dollars

12 Trust and 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 special funds are held in bank accounts that are separate from the DHB's normal banking facilities.

Non patient funds	2012 Actual	2011 Actual
Balance at 1 July 2011	7,577	7,242
Monies received	1,538	2,264
Interest received	303	266
Payments made	(1,928)	(2,195)
Balance at 30 June 2012	7,490	7,577
Patient funds		
Balance at 1 July 2011	151	141
Monies received	231	239
Interest received	22	2
Payments made	(240)	(231)
Balance at 30 June 2012	144	151
Total trust and special funds	7,634	7,728

13 Interest bearing loans and borrowings

	2012 Actual	2011 Actual
Current		
Secured CHFA loans	125,000	80,000
Secured bank loans	28,000	28,000
Finance leases	278	276
	153,278	108,276
Non-current		
Secured CHFA loans	186,000	231,000
Finance leases	261	540
	186,261	231,540

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

Interest rate summary	2012 Actual	2011 Actual
Crown Health Financing Agency	3.16% - 7.13%	5.16% - 7.13%
Bank loan	4.54%	3.18% - 4.54%
Finance leases	6.50%	6.50%

in thousands of New Zealand dollars

13 Interest bearing loans and borrowings (continued)

Loans repayable as follows:	2012 Actual	2011 Actual
Within one year	153,000	108,000
One to two years	-	70,000
Two to five years	124,000	99,000
Later than five years	62,000	62,000
	339,000	339,000

Analysis of finance leases	2012 Actual	2011 Actual
Minimum lease payments payable		
Within one year	313	329
One to two years	270	313
Two to five years	9	279
Later than five years	-	-
Total minimum lease payments	592	921
Future finance charges	(53)	(105)
Present value of minimum lease payments	539	816
Present value of minimum lease payments payable		
Within one year	294	309
One to two years	238	276
Two to five years	7	231
Later than five years	-	-
Total present value of minimum lease payments	539	816

Term loan facility limits	2012 Actual	2011 Actual
Crown Health Financing Agency	311,000	311,000
Bank loan	28,000	28,000
	339,000	339,000

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.

in thousands of New Zealand dollars

14 Employee entitlements

	2012 Actual	2011 Actual
Current liabilities		
Liability for long service leave	1,730	1,711
Liability for sabbatical leave	290	240
Liability for retirement gratuities	786	830
Liability for annual leave	33,001	31,835
Liability for sick leave	1,673	1,734
Liability for continuing medical education leave and expenses	8,348	7,822
Salary and wages accrual	8,623	7,262
	54,451	51,434
Non-current liabilities		
Liability for long service leave	3,724	3,399
Liability for sabbatical leave	421	383
Liability for retirement gratuities	2,513	2,334
	6,658	6,116

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 3.5%, (2011: 3.0%) and a discount rate ranging from 2.28% to 6.00% (2011: 3.09% to 6.14%) from 1-10+ years.

15 Provisions

	2012 Actual	2011 Actual
Current provisions		
ACC Partnership Programme	323	307
Provision for demolition	-	700
	323	1,007
Non current provisions		
ACC Partnership Programme	269	354

ACC Partnership Programme	2012 Actual	2011 Actual
Undiscounted amount of claims at balance date	489	562
Discount	21	34
Central estimate of present value of future payments	533	596
Risk margin	59	65
	592	661

in thousands of New Zealand dollars

15 Provisions (continued)

The movement in provisions is represented by:

	ACC Partnership Programme
2011	
Balance at 1 July 2010	1,285
Additional provisions during the year for the risks borne in current period	302
Decrease 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)

	ACC Partnership Programme
2012	
Balance at 1 July 2011	661
Additional provisions during the year for the risks borne in current period	270
Additional provisions relating to a reassessment of risks in a previous period	28
Subtotal	959
Amounts used during the year	367
Total liability	592
(Decrease) / increase in provision	(69)

ACC Partnership Programme

The 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

in thousands of New Zealand dollars

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 3.0% for the year ending 30 June 2012. A discount rate of 3.5% has been used for the year ended 30 June 2012.

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.

16 Trade and other payables

	Note	2012 Actual	2011 Actual
Trade payables to other related parties	20	6,731	3,940
Trade payables to non-related parties		5,371	4,973
GST and other taxes payables		13,558	9,412
Income in advance		914	554
Capital charge due to the Crown		-	976
Other non trade payables and accrued expenses		42,636	45,276
		69,210	65,130

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

17 Patient and restricted funds

Patient funds	2012 Actual	2011 Actual
Balance at 1 July 2011	151	141
Monies received	231	239
Interest received	2	2
Payments made	(240)	(231)
Balance at 30 June 2012	144	151

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 2012 are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as at 30 June 2012, both as an asset and a liability.

Holiday homes funds	2012 Actual	2011 Actual
Balance at 1 July 2011	63	59
Monies received	15	14
Interest received	1	1
Payments made	(10)	(11)
Balance at 30 June 2012	67	63
Hutt Valley DHB portion ¼ of holiday homes total	17	16
Total patient and restricted funds	161	167

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 Capital and Coast District Health Board, 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:

	2012 Actual	2011 Actual
Less than one year	2,766	2,407
Between one and five years	1,574	2,891
More than five years	-	-
	4,340	5,298

During the year ended 30 June 2012, $2.5m was recognised as an expense in the statement of comprehensive income in respect of operating leases (2011: $2.6m)

The DHB:

- leases a number of buildings, vehicles and items of medical equipment under operating leases.
- 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.
- leases include no contingent rentals.
- operating lease payments are recognised as an expense on a straight line basis over the term of the lease.
- leased properties are not subleased by the DHB.

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:

	2012 Actual	2011 Actual
Less than one year	145	164
Between one and five years	626	524
More than five years	1,406	1,371
	2,177	2,059

During the year ended 30 June 2012, $2.6m was recognised as rental income in the statement comprehensive income (2011: $3.4m)

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.
- 37 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 DHB 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 DHB 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 44% in 2012 (2011: 24%). 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 subject to an interest rate swap.

The only financial instrument that DHB measures at fair value in the statement of financial position is the interest rate swap. The fair value of the interest rate swap is determined using a valuation technique that uses observable market inputs (level 2).

The net fair value of the interest rate swap at 30 June 2012 was $0.2m (2011: $0.4m)

Sensitivity analysis

If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $0.02m in 2012. (2011: $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 2012, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $3.4m (2011: $4.9m). 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 $0.0002m for the year ended 30 June 2012 (2011: $0.0005m).

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.

	2012 Actual							2011 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*	3.16	55,000	55,000					6.33	55,000	55,000				
NZD fixed rate loan*	3.72	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					4.54	28,000	28,000				
Finance leases*	6.50	539	147	147	238	7	-	6.50	816	154	154	276	230	-
		339,539	83,147	70,147	238	124,007	62,000		339,816	83,154	25,154	70,276	99,230	62,000

* 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.

2012	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Creditors and other payables	69,210	69,210	69,210	-	-	-
Secured loans	339,000	391,113	169,795	11,058	146,269	63,991
Finance leases	539	592	313	270	9	-
Patient and restricted funds	161	161	161	-	-	-
Total	408,910	461,076	239,479	11,328	146,277	63,991
2011						
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

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.

2012	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Cash and cash equivalents	252	252	252	-	-	-
Debtors and other receivables	39,789	39,789	39,789	-	-	-
Trust and special funds - bank	279	279	279	-	-	-
Trust and special funds – term deposit	7,300	7,402	7,402	-	-	-
Trust and special funds – debtors	55	55	55	-	-	-
Total	47,675	47,777	47,777	-	-	-
2011						
Cash and cash equivalents	5,581	5,581	5,581	-	-	-
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	-	-	-

in thousands of New Zealand dollars

19 Financial instruments (continued)

Maximum exposure to credit risk

The DHB's maximum credit exposure for each class of financial instrument is as follows:

	2012 Actual	2011 Actual
Cash and cash equivalents	252	5,581
Debtors and other receivables	39,789	30,346
Trust and special funds – bank	279	266
Trust and special funds – term deposit	7,300	7,100
Trust and special funds – debtors	55	362
	47,675	43,655

	2012	2011
Counterparties with credit ratings		
Cash at bank and term deposits		
AA (Standard & Poor)	7,831	12,947

Debtors and other receivables mainly arise from the DHB'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 2012 was $nil (2011: $nil), comprising assets of $nil (2011: $nil) and liabilities of $nil (2011: $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 statement of comprehensive income. The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2012 was $nil (2011: $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	Carrying amount 2012 Actual	Fair value 2012 Actual	Carrying amount 2011 Actual	Fair value 2011 Actual
Trade and other receivables	10	39,789	39,789	30,346	30,046
Cash and cash equivalents	11	252	252	5,581	5,581
Secured loans	13	(339,000)	(365,951)	(339,000)	(360,586)
Finance leases	13	(539)	(592)	(816)	(921)
Trade and other payables	16	(69,210)	(69,210)	(65,130)	(65,130)
		(368,708)	(395,712)	(369,019)	(391,010)
Unrecognised (losses)/gains			(27,004)		(21,991)

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 and payables

For receivables and payables with a remaining life of less than one year, the notional amount is deemed to reflect the fair value. All other receivables and payables are discounted to determine the fair value.

Interest rates used for determining fair value

The entity uses the government bond rate as at 30 June 2012 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2012 Actual %	2011 Actual %
Derivatives	N/A	N/A
Loans and borrowings	3.16, 3.72, 4.54, 5.16, 6.075, 6.295, 6.37, 6.39, 6.57, 6.95, 7.13	4.54, 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 are related parties with the DHB's customers and suppliers:

- Dr Virginia Hope is the Chairman of Hutt Valley District Health Board. 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.
- Dr Judith Aitken and Barbara Donaldson are both members of the Greater Wellington Regional Council.
- Peter Douglas is a member of Hutt Valley District Health Board.
- Keith Hindle is a Board Member of Hutt Valley District Health Board. He is also a Consultant for the Wellington Tenths Trust and a Director of Metlifecare Palmerston North.
- Helene Ritchie and Darrin Sykes are Councillors at Wellington City Council.
- Margaret Faulkner is a trustee of Whitireia Foundation and a community representative of Social Welfare Benefit Review Committee.
- Debbie Chin is a Crown monitor for Hutt Valley District Health Board and the CEO of Standards New Zealand.

The following members of the key management personnel are related parties with the DHB's suppliers and customers:

- Cathy O'Malley is the CEO of the following suppliers, Compass Primary Health Care Network, Compass Health Wellington Trust (which includes Capital PHO, Tumai mo te Iwi, Kapiti PHO), MATPRO Ltd, She is a director of MATPRO Ltd and is also a trustee of Wellington Free Ambulance.
- Adrian Gilliland is a Clinical Tutor at The University Of Otago Wellington School of Medicine. He is also a member of the Clinical Advisory Group and a practicing GP at Ora Toa PHO.
- Bryan Betty is a Board member of Porirua Union and Community Health Service. He is also a director of Dramatic Change Pty Ltd (Australia).
- Taima Fagaloa is the director at TCF Consulting Limited.
- 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 and a board member of Health Roundtable and Technical Advisory Services.

Remuneration

Key management personnel remuneration is as follows:

	2012 Actual	2011 Actual
Short-term employee benefits	2,683	1,826
Post-employment benefits	19	15
Termination benefits	-	-
Executive team	2,702	1,841
Board members	371	387
	3,073	2,228

Key management personnel include all Board members, the Chief Executive, and the other 13 members of the executive management team.

The Board of the DHB as at 30 June 2012, 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 2012.

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 2012			**2012**	**2011**	**2012**	**2011**
Dr Virginia Hope	Elected	Board Chair from 1 Dec 2010 Chair HAC to 30 Nov 2010	50	43	6	7
Mr Peter Glensor	Appointed	Deputy Chair from 1 Dec 2010 Deputy Chair HAC from 1 Dec 2010	35	15	6	1
Dr Judith Aitken	Elected	Chair DSAC to 30 Nov 2010 Deputy Chair CPHAC from 1 Dec 2010	25	25	4	5
Mr David Choat	Elected	Member from 1 Dec 2010	25	15	3	2
Ms Barbara Donaldson	Elected	Member from 1 Dec 2010	25	15	2	1
Mr Peter Douglas	Appointed	Chair HAC from 1 Dec 2010	25	25	5	4
Ms Margaret Faulkner	Elected	Chair DSAC from 1 Dec 2010 Deputy Chair FRAC until 30 Nov 2011	25	26	6	7
Mr Keith Hindle	Appointed	Chair FRAC	24	24	5	4
Ms Helene Ritchie	Elected	Member from 2001	25	26	4	6
Mr Darrin Sykes	Appointed	Member from 1 Dec 2010	25	15	4	3
Board members who resigned/left during the year						
Dr Donald Urquhart-Hay	Elected	Passed away Aug 2011	2	25	-	2
Sir John Anderson	Appointed	Board Chair to 30 Nov 2010 Resigned 30 Nov 2010	-	21	-	-
Ms Ruth Gotlieb	Elected	Resigned 30 Nov 2010	-	10	-	1
Mr Selwyn Katene	Appointed	Resigned 30 Nov 2010 Chair CPHAC to 30 Nov 2010	-	10	-	1
Dr Peter Roberts	Elected	Resigned 30 Nov 2010	-	10	-	3
Crown monitor						
Ms Debbie Chin	Appointed	Crown Monitor	35	35	5	-
			321	340	50	47

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)	**2012**	**2011**
Community and Public Health Advisory Committee		
Herani Demuth	2	1
Tavita Filemoni	1	1
Kayleen Katene	-	1
Stephen Palmer	-	2
Api Rongo-Raea	-	1
Jack Rikihana	7	-

in thousands of New Zealand dollars

20 Related parties transactions and key management personnel (continued)	2012	2011
Disability Support Advisory Committee		
Nathan Bond	-	2
Judy Small	-	1
Hillary Stace	-	1
James Webber (from March 2011)	2	4
Hospital Advisory Committee		
Hilda Broadhurst	3	2
Malakai Jiko	1	2
Lynn McBain	2	2
Karen Coutts	4	4
	22	24

Sales to related parties - Key management personnel	2012 Actual	2011 Actual
Compass Health Wellington Trust	154	162
MATPRO Ltd	1	-
Medical Research Institute of New Zealand	104	163
Ora Toa PHO	10	12
Southern Cross Hospital	1	-
Wakefield Hospital	1	38
Wellington Free Ambulance	135	79
Wellington Hospitals & Health Foundation	685	33
	1,091	487

Purchases from related parties	2012 Actual	2011 Actual
Compass Health Wellington Trust	6,314	6,990
Compass Primary Health Care Network	43,048	42,284
Greater Wellington Regional Council	1	-
Health Partners Consulting Group Ltd	-	68
Home of Compassion	-	1
Institute of Environment Science and Research	-	10
MATPRO	119	128
Medical Research Institute of New Zealand	87	87
Metlife Care Palmerston North	1,205	-
Ora Toa PHO	3,568	3,595
Porirua City Council	-	314
Porirua Health Plus Limited	-	56
Porirua Union and Community Health Service Inc	551	817
Royal Australian College of Physicians	-	27
Southern Cross Hospital	1	-
Te Runanga O Toa Rangatira Inc	190	-
The Health Roundtable	56	-
Wakefield Hospital Limited	430	769
Well Health PHO	387	-
Wellington City Council	823	965

in thousands of New Zealand dollars

20 Related parties transactions and key management personnel (continued)

Purchases from related parties *(continued from previous page)*

	2012 Actual	2011 Actual
Wellington Free Ambulance	1,114	211
Wellington Hospitals and Health Foundation	358	10
Wellington Tenths Trust	161	-
Wesley Community Action	510	-
	58,924	56,332

Outstanding balances to related parties	2012 Actual	2011 Actual
Compass Health Wellington Trust	533	-
Compass Primary Health Care Network	377	-
MATPRO	10	-
Medical Research Institute of New Zealand	101	-
Metlife Care Palmerston North	4	-
Ora Toa PHO	59	-
Porirua Union and Community Health Service Inc	25	-
Te Runanga O Toa Rangatira Inc	180	-
Wakefield Hospital Limited	175	-
Well Health PHO	220	-
Wellington City Council	19	-
Wellington Free Ambulance	70	-
Wellington Tenths Trust	40	-
Wesley Community Action	29	-
	1,842	-

Outstanding balances from related parties – Key management personnel	2012 Actual	2011 Actual
Compass Health Wellington Trust	(42)	89
Medical Research Institute of New Zealand	33	24
Ora Toa PHO	1	2
Southern Cross Hospital	2	-
Wakefield Hospital	-	2
Wellington Free Ambulance	15	14
Wellington Hospital and Health Foundation	19	12
	28	143

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 (2011: $nil).

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.

in thousands of New Zealand dollars

20 Related parties transactions and key management personnel (continued)

Ownership

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

Significant transactions with government-related entities

The DHB has received funding from the Ministry of Health of $691m (2011: $650m) to provide services to the public for the year ended 30 June 2012.

Collectively, but not individually, significant, transactions with government-related entities

In conducting its activities, the DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

The DHB also transacts with entities controlled, significantly influenced, or jointly controlled by the Crown. These include: Inland Revenue Department, Accident Compensation Corporation, Crown Health Financing Agency, Clinical Training Agency, Pharmaceutical Services Ltd, Hutt Valley District Health Board, New Zealand Blood Service, University of Otago.

	2012 Actual	2011 Actual
Purchases from government related entities	286,153	285,690
Sales to government related entities	225,495	202,999
Outstanding balances to government related entities	21,964	15,174
Outstanding balances from government related entities	23,088	8,400

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 2012	Number of Employees 2011
100 – 110	108	87
110 – 120	47	61
120 – 130	39	45
130 – 140	43	34
140 – 150	17	23
150 – 160	17	20
160 – 170	17	18
170 – 180	11	12
180 – 190	8	21
190 – 200	13	14
200 – 210	20	12
210 – 220	16	20
220 – 230	15	15
230 – 240	20	15
240 – 250	15	17
250 – 260	18	14
260 – 270	11	4
270 – 280	16	8
280 – 290	8	7
290 – 300	11	4
300 – 310	10	3
310 – 320	7	9
320 – 330	4	4
330 – 340	6	4
340 – 350	6	2
350 – 360	4	5
360 – 370	4	2
370 – 380	-	1
380 – 390	5	1

in thousands of New Zealand dollars

21 Employee remuneration (continued)

	Number of Employees 2012	Number of Employees 2011
390 - 400	4	2
400 - 410	2	-
410 – 420	3	1
430 – 440	2	1
450 - 460	-	1
500 - 510	-	1
550 – 560	-	1
590 - 600	1	-
660 - 670	1	-
	529	489

Of the 529 employees shown above, 373 are or were medical or dental employees and 156 are or were neither medical nor dental employees. This represents an increase of 40 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 781, compared with the actual total number of 529.

22 Termination payments

During the year ended 30 June 2012, 13 (2011: 20) employees received compensation and other benefits in relation to cessation totalling $0.3m (2011: $0.5m).

No Board members (2011: nil) received compensation or other benefits in relation to cessation (2011: nil).

23 Explanation of financial variances from budget

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2012 are provided below.

Statement of comprehensive income

The DHB recorded a deficit of $19.9m compared with the budgeted deficit of $20m.

Revenue for 11/12 was greater than budget due to increased MOH and IDF revenue due to higher levels of activities.

Expenditure was higher than budget for the reasons noted below:

- Clinical supply costs were above budget due to higher levels of activity that was not budgeted for and delays in the implementation of targeted savings initiatives.
- Increased outsourced services were contracted to meet health targets

Statement of financial position

Major variances were:

- Property, plant and equipment values were lower due to lower expenditure on capital items.
- Crown equity is lower due to no draw down of deficit support

Statement of cash flows

Major variances were:

- Operating cash flows were lower due to higher payments to clinical suppliers.
- Cash outflow from investing activities is lower than budget due to lower capital expenditure.

Cash flow from financing activities is lower due to no draw down of deficit support.

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		
	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual
Revenue															
Crown	6,469	7,348	11,516	223,282	216,329	199,626	547,891	541,984	510,146	111,959	98,799	113,598	889,601	864,460	834,886
Other	-	235	-	-	6,084	65	29,722	20,394	51,461	-	2,708	-	29,722	29,421	51,526
Total revenue	**6,469**	**7,583**	**11,516**	**223,282**	**222,413**	**199,691**	**577,612**	**562,378**	**561,607**	**111,959**	**101,507**	**113,598**	**919,322**	**893,880**	**886,412**
Expenditure															
Personnel	-	-	-	-	2,921	-	366,036	364,517	347,448	3,751	1,252	3,581	369,787	368,689	351,029
Depreciation	-	-	-	1	-	2	41,640	40,068	43,148	-	-	-	41,641	40,068	43,150
Capital charge	-	-	-	-	-	-	9,629	10,864	8,807	-	-	-	9,629	10,864	8,807
Provider payments	6,050	7,468	11,063	187,274	184,377	163,145	37,123	36,796	35,739	88,189	85,590	100,848	318,636	314,231	310,795
Other	419	-	469	36,008	35,483	36,734	142,554	129,753	157,695	20,593	14,822	9,320	199,574	180,058	204,218
Total expenditure	**6,469**	**7,468**	**11,532**	**223,283**	**222,781**	**199,881**	**596,982**	**581,998**	**592,837**	**112,533**	**101,663**	**113,749**	**939,267**	**913,910**	**917,999**
Net surplus/ (deficit)	**-**	**115**	**(16)**	**(1)**	**(368)**	**(190)**	**(19,369)**	**(19,620)**	**(31,230)**	**(573)**	**(156)**	**(151)**	**(19,944)**	**(20,029)**	**(31,587)**

in thousands of New Zealand dollars

25 Summary revenue and expenses by output class (continued)

	Prevention services	Early detection and management	Intensive assessment and treatment	Rehabilitation and support	Total DHB
Revenue					
Crown	8,516	175,275	603,276	102,534	889,601
Other	-	-	29,722	-	29,722
Total revenue	**8,516**	**175,275**	**632,997**	**102,534**	**919,322**
Expenditure					
Personnel	-	-	366,036	3,751	369,787
Depreciation	-	1	41,640	-	41,641
Capital charge	-	-	9,629	-	9,629
Provider payments	8,004	154,682	70,312	85,638	318,636
Other	513	20,594	164,750	13,718	199,574
Total expenditure	**8,516**	**175,277**	**652,366**	**103,107**	**939,267**
Net surplus/(deficit)	**-**	**(1)**	**(19,369)**	**(573)**	**(19,944)**

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 or Intensive assessment and treatment.

For 2011-12 the description of the four output classes were changed to better reflect the nature of the service provided. The expenditure by output class for 2011-12 has used the original description for comparison to prior year actual and budget in addition to the new description for 2011-12 actual expenditure.

The above tables show the consolidation of service statements for each output class.

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual	2012 Actual	2012 Budget	2011 Actual
Opening balance	(274,642)	(292,683)	(246,287)	(18,338)	(18,076)	(18,950)	469	2,161	4,313	(292,511)	(308,598)	(260,924)
Surplus/(deficit) for the year	(10,599)	(9,972)	(28,355)	574	(1)	612	(9,919)	(10,056)	(3,844)	(19,944)	(20,029)	(31,587)
Closing balance	**(285,241)**	**(302,655)**	**(274,642)**	**(17,764)**	**(18,077)**	**(18,338)**	**(9,450)**	**(7,895)**	**469**	**(312,455)**	**(328,627)**	**(292,511)**

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 2011/12 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 25 September 2012 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. Based on the Letter of Comfort, the Board is confident that the equity injections in 2012/13 year related to operating cash flows will be forthcoming if required.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next 3 years prepared by the DHB 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.

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA