Capital & Coast DHB Annual Report 2013/2014

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

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

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PHOTOS: Thanks to clinical photographer Louise Goossens and the communications team.
Cover photo: Hania Street Clinics' new mural - see page 60.

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Capital & Coast District Health Board
Ūpoko ki te uru hauora

BETTER HEALTH AND INDEPENDENCE FOR PEOPLE, FAMILIES AND COMMUNITIES

A Day in the Life...

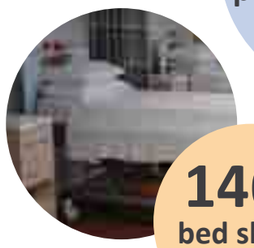
6500 prescriptions are filled in the community

4300 lab tests are done in the community

800 people visit a practice nurse

2800 people visit their GP

10 babies are born



99 people get their eyes tested

350 people get a Radiology procedure

1469 bed sheets are used

4890 bath towels are used

1749 cups of tea made

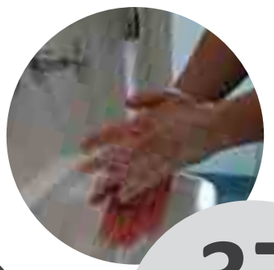
101 apples are eaten

333 eggs are cracked

158 bananas peeled

192 people are admitted to our hospital

35 babies are in NICU



37 litres of hand soap lathered

157 people go to the Emergency Department

Debbie Chin, Interim Chief Executive and Dr Virginia Hope, Board Chair

Message from the Chair and CEO

Much has been achieved over the past year and it is a pleasure to report on another year of excellent performance.

The year ended on a high note with the announcement we had achieved the shorter and safer stays, and Emergency Department target for the first time. Achieving this target has been a long-term focus for us and highlights the hard work of all our staff, from doctors, nurses, and allied health staff to cleaners, orderlies and administrators. By working together we have been able to make changes across the organisation so we work smarter, use our resources more wisely, and improve patient care.

Improving the quality of patient care has been central to every initiative and investment we make. Some of the highlights over the past year include:

- Opening a new $5 million satellite dialysis unit at Keneperu Hospital. The 24-station unit replaces a nine-station unit and will meet growing demand in the region for this life-saving treatment.
- Opening the Surgical Assessment and Planning Unit at Wellington Hospital to streamline how we care for patients who urgently require surgery. The 10-bed unit also serves as a short stay area for other surgical specialities.
- Reducing how long patients wait for elective surgery, such as hip and knee replacements. In addition to reducing waiting times, the elective surgery team also delivered an additional 226 operations in 2013/14, which again exceeded our elective surgery discharge target.

We also achieved this year's national immunisation target for children, with 93 percent of eight-month-olds having had their primary course of immunisation at six weeks, three months, and five months. However, the target is now 95 percent for the next quarter, so there is still work ahead of us to ensure we are giving young people the best possible start in life.

CARE CLOSER TO HOME

We need to continue to work closely with community based health services to come up with new and innovative ways to deliver health services. As our ageing population grows, demand on services will increase. Frail elderly represent approximately 2.4 per cent of our population but make up 75 per cent of acute medicine bed days in hospital. We need to keep focusing on ensuring people get the right care as close to home as possible.

Collaboration with community based health services, such as general practices, community pharmacists and home support is key to this new approach. Our strong links with these organisations enable us to improve patient care.

We have begun work on developing health pathways to provide Primary Health Organisations across the greater Wellington region with quick access to information about how to best manage common health conditions such as obesity, dementia and cellulitis in the community, and how and when to refer a patient with these conditions to hospital. This work will continue to be a priority for us in the coming year.

There has been a lot of work done to improve the way we care for our elderly patients. We want to ensure patients who would benefit most from geriatrician care are admitted to the hospital without delay, and that inpatient admission is actively managed to reduce unnecessary lengthy admissions, which can cause increased risk to vulnerable elderly patients. Health professionals from the hospital and community are also working more closely together to ensure a patient continues to receive the care and support they need once they return home.

We are continuing to invest in large community projects including aged residential care improvements, introduced the Shared Care Record so medical records are shared amongst health professionals working in the community and hospital, and developed better ways to support people with diabetes.

This focus will continue in the coming year as we look at smarter uses of modern technology to provide more proactive, community-based, individualised health care.

WORKING WITH OUR NEIGHBOURS

Part of our new approach to delivering health services has seen us build stronger relationships with our neighbouring district health boards, Hutt Valley and Wairarapa. For the past two years, the sub-regional Clinical Leadership Group has progressed integrated activity in a number of specialties including Ear, Nose and Throat, Gastroenterology, Child Health, and Palliative Care. We have also created a single laboratory across Hutt Valley and CCDHB, and are progressing a single Mental Health, Addictions, and Intellectual Disability directorate for the sub-region.

Done right, all three Boards firmly believe that greater integration will remove many of the artificial boundaries and barriers that hamper effective health care delivery, which at times frustrates both patients and clinical staff alike. It will lead to better use of human resources in the form of our experienced and capable staff, and help ease the financial pressures we are all experiencing as we create services that are sustainable. Most importantly, we believe this partnership approach will make a material difference to fundamentals such as reducing waiting times and providing better and equitable access to diagnostic and elective services.

Looking forward, 2014/15 will bring its own challenges and opportunities as we continue to drive service improvements and put our services on a more sustainable footing.

We would like to thank the Board, staff, and our community partners for their continued support and commitment to the people of the region. We recognise that all these achievements are part of a wider change in our approach to change the way we do things, so that we can deliver a more sustainable, safer and more convenient patient journey for the people of our region. We believe that we are on track and focussed on delivering first-rate health services.

Dr Virginia Hope MNZM, Chair

Debbie Chin, Interim CEO

Vicky Noble, Director of Nursing, Primary Health Care and Integrated Care, Dr Geoff Robinson, Chief Medical Officer, Andrea McCance, Director of Nursing and Midwifery and Christine King, Associate Director of Allied Health, Scientific and Technical.

Message from the Professional Heads

The last year has been busier than ever, with significant activity undertaken across a range of services. The focus continues to rest on enabling seamless care for patients, recognising that patients today require support from a multitude of different services and health professionals.

We realise for patients it is about receiving the right care, at the right time and in the right place. This continues to be the focus and challenge for us all in delivering services that meet the needs of our patients and communities.

In that sense we have been governed by the patient mantra: 'no decisions about me without me', and we believe patients should be able to answer the following questions:

- What is wrong with me?
- What is going to happen today and tomorrow?
- What needs to be achieved to get me back on 'track' (back to work, home, restart sports etc.)?
- When is this going to happen?

We are also actively managing inpatient admission to reduce treatment delays and length of hospital admission overall. Inspired by a visit from geriatrician and NHS advisor Dr Ian Sturgess, this approach recognises that shorter patient journeys are safer, as well as being more convenient for patients. The length of hospital admissions has decreased accordingly, particularly in internal medicine.

To ensure that our focus on quality and safety is retained alongside these changes, we have also refined our clinical indicators, so that we can measure the impact of these changes by comparing variables like re-admission rates, surgical harm or reported medication incidents.

These changes have also supported the Health Quality & Safety Commission campaigns, which have targeted key areas including inpatient falls, healthcare-associated infections and hand-hygiene compliance.

To ensure the seamless aspect of patient care, we have embarked on the 3DHB Health Pathways project with our primary care partners, alongside Wairarapa and Hutt Valley DHBs.

Primary and secondary care clinicians are now working in partnership on the development of 'care pathways', which describe the best agreed-upon route for the patient to take as they move from primary care through the health system. By standardising clinical practice and the best way to access it, we expect to see significant gains for the patient and health organisations alike.

Similarly, the Alliance Leadership Team consisting of Primary Health Organisation (PHO) and DHB staff has also embedded a 'whole of system' approach to health across the lower North Island.

Evidence of this approach in action includes the Nursing Practice Partnership (NPP) which was piloted at Karori Medical Centre. Pairing the expertise of hospital-based

diabetes nurse specialists with practice nurses in the GP setting, the NPP model enables practice nurses to manage their patients' care closer to home. A similar model is also in progress with aged residential care nurses to support the care of frail elderly and complex patients.

In the meantime, Service Level Alliances have been set up in areas such as Child Health and Laboratory Services, where we have identified that working collaboratively can deliver better services more quickly to our patients.

This year has also seen the coming together of the Māori Health Service and Mental Health, Addictions and Intellectual Disability Service directorates, respectively.

With all this activity underway, we must acknowledge the commitment and professionalism of our staff across all directorates and vocations. The partnerships across teams and services have enabled these gains for patients and we continue to look for opportunities to acknowledge our workforce.

Long service and the value of improvement work by individuals and teams across the DHB were recognised with this year's Staff Recognition Awards and the annual Quality Awards.

Looking more specifically, we had the inaugural 3DHB Allied Health, Technical & Scientific Awards this year, which recognises the key role Allied Health professions play in healthcare delivery alongside our annual Nursing and Midwifery Awards.

The on-going commitment to training our workforce; both present and future, remains a key driver to our success. As a teaching hospital, our commitment to research and to training a wealth of undergraduate and post graduate students is well established.

We have strong links across the organisation into each of the four universities and polytechnics in and around Wellington, as well as across New Zealand.

The Professional Heads 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 we all practice safe, high quality, and effective healthcare. Together we are contributing to, implementing, and in some cases, driving international best practice for health care.

About CCDHB

We receive 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 primary health organisations, general practices, primary care practices/ services, non-governmental organisations, rest homes, dentists, pharmacists, and Māori and mental health providers) or providing the services directly (such as hospital services).

Currently just over 300,000 people live within the Capital & Coast district, with two thirds of the population in Wellington City, 18% in Porirua and 14% on the Kāpiti Coast.

The DHB must assess the health status of the population and determine 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.

We are 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.

Our DHB operates two hospitals; Wellington and Kenepuru, supported by the Kāpiti Health Centre, a large Mental Health campus at Kenepuru and other community based services. It is a major employer in the Wellington region with about 4,200 full-time equivalent staff with an additional number working on a casual basis.

THE HEALTH OF OUR POPULATION

Our DHB is the sixth largest in New Zealand and spans three territories; Wellington City, Porirua City and part of Kāpiti Coast district. The actual combined population of these three districts is 301,510.

The people of the Wellington region enjoy, on average, better health, 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
- Kāpiti Coast has a large population aged over 65 years.

We have fewer than average Māori (11%) and a higher than average Pacific (7%) and Asian (12%) 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 10.5% by 2026 with the highest growth in Wellington and Kāpiti. 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 2014 – 2015 Annual Plan and the 2014-15 Statement of Intent.

ABOUT OUR ANNUAL REPORT

This report presents Capital & Coast District Health Board's performance for the year 1 July 2013 to 30 June 2014. 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) 2013/14, 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.

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:

- reduction of health disparities within our population
- integrated delivery of services
- improving the health of children in vulnerable communities, with a particular focus on rheumatic fever, serious skin infection and respiratory conditions
- financial and clinical sustainability
- a culture of collaboration with local and regional 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 Quality Improvement and Patient Safety.
- Governing the DHB.

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 CCDHB 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 (last held in October 2013) and four are appointed by the Minister of Health. A Crown Monitor was appointed in November 2009.

OUR OBJECTIVES AS A DHB

The objectives of DHBs are described in 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 members during induction

OUR PEOPLE

Delivering expert health care requires the right mix of trained and qualified people. In order for us to do this we work hard to attract and retain a skilled and responsive workforce that can deliver a sustainable service that looks to continually improve patient care.

A key priority for us is improving clinical workforce retention by continuing to support and grow clinical leadership, by supporting clinical governance of the patient journey across primary and secondary services.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level; controlling the growth of hospital labour costs; maintaining and where possible, improving hospital productivity: and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB continues to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. This strengthened clinical leadership was assisted through the activity of the Alliance Leadership Team, the Strategic Clinical Governance Group and involvement of clinicians in the development of collaborative service models at a sub-regional and regional level.

The Strategic Clinical Governance Group is responsible for providing clinical leadership; leading the development of clinical governance across all of the services provided by the DHB; overseeing the quality and safety of services delivered by DHB providers and the clinical quality programme; and providing advice and recommendations to the DHB Board, Chief Executive and management.

AN EMPLOYER OF CHOICE

A key value of the DHB is to be a good employer. CCDHB embraces the seven key elements of 'the Good Employer' as prescribed by the EEO Commissioner. The elements are:

- Leadership, accountability, and culture
- Recruitment, selection, and induction
- Employee development, promotion, and exit
- Flexibility and work design
- Remuneration, recognition, and conditions
- Harassment and bullying prevention
- Safe and healthy environment

A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity and we have an equal employment opportunities focus within the relevant polices. Training and development opportunities are offered to all staff, and personal performance and development plans are done annually.

Several forums are in place comprising of employees from across the CCDHB. These forums meet to consider workplace practices. Topics include health and safety, and professional practices for nursing, clerical, and administration staff.

As a good employer CCDHB values professionalism through leadership. Therefore unacceptable employee behaviour is not tolerated. This is supported by a suite of HR policies and guidelines related to discipline, performance, a code of conduct, harassment prevention, and protected disclosures.

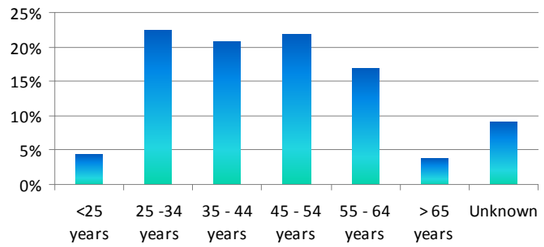
Approximately 92% of employees are covered by Collective Employment Agreements (CEA). All the CEAs have remuneration, recognition and conditions clauses. We also take a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the organisation.

The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the employee assistance programme.

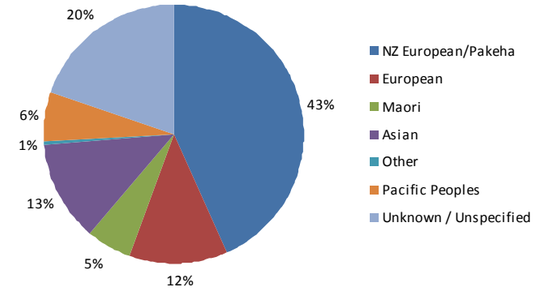
FULL TIME EQUIVALENT STAFF NUMBERS

	2014	2013	2012	2011	2010	2009
Medical	618	587.71	563.58	524.16	510.32	490
Nursing	1895	1909.99	1804.96	1789.38	1791.15	1639.69
Allied Health	767	759.87	727.11	705.54	684.84	645.75
Other	877	1011.13	958.46	957.16	968.29	971.31
Total	**4257**	**4268**	**4054**	**3976**	**3954**	**3746**

AGE PROFILE OF WORKFORCE



STATISTICS BY ETHNICITY



STATISTICS BY GENDER

	2014	2013	2012	2011	2010	2009
Female	72%	73%	73%	73%	73%	72%
Male	28%	27%	27%	27%	27%	28%

Staff and family enjoy a cup of tea after the Staff Recognition Awards - September 2013

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.

Please note: In February 2013 a joint CPHAC and DSAC was established across Wairarapa, Hutt Valley and Capital & Coast DHBs. In addition to the statuary roles, these committees are now the key mechanisms whereby the work of the Service Integration and Development Unit (SIDU), and in particular the monitoring of progress across the 3DHB work programme, take place.

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 Finance Risk and Audit Committee (FRAC) has responsibility for the overview of the Risk Management Processes, External and Internal Audit processes, and financial matters.

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

Statement of Responsibility:

FOR THE YEAR ENDED 30 JUNE 2014:

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 2014, fairly reflect the financial position and operations of Capital & Coast District Health Board.

Dr Virginia Hope MNZM, Chair
31 October 2014

Debbie Chin, Interim Chief Executive
31 October 2014

Derek Milne, Deputy Chair
31 October 2014

Tony Hickmott, Acting Chief Financial Officer
31 October 2014

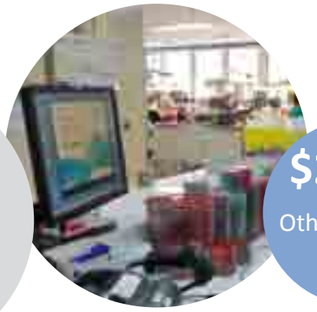
Where the money went

$254.38
HOSPITAL
Surgery, Women's & Children

$211.14
HOSPITAL
Medicine, Cancer & Community

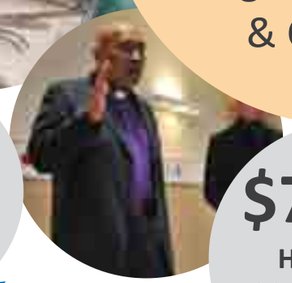
$16.35
Care Coordination and Home based Services for the Elderly

$16.80
Community Laboratories



$20.94
Other Services

$1.59
HOSPITAL
Clinical & Support Services



$78.79
HOSPITAL
Mental Health Services

$47.08
Inter-district Outflows

$18.61
Other Elderly and Disability Support Services

$54.23
Primary Health Organisations and GP Services

$13.12
Other Hospital Services

$58.07
Aged Residential Care

2013/2014 SPENDING ($M)
TOTAL $880.19

2013/2014 REVENUE ($M)
TOTAL $895.68

$63.21
Community & Pharmaceuticals

$25.88
Community Mental Health Services

$708.80
Ministry of Health

$185.10
Other DHBs

$1.78
Other Revenue

COMMUNITY HIGHLIGHTS

‘Better, Sooner, More Convenient Health Care’ is the government’s initiative to deliver more personalised primary health care services that are closer to home and improve the health of the population. With new models of funding and service delivery, Primary Health Care Services are able to reduce acute pressure on specialist services and hospitals by better managing long-term conditions and proactively supporting Māori, Pacific and high needs populations.

The Integrated Care Collaborative (ICC) programme has been developed to help deliver this by providing the best health care for our patients and population through improved experience, safety and quality of care with easy access and equity for all populations. It is an initiative between CCDHB and its primary care partners, and has been running since 2010.

URGENT COMMUNITY CARE (UCC)

Managing acute demand is one of CCDHB’s three top priorities for 2013/14. This work stream within the ICC is exploring alternative options to Emergency Department (ED) attendance and avoidance of unnecessary admissions for people presenting with urgent or unplanned care. In late 2013 this project, with support from Wellington Free Ambulance, looked at enhancing the UCC services to address some of the requirements of the afterhours care by expanding the Extended Care Paramedic service already implemented in Kāpiti into Porirua.

The UCC service model has a single paramedic attending 111 calls triaged as low level in a car, compared to the standard crew of two paramedics in a fully-equipped ambulance. The paramedic has advanced training and is able to administer certain medicines and undertake suturing.

This model allows a more rapid response by the Extended Care Paramedic to life threatening emergencies and helps avoid unnecessary transport to Wellington Hospital ED and possibly admission for people who can be safely treated in their own homes.

The objectives of the UCC service are to:

- Focus on delivering services in local community settings.
- Reduce demand on a hospital’s emergency department.
- Reduce the number of patients needing to be transported by an ambulance.

- Provide a service for low acuity calls where it is clinically appropriate that the UCC service is dispatched.
- Improve ambulance response performance to life threatening calls.

After consultation with community stakeholders, CCDHB and Wellington Free staff, the new model will be launched in Porirua in July 2014. We believe the new community-based model will be better for patients and whānau as they will no longer have to travel to Wellington for non-life threatening health needs. The fact that they can be seen in their home, will also reduce the number of patients presenting at Wellington ED with minor injuries.

THE SHARED CARE RECORD

In April a new online system was launched that enables hospital staff to access primary care health records from Wellington, Porirua and the Kāpiti Coast.

Emergency Department Clinical Director Dr Andre Cromhout and Intensive Care Specialist Dr Peter Hicks demonstrate the benefits of the Shared Care Record.

Called the Shared Care Record, this system makes health record summaries from General Practices immediately available to hospital clinicians through a secure connection. Access to this information is restricted to authorised health professionals, which ensures it remains confidential.

Intensive Care Specialist Dr Peter Hicks said while some clinical information was already shared using paper systems, it was not always available when it was needed. “The Shared Care Record allows hospital clinicians to check patient medical histories from their on-screen hospital record. This clinical information can make a real difference to the quality and safety of care.”

Wellington GP Richard Medlicott was equally positive about the benefits for patients of the new system. “If an elderly patient suddenly goes into hospital at night, the hospital doctors can get a more complete view of that person’s medical history and easily see what medication they are taking and if there are any recent test results.”

The Shared Care Record removes the need to duplicate previously undertaken X-rays or blood tests and means that a patient’s medical history is available if they are unconscious.

Patients can choose to opt out of the system, but a better knowledge of patients’ medical histories makes for treatment that is safer, faster, and easier to dispense. Sensitive information can also be withheld from hospital access by GPs, if patients would prefer to share certain details only.

The development of the Shared Care Record was managed by CCDHB and local Primary Health Organisation Compass Health, who maintain responsibility for auditing and maintenance of the record.

PRIMARY OPTIONS FOR ACUTE CARE

On 1 May, 2014, a new initiative known as Primary Options for Acute Care (POAC) was implemented to enable better management of lower-limb Deep Vein Thrombosis (DVT) and cellulitis in the community.

This change in practice came about after a study concluded that some ED admissions for unplanned care could be avoided if these conditions were clinically managed in the community.

Cellulitis presentations to ED numbered 1071 cases in 2012, with 56% of those admitted to hospital. Of those, 66% were self-referrals, which suggested that patients did not understand the need to seek early treatment for skin infections from their GP.

In the same year, 122 presented with lower limb DVT, and it was assumed that the 47% not admitted could also be effectively cared for in the community, with the aim of preventing avoidable hospital admissions.

International studies have established that hospital admission exposes elderly people to risk of significant harm from falls, hospital-acquired infections, and other factors – so it is always preferable to treat them within the convenience of their local surroundings if possible.

POAC enables this by funding GPs to provide necessary treatments, such as IV therapy or compression stockings, from their practices. It is currently facilitated through the Primary Care Alliance Trust, a combined group representing several PHOs.

While similar models exist in the Hutt and Wairarapa DHBs, the current long-term view is to establish a single POAC across the sub-region.

HOME IS WHERE THE HEART IS – THE CHILD HEALTH HOUSING PROJECT

While rheumatic fever can arise from untreated ‘strep throat’ caused by a Group A Streptococcus (GAS) throat infection, poor housing conditions and overcrowding are also risk factors for this disease.

Regional Public Health has developed a housing assessment and referral service that identifies children who are at risk of rheumatic fever. The service offers a home visit by a housing nurse, links clients with housing interventions that make a home warmer and drier, provides education about healthy housing, and follows up each family to check on completion of referrals made.

New clinical pathways established with Capital & Coast’s Service Integration & Development Unit (SIDU) will ensure straightforward access to this referral service for primary and secondary healthcare professionals who believe their patients met certain criteria, including:

- community service card or financial hardship
- one of the following health conditions – rheumatic fever (acute or past history), communicable disease (meningococcal disease), respiratory conditions (asthma, COPD, bronchiolitis, pneumonia, bronchiectasis) or skin infections.

Community workers across the sub-region are able to use a housing assessment tool themselves to address housing need with their clients, or alternatively the housing nurses are available to work in partnership with the community workers to address housing need by doing joint visits.

Referrals identified by secondary care clinicians will be linked back to their primary care provider.

DIABETES AND ENDOCRINE

A large part of the Diabetes and Endocrine Department’s focus in the past year has been on working with community groups and raising awareness around Type 1 and Type 2 diabetes. This has resulted in the establishment of the Child Obesity & Diabetes Network, a multi-disciplinary member association that meets to share best practice ideas.

Two social media projects have also been gaining positive attention. One is www.diabeteslive.co.nz/ which is focused on teenagers living with Type 1 diabetes and dealing with some of the challenges that arise. The other is also a diabetes nursing initiative which saw a Facebook page set up, “Don’t buy Type 2 Diabetes”, to raise awareness around healthy eating.

Food was also the focus of the ‘Garden to Table’ programme which supports teaching children in schools on how to be self-sufficient. Corporate sponsorship from The Tindle Foundation will see this programme rolled out in four Porirua decile one schools and focus

on the growing, harvesting, preparing and then sharing of food around a table and is linked to schools’ core subjects.

NURSING PRACTICE PARTNERSHIP

People with diabetes are receiving better, sooner and more convenient care thanks to a Nursing Practice Partnership (NPP) between primary health organisations and CCDHB.

The Nursing Practice Partnership model pairs the expertise of hospital-based diabetes nurse specialists with practice nurses in the GP setting, enabling them to manage patients’ care closer to home.

Karori Medical Centre has been trialling the model since May 2012. Of the 55 patients who took part in the pilot, nearly 80% have dropped their HBA1C glucose levels to a more manageable level.

Having a lower HBA1C level means patients are at less risk of micro vascular complications such as impaired vision, kidney problems, ulcers, and lower limb amputations.

“It’s about using the nursing workforce in a different way. We’re not talking primary or secondary diabetes care, just diabetes care. We believe that’s the future,” GP Dr Jeff Lowe said.

Karori Medical Centre practice nurse Jacqui Levine said the opportunity to work with CCDHB diabetes nurse specialist Lorna Bingham “has certainly increased my confidence in working with patients with diabetes. Lorna has given us a lot of skills and knowledge”.

Managing patients in the community provides continuity of care for patients and staff alike, says practice nurse Heather Wilson. “It means knowing the patient, knowing where they’re at and working with them to get their diabetes under control. It’s having the opportunity to ring them up if they haven’t had their blood test done, so we are keeping in touch.”

Patient Chris Ward, who was able to start insulin medication in the community rather than the hospital during the pilot, says the partnership is “brilliant” and knowing that he can contact his nurse at any time means that he feels more confident managing his diabetes.

“Starting insulin was something I was concerned about but I learnt how to do it all [at KMC]. Now I can deliver the injection myself and it’s just a quick phone call to Heather if I have a problem. I feel more in control now,” he said.

More than 243,000 Kiwis have been diagnosed with some form of Diabetes, and 22,593 of those live within the greater Wellington region of Capital & Coast, Hutt Valley and Wairarapa districts.

CCDHB is currently rolling out this model of care to a further 15 general practices to provide better support for people with diabetes.

Minister of Health Tony Ryall talks to a patient during the launch of the Nurse Practice Partnership model at Karori Medical Centre.

WOUND MANAGEMENT FIRST

CCDHB is the first DHB in New Zealand to implement the Silhouette wound assessment and information management system and its introduction into District Nurse Clinic’s in the community has been a big success. Silhouette is an easy-to-use wound imaging, 3D measurement and documentation system providing accurate wound information at the point of care and supporting the overall clinical management of wounds. Wound management equates to an estimated 60% of the Community Health Service nursing workload.

The system includes a point of care, laser-based imaging device that precisely and consistently measures the area, depth and volume of wounds and their healing progress. It enables wound assessment activity to be monitored, providing instantly-available wound information to key stakeholders, including accurate healing trend data, ethnicity data, patient medical history, quality imaging and standardised wound assessment.

The service has seven silhouette cameras and laptops loaded with the application that are able to send the information to the database and in the past year we have trained 60 district nurses in silhouette usage who have used this system on 520 patients in the Kāpiti, Kenepuru and Wellington area.

As there are limited studies on leg ulcer prevalence in NZ, and no research has been published to date around leg ulcer prevalence for Māori and Pacific Island population groups, this data captured will be collated and published to inform best clinical practice.

The end result has had a positive influence on treatment outcomes, lifting standards of care through robust measurement leading to efficacy in wound management, helping multi-disciplinary teams to be more productive and thereby supporting better-informed decisions.

Nurse practitioner Julie Hollingsworth discusses infection prevention and control tips with staff from local rest homes at Longview Rest Home in Tawa.

AGED RESIDENTIAL CARE QUALITY IMPROVEMENT

Older people can respond to illness differently, so it’s important that clinical staff, whether in the community or hospital environment, know what they are looking for. In the past year CCDHB nurse practitioners have been reviewing guidelines and sharing their knowledge with local rest home staff, with the goal of preventing unnecessary hospitalisations.

Aside from the inconvenience caused to patients, hospitals also present a greater infection risk, particularly for older adults. The body’s ability to fight infections declines with age, which can make assessing an older patient’s condition difficult, especially with multiple co-morbidities and medications to consider.

Nurse practitioner Julie Hollingsworth says it’s about knowing what to look for.

“Older people tend to have a lower body temperature in general, which can make a feverish rise seem normal.”

Julie says the Aged Residential Care work is one of the many ways in which CCDHB is actively strengthening local bonds between the primary, secondary, and tertiary health sectors to support better patient care.

“We’re encouraging nurses to make a difference by being proactive – liaising with GPs, working out care plans in advance, and ensuring they’re communicating effectively with tools like ISBAR.”

Julie also works closely with a CCDHB geriatrician and local GP who carry-out a six-weekly review of residents in aged-care hospitals together.

PORIRUA SOCIAL SECTOR TRIAL

In December 2013 the Minister of Health Tony Ryall launched the Tumai Hauora ki Porirua Action Plan, which is part of the Porirua Social Sector Trial. It sets out actions that will be taken over a two year timeframe, to reduce the number of people being admitted to hospital for Ambulatory Sensitive Hospitalisations and to reduce the number of people attending the Emergency Department. This is the first of its kind in New Zealand.

There is commitment and support from the Ministries of Health, Social Development, Education and Justice, the New Zealand Police, Te Puni Kōkiri, Regional Public Health, Ngati Toa, Porirua City Council and non-government organisations to ensure that we work together towards these outcomes.

During the past year we have been implementing the Action Plan using innovative approaches to social sector change. This includes the development of message toolkits aimed at a consistency of approach to health and wellbeing across the community. It is focused on five key topics: rheumatic fever, skin infection, oral health, hand washing, and the promotion of the 0800 Healthline.

Celebrating the first birthday of The Social Sector Trial, were CCDHB Board member and Porirua Mayor Nick Leggett, Programme Lead Ranei Wineera-Parai, Compass Health CEO Martin Hefford, and National Social Sector Trial director Carl Crafar.

Other key initiatives include:

- improved access to affordable health care
- increased respiratory services in Porirua
- consistent nurse triage training across Porirua
- improving the availability of primary care
- increasing the screening for cardiovascular disease and diabetes.
- improving access to warm housing and reducing the impacts of overcrowding
- reducing the misuse of alcohol in Porirua
- better understanding domestic violence determinants to reduce the impacts of domestic violence.

DEVELOPING A FUTURE WORKFORCE

Kia Ora Hauora is a national Māori health workforce development programme aimed at building Māori workforce capacity and capability. This year the Ministry of Health agreed to extend the programme for another three years concentrating on Māori:

- currently studying at secondary level (aged 13-18)
- studying at tertiary levels
- in-work
- in the community.

CCDHB is leading and hosting the Central Region's Coordination Centre of this programme with the intention of enrolling and retaining 125 Māori on health-related career pathways and at least 25 new Māori into first year tertiary study at a Tertiary Institute, per year.

To date, the central region has 1383 registered Māori enrolments. This is made up of 902 secondary school; 267 tertiary institute and 214 within the community.

Key regional initiatives undertaken in 2013/14 include been around a more focused approach to meet annual enrolment targets and better engagement with secondary schools, and stronger relationships with other health, secondary schools and tertiary institutions.

This year CCDHB Māori Health Development Group and Human Resources partnered with the Kia Ora Hauora to deliver Work Observation Week, Work Observation Day, and Work Exposure Day. These initiatives profiled Allied Health, Technical and Scientific careers and multi-disciplinary team roles to college students during April and May.

Work Exposure Day targeted Year 9 and 10 students, exposing them to health career opportunities and the necessary NECA subjects that support entry into health studies at university. Students were exposed to interactive rotations profiling careers, across a range of professions and team roles. All events were successful with 11 schools and 79 students taking part.

Students are shown parts of ED by Associate Charge Nurse Manager Craig Jenkins

PACIFIC HEALTH

Health Science Academy

After the successful launch of the Health Science Academy initiative last year, the Pacific Health Service hosted Partners Porirua and other college visits so students could get a good feel for the careers available in health.

Growing the Pacific Workforce is one of the key government goals through the Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014 Ministry of Health Pacific Strategy.

Director for Pacific Health, Taima Fagaloa said "when we launched the Academy last year we wanted to reinforce the Minister's commitment to growing Māori and Pacific workforce. This year we have built on this work and extended the college's visiting so we can share the different career path available".

Pacific Health Unit & Pacific Navigation Service

The Pacific Health Directorate, in collaboration with the Child Health Integrated Care Collaborative have developed a new referral pathway, connecting CCDHB Child Health Services with both the onsite Pacific Health Unit and the Pacific Navigation Service based in Primary Care. The Pathway offers a clear, step by step process for referring Pacific children to both sites, allowing for consistency and continuity of care.

The Pacific Health Unit provides Pacific patients with any cultural and social support needed while an inpatient at CCDHB, while also assisting with cultural clinical input and translation.

The Pacific Navigation Service is a community service focused on Pacific children and Pacific adults, with long-term conditions in areas of high need. The service also provides linkages to any additional services required, such as WINZ or Housing NZ.

Attendees of the Pacific Intersectoral Symposium take a break with some group exercises

SUB REGIONAL PACIFIC STRATEGIC HEALTH GROUP

In November 2013, the group hosted the first Pacific Intersectoral Symposium which brought together around 80 Pacific public servants, analysts, policy advisors, and NGO leaders based in the Wellington Region. The symposium was an opportunity to examine current service delivery activities targeting Pacific communities in the wider region with the view to creating a more coordinated and effective collaborative approach for these activities.

All government and third party funders including DHBs and local governments were invited. In addition, Pacific collectives, PHOs, NGOs, providers and networks across the region also take part.

The group captured the findings from the symposium as part of its efforts to establish an over-arching service delivery strategy for the region. The Group is keen to explore processes for building evidence and research to help support a region-wide approach to health and social outcomes for Pacific people.

"Staff have all been considerate and caring, cheerful and have interacted with me and my partner. Their good humour have made dealing with the hospital environment and procedures a joy. All staff were excellent at informing me about procedures and introducing themselves and their roles. Without their care and support this would have been a sterile and frightening place. This was also done while they were continually busy dealing with their work."

Interventional Recovery Ward

ALCOHOL REFORM

Regional Public Health (RPH) and CCDHB successfully used data on alcohol related Emergency Department attendances at Wellington Hospital as evidence of harm in opposing licensing applications and in presenting to the Local Alcohol Policy development. Wellington Hospital is in a unique position with up to four years of data available to evaluate and gauge the impact of alcohol on injury presentations to the Emergency Department.

Together RPH and CCDHB have had significant success in ensuring the safe sale of alcohol through the opposition of licensing applications and supporting the community to have their voices heard. The approach has effectively combined regulatory and health promotion activities together into a single hearing evidence from health, police, licensing inspectors, and the community. This framework is an important change assisting the effective implementation of the Sale and Supply of Alcohol Act 2012.

RPH completed a before and after observational study in Wellington's Courtney Place on the implementation of the national maximum on-license hours in Wellington City. This "intoxication study" was to aid our understanding of the impact of reduced hours. Results reported demonstrate a significant improvement in intoxication levels and improved behaviour particularly in public places. Researchers commented that intoxication of patrons in bars is difficult to assess particularly when the bars are very busy and comments that this may give an under representation of the true levels of intoxication within premises. The study results mirror the crime statistics reported by police. This report has been produced to inform our work on Local Alcohol Policies.

FLUORIDE

This year the Kāpiti Coast District Council decided to consider whether to continue community water fluoridation in Waikanae, Paraparumu and Raumati as part of its draft annual plan process for 2014/15.

CCDHB supports community water fluoridation as an effective public health measure that contributes to oral health, prevention of tooth decay and a reduction in health equalities. It is a low cost measure that benefits people of all ages with natural teeth and has over 65 years of evidence proving it to be safe.

In May, Kāpiti Mayor Ross Church and elected councillors heard several presentations from Surgery, Women's and Children Executive Director (Clinical) Mr John Tait, CCDHB Dental Clinical Leader Dr Liz Hitchings, Medical Officer of Health Dr Stephen Palmer, and Regional Dental Operations Director Andrea Rutene around the benefits of fluoridation.

It focussed on the relevance of maintaining fluoridation in Kāpiti for the benefit of the whole population, and followed a position statement adopted by the Board in favour of community water fluoridation.

It was noted that school dental service data showed fluoridation was particularly effective in reducing local dental health disparities between Māori and non-Māori children aged 2 – 12 years.

CCDHB's presentation acknowledged that tooth decay had many causes and therefore required many solutions, including community water fluoridation, good education around diet and oral hygiene, and regular dental visits.

A total of 627 written submissions were received by the Council on fluoride alone. Of these, 366 were in favour and 261 against fluoride being added to the District's water supply.

Kāpiti dentists were unequivocal in their support for continuing community water fluoridation and the Council subsequently voted 8-2 (one absention) in favour of continuing fluoridation.

CREEKFEST '14

Our diabetes team attended Creekfest again this year, along with Regional Public Health and other local health providers.

They provided 80 free type 2 diabetes risk assessments for festival goers – just over double their regular intake. Many fell into the high risk category, with two or more risk factors indicated.

"There was a lot more awareness this year but most people are still generally quite surprised when we ask them because they don't usually think diabetes is relevant to them," said inpatient nurse Tessa Clarke.

"Around 90% of the people we surveyed were high risk, and 95% of those were under 40, which we found quite scary."

Those classified as medium or high risk were provided with advice on simple everyday lifestyle changes they could make to reduce their risk.

In between music acts, Creekfest attendees could bowl fizzy for six at Compass Health's tent, get a free hearing check from Regional Public Health's mobile ear clinic and learn more about keeping their teeth strong via the Bee Healthy regional dental service.

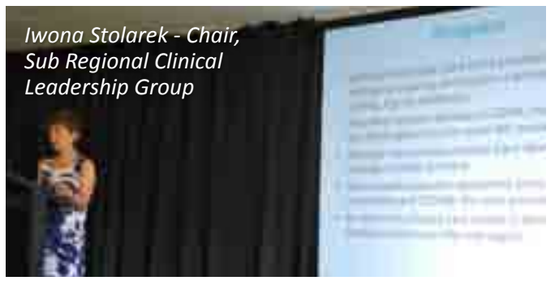
COLLABORATION HIGHLIGHTS

3DHB Partnership Programme

The past year has seen a continued commitment to partnership between Wairarapa, Hutt Valley, and Capital & Coast DHBs as we focus on providing sustainable services, both clinically and financially. The 3DHBs believe that the best health gains for patients can be achieved through a joined-up approach to service delivery across the sub-region, and that by removing artificial boundaries decisions can be made in the collective interest of the sub-region's population. This includes improving equity of access to services for the combined population.

The 3DHB Health Service Delivery programme has continued to focus on specific clinical service projects identified as critical services for integration, along with the key enablers required to support these. Service design has been clinically led, with representation from across the individual sub-regional services as appropriate.

To enable our progress towards fully integrated sub-regional services, we developed a clear framework that identified the stages of integration for this programme. This included the definition of the agreed sub-regional approach at each integration stage for governance, clinical leadership, management, responsibility, accountability, funding, service delivery, operational activity, and employment.



Iwona Stolarek - Chair, Sub Regional Clinical Leadership Group

A report outlining the considerations needed to progress service design was informed by sub-regional workshops with clinical and management representation from services across the DHBs. These workshops gave many staff the opportunity to see the benefits that integration provides, and areas where they felt careful consideration is needed.

This information now used by all services progressing sub-regional integration design.

Integration continues with Child Health, Radiology, and Gastroenterology services, linking them directly into local primary services where appropriate through Primary Care Alliance Leadership Teams.

A PATHWAY TO GOOD HEALTH

The 3DHB Health Pathways project was launched in February 2014. This collaboration between Primary Care and DHBs sees care pathways developed to take the uncertainty out of patient care by ensuring a clear and consistent treatment regime for patients to be referred along.

In doing so, health professionals from across different sectors and organisations must agree upon best practice treatment guidelines, and discuss any existing barriers to implementation.

The implementation team includes sub-regional specialists, a programme manager, and five general practitioners as clinical editors. A further editor with a dedicated focus on faster cancer treatment is currently being finalised. The governance group comprises clinical and corporate members from the 3DHB executive teams and primary care services across the sub-region.

There are currently 95 pathways on the work programme. An example of the co-design approach is the local pathway under development to treat Carpal tunnel syndrome, a disabling condition that causes wrist pain and numbness. CCDHB's orthopaedic department has agreed to accept surgical treatment referrals directly from GPs, provided the treatment steps outlined in the pathway are first followed. This means patients can go to their GP, who will perform the appropriate treatment steps, and if surgical treatment is necessary, give certainty that they will receive it.

"That's a really powerful thing to say 'I'm referring you for an operation', not 'I'm referring you to see a specialist first'," said Lower Hutt GP Dr Chris Masters, who is one of five 'clinical editors' who have been appointed to work with hospital and community-based specialists as part of the integrated approach.

"While hospital treatment may be necessary for some complex conditions, people don't want to go to hospital when they can come and see their local family doctor or medical centre to get treatment that is closer to home and more convenient," Dr Masters said.

The new general practice model recognises that long-term conditions require coordinated care from different health services. Practice nurses and community health providers such as Physiotherapists are seen as key to this.

While the project is still in its initial stages, it is seen as a priority for the coming year. Pathways in development include: diabetes nutrition, frail elderly patients, gastroenterology, cellulitis, older persons health, orthopaedics, haematology, general surgery and rheumatic fever.

APPOINTMENTS

In the past year new joint appointments have been created that will continue to build on the work of the integration programme. We are excited to report the development of the first 3D clinical service position with the agreement to progress a 3DHB General Manager of Mental Health and Addiction Services. The appointment of this position will enable the general manager to lead the staff involved in the delivery of Mental Health and Addictions Services across the sub-region to develop a single approach to service design and delivery.

Other appointments have progressed with the appointment of a 3DHB Executive Director Corporate Services Group, a 3DHB Chief Information Officer and a 3DHB Facilities Management structure. The focus of these positions in the short-term is to support the 3DHB development to keep us on the pathway toward sustainability and strengthening the back office systems and functions that underpin the way we do business.

These positions will provide strategic advice and direction for Wairarapa, Hutt Valley and Capital & Coast DHBs in relation to financial management, information communications technology, facilities management and payroll. This ensures that the strategic direction translates into tactical and operational activity supporting all DHBs wider goals as well as individual service goals.

MĀORI HEALTH

In April 2014, Riki Nia Nia was formally inaugurated as Executive Director Māori Health for Wairarapa, Hutt Valley, and Capital & Coast DHBs. The focus in this role is to improve performance against the national Māori Health targets for each of the three DHBs.

"There are different views on what a 3DHB Māori health approach will look like but each of the three teams are unique and have their own strengths that we can collectively learn from," said Riki.

"For example, Wairarapa leads the country for screening 80% of Māori women for cervical cancer checks. Having a single point of responsibility will provide leadership and insight for the wider teams to learn from each other."

The 3DHB sub-region was home to 438,345 or nearly 11% of New Zealanders in 2013. The Māori populations of the Hutt Valley and Wairarapa districts are higher than the 15% national average, at 18% and 16% respectively, while 11% of people in the Capital & Coast district identify as Māori.

Additionally, the Māori population of all three DHBs is expected to grow within an overall sub-regional growth rate projected at 0.6% per year to 2026.

Riki Nia Nia

LABORATORY

The laboratories of HVDHB and CCDHB combined into a single service, OneLab, in March 2014 with a Laboratory Manager appointed across the sites. Work is underway to align processes and protocols as far as possible and to utilise opportunities as they present to continuously improve service delivery for patients.

The combined laboratories installed a new combined laboratory information system, Sysmex Delphic, across both DHBs. The implementation was completed in November 2013 in CCDHB and April 2014 in HVDHB. It was notable for a number of things.

- The project required the two laboratory teams and ICT to work closely together to create a single system that could be used by both DHB laboratories. This has successfully occurred and, except where required for technical reasons, the system is configured the same in both laboratories.
- The Anatomic Pathology portion of the system is ahead of the rest of the DHB laboratories in the country. At least four other laboratories have been to visit the system and Canterbury DHB laboratory has just gone live with a similar system, with many of the configurations learnt from our system.

KENEPURU SATELLITE DIALYSIS UNIT

The long-awaited new satellite dialysis unit at Kenepuru Hospital was completed to schedule, and officially opened by Minister of Health Tony Ryall on 20 March 2014. The doors opened for the first patient treatments a few days later.

The opening of the new unit marked the end of an era for the Porirua Community Dialysis Centre based in Porirua's BNZ Tower Building, which had been the satellite dialysis unit for the past 13 years.

Patients and staff embraced the move to the new purpose built unit, which is more accessible, spacious and has plenty of natural light. Feedback received from patients has been overwhelmingly positive with everyone appreciating the state-of-the-art facility that is not just aesthetically pleasing but also more comfortable, with TV's provided for each patient.

Minister of Health Tony Ryall talks to a dialysis patient at the opening of the new unit.

The unit is operational seven days a week with up to 32 patients receiving treatment each day. In addition to the patients who attended the previous satellite unit, a significant number of patients have transferred from the main hospital unit out to Kenepuru. Patients have adapted well to the change in environment with many patients embracing the opportunity to become more actively involved in aspects of their treatment. Feedback from patients includes one saying: "I enjoy being able to do things for myself – learning is good for me."

The opening of the new larger unit has given the renal service the capacity to provide patients with dialysis treatment in the most appropriate facility based on the level of care they require. With 16 of the available 24 dialysis stations currently commissioned for use, the unit will be able to cope with additional demand over the coming years.

Kenepuru dialysis unit

Sub-regional Disability Advisory Group

OPHTHALMOLOGY

This year CCDHB started a minor opthamologists operations session each week at the Hutt Valley DHB, meaning patients from the Hutt and Wairarapa no longer have to travel to Wellington for minor surgical procedures.

The plan is to extend this to a full day Outpatient Department session at the Hutt, so staff can continue to help clear the backlog of children with squints and be available to backfill the permanent paediatric surgeons lists. This will mean that paediatric patients who live in the Hutt and Wairarapa will no longer have to travel to Wellington for Outpatient appointments.

EAR, NOSE & THROAT

The sub-regional Ear, Nose & Throat steering group formally disbanded during 2013/14 following completion of its work programme, which included the development and implementation of management and referral pathways, and agreement on workforce strategies. The members of the group continue to take a sub-regional approach to achieving targets and developing the workforce.

DISABILITY SERVICES

Great progress has been made during 2013/14 in improving health services for people who experience long-term impairments/disability in the wider Wellington region.

In December 2013 the first sub-regional New Zealand Disability Strategy Implementation Plan was agreed by the Wairarapa, Hutt Valley, and Capital & Coast Boards at their first combined meeting. To support the roll out and to provide a voice at governance level, the sub-regional Disability Advisory Group was formed.

The group produced its first newsletter in May 2014 providing a means for community engagement across all sectors, including mental health, older people, primary care and young peoples' networks.

A sub-regional Disability Forum was held, which provided an opportunity for people with disabilities to give their feedback on the implementation of the sub-regional disability plan. The key themes that arose from the forum correspond with the determinants of the Triple Aim approach which, in relation to disability, means the need to balance patient experience; visibility of disability (within population health initiatives) through more robust data collection; and through efficient and financially sustainable systems that enable all to access services they need.

Other Disability Service highlights include:

- The launch of the Health Passport in Wairarapa, Hutt Valley and Capital & Coast DHBs. The Health Passport will assist health providers to better understand the care and communication needs of people who experience long-term impairments/disability.
- The Disability Alert icon was launched at CCDHB and HVDHB. The icon will alert staff to patients' particular needs when using health services, including what they need to be kept safe.
- An eLearning module for all CCDHB staff was launched. This gives basic education and specific instructions on the use of the Disability Alert Icon, and the link to the Health Passport.
- A disability champion/facilitator network made up of staff across all three sub-regional District Health Boards and community services was launched to help improve services and information to health staff and people with disabilities.

RHEUMATIC FEVER PREVENTION

In 2013/14 a sub-regional rheumatic fever plan was developed that built on the Rheumatic Fever Prevention Programme operating in Porirua. The aim of the sub-regional plan is to reduce the incidence of rheumatic fever in the region by focusing on prevention, treatment, and follow-up of rheumatic fever. The plan is part of the Government's Rheumatic Fever Prevention Programme which is working to improve outcomes for vulnerable children and achieve

the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds, to a rate of 1.4 cases per 100,000 people by June 2017.

The goal are to prevent the transmission of Group A streptococcal throat infections in the Wairarapa, Hutt Valley, and Capital & Coast districts.

This will be achieved through:

- The development and implementation of a pathway to identify and refer high risk children to comprehensive housing, health assessment and referrals services, in 2014/15.
- The development of the Housing and Health Capability Building Programme and implementation of insulation referral process for high-risk patients, in 2014/15.
- Raising community awareness.

To ensure Group A streptococcal infections are treated quickly and effectively there has been increased training and information for primary care providers, and an algorithm tool for the treatment of sore throats in primary care has been developed. A review of the sore throat swabbing in schools model will happen in the coming year. In 2013/14 the total number of throat swabs was 7,180, with 11.2% positive swabs.

Results for 12/13 and 13/14 for Porirua, 4-19 year olds:

	2013/14	2012/13
Positive	802	791
Negative	6378	5890
Total swabs	7180	6681
% positive	11.2%	11.8%

Hutt Valley DHB and CCDHB are steadily reducing the rate of first episode rheumatic fever hospitalisation (per 100,000 total population), with CCDHB achieving 1.7 (per 100,000 total population) in 2013/14, ahead of target for the year.

Rapid Response Clinics were opened in Porirua, with ongoing review and refinement of the services as required. Engagement with the Pacific Health and Wellbeing Collective continued to ensure key messages are reaching Pacific families. This collaborative approach will continue with ongoing engagement with local providers in Porirua East through the Porirua Kids Group and Porirua Social Sector Trial.

Walk-in sore throat treatments clinics were commenced at Hutt Valley DHB from June 2014 at three pharmacies, three general practices and one After Hours Medical Centre.

INFORMATION, COMMUNICATION & TECHNOLOGY (ICT)

ICT has had a significant year of achievements as we continue to enhance the 3DHB ICT integration. The three pillars of work being progressed are:

- convergence of platforms, systems and processes
- one approach where possible
- intellectual property sharing.

This collaborative approach was formalised in May 2013 with the development of a 3DHB ICT service. A senior management structure and 3DHB ICT Governance Group was implemented to drive and support the next level of changes to occur over the coming financial year.

Security continues to be a key focus for the organisation with the formation of an Information, Privacy and Security Group to support and manage key security matters.

During the past year a number of ICT projects have been completed to support the Minister's initiative of Better, Sooner, More Convenient healthcare delivery, including significant input in supporting the Central Region Information Systems Plan (CRISP). The key projects include:

- Electronic results sign-off
- Occupancy at a Glance
- Clinical Audit tool
- Laboratory system upgrade
- The Referral Management Module for Outpatients and Allied Health (which offers a number of benefits including more accurate data capture and reporting, ability to view and better manage a patient's full episode of care and management of referrals in real time)

During the past year the Department of Internal Affairs (Government Chief Information Officer) released the Whole of Government Direction for ICT Functional Leadership of District Health Boards in respect of:

- ICT Strategic Planning and Investment
- ICT Procurement
- ICT Assurance

These directives are to be effective from 1 July 2014. As a result of this initiative there are a number of 3DHB ICT activities planned to align current processes to this approach.

A number of Ministry of Health (National Health IT Board) projects, including National Patient Flow, Maternity and e-Pharmacy have either been implemented or are underway in conjunction with other projects.

Sub-regional activity has seen a number of activities underway to integrate the three District Health Boards. Convergence work completed includes the implementation of a Microsoft 3DHB Outlook service. This activity has facilitated all staff to electronically communicate with ease.

The Common Operating Environment programme of work, which included the migration of Microsoft XP to Windows 7 is well underway. This is providing a sub-regional platform for DHB staff.

Other collaborative work includes:

- A standardised single time sheeting process for projects across the 3DHBs has been implemented. This has enabled more accurate and timely reporting to support the financial and resource management of projects and business as usual activities.
- Work to collaboratively manage risk across the 3DHB's is underway. In support, Audit NZ has been engaged in a common audit review process across the sub region.
- Building on the existing quality control and compliance activities, ICT have commenced a programme of independent quality audits on key projects which will continue through the next financial year.
- The Wairarapa District Health Board service calls are now managed by the Capital & Coast Service Desk. This enhances the capture of data and enables the Wairarapa ICT team to focus on project and business as usual activities.

The establishment of a single 3DHB ICT structure is to commence in the first quarter of 2014/15. This will support integration activities and enable both effectiveness and efficiency gains across the 3DHB's.

HOSPITAL HIGHLIGHTS

Surgical Services

CARDIOTHORACIC

This year the cardiothoracic waiting list increased from 20 at the beginning of July 2013 to 47 at the end of June 2014, making it easier to manage short notice cancellations. Along with making the lists more manageable, we are also required to add patients to the waiting list before they are dentally fit.

As a number of the patients have not visited the dentist in many years, a significant number require oral surgery, but very few are in the financial position of being able to afford this privately so rely on the referring DHB dental service. To assist us we have been working closely with the dental departments at the referring DHBs encouraging them to see these patients faster.

As one of the five centres that offer cardiac surgery we have been working with the Ministry of Health to implement a national register of patients, to enable National Quality Assurance Audits to take place. Christchurch is now in the test phase and CCDHB is lined up to begin the training and testing in August and September 2014.

Nationally, cardiothoracic services have been nominated as the next service to implement the Surgical Site Infection Surveillance Programme. International research estimates up to 10% of all hospital inpatients will acquire one or more infections during their stay, and that 20% or more of these infections occur as a result of surgery.

Surgical Site Infections (SSI) are the second largest cause of hospital acquired infections, after urinary tract infections. According to the Health Quality and Safety Commission, on average an SSI prolongs a patient stay by 7.4 days, at a cost of $1000 a day.

Learnings from the implementation of the Surgical Site Infection Surveillance Programme in orthopaedics will inform the process for Cardiothoracic.

VASCULAR DEPARTMENT

The waiting list for vascular has significantly reduced to the extent we have been able to write to the GPs advising them that we are currently able to lower the threshold on treatment for varicose veins. 68 patients had surgery for varicose veins in the last four months of the year compared with the usual average period of five to six months.

Our permanent fourth vascular surgeon, Dr Lupe Taumoepeau, took up post in February 2014. Lupe was a trainee who left to complete her fellowship training and returned to a position that was offered to her on the completion of her training.

GENERAL SURGERY

There have been a number of staff changes this year. We welcomed Dr Ineke Meredith as our 2014 surgical locum. Mr Ali Shekouh became our 12th permanent surgeon when he arrived in mid-April and is the third colorectal surgeon.

We also welcomed Kapua Quinn as the new Charge Nurse Manager for Ward 7 North and Regan Spillane, Charge Nurse Manager for Surgical Assessment & Planning Unit (SAPU) became the Surgical Service Leader.

SURGICAL ASSESSMENT AND PLANNING UNIT (SAPU)

The opening ceremony for SAPU was held on 30 August 2013, and began receiving patients the following week. This coincided with the change to the on-duty model which saw a Senior Medical Officer (SMO) on-duty Monday to Friday from 07.30 – 18.00, on-site with no elective or private commitments.

SAPU provides 10 dedicated short stay beds and two assessment beds. All surgical specialties use the inpatient beds, while the two assessment beds are used by general surgery. New pathways have been developed to remove barriers to patient flow, including:

- GP fast track referral to SAPU;
- ED to SAPU pathway;
- Designated CT and Ultrasound spaces in the morning, Monday to Friday;
- Designated access to an acute afternoon theatre, 12.30pm – 4.30pm.

The on-duty trial concluded at the end of February 2014 and the surgeons voted to adopt this model permanently.

Chief Operating Officer Chris Lowry (left) and Clinical Leader Tony Phang open the new SAPU.

"Last week I overnighted in Wellington Hospital following ENT surgery. I would like to acknowledge the care that I received during my short stay. The nurses displayed an extremely professional, competent and caring manner and are excellent representatives of the nursing profession. Indeed their attention certainly made my sojourn post-surgery as comfortable as possible. The Health system at large occasionally gets some (mostly unwarranted) media attention. However, with staff such as these on the shop floor it appears that this ward has high quality staff on its compliment."

7 North

WARD 7 NORTH

Six additional beds were opened on Ward 7 North this year with two of them being flexible beds (not resourced but staffed up if the hospital capacity required).

To ensure the focus on patient flow is maintained over the weekend, and that beds are available for elective patients on a Monday, a trial started in August 2013 to close four of these additional beds every weekend.

The ward has also been focusing on ensuring all the patients, and are aware of their expected date of discharge on admission. This ensures factors that could delay discharge can be mitigated.

ORTHOPAEDICS

A new process for triaging acute referrals to the Orthopaedic Clinic from ED was developed in the latter part of 2013 and trialled in 2014. This process enables non-contact assessment and advice, and it is anticipated that it will result in less patients having to come to the clinic to have their treatment plan confirmed or amended, thus freeing up clinic time for elective patients.

The service also began a project in collaboration with the Emergency Department, Allied Health and Geriatric Services to develop an enhanced recovery after surgery pathway for patients with fractured neck of femur. This will be implemented in 2014/15.

The Ministry funded orthopaedic re-design project has been completed. This included the development and implementation of new referral pathways and the hip and knee replacement enhanced recovery after surgery pathway. The project also involved analysis of clinic and theatre capacity; opportunities to increase elective discharges are being pursued via a further project that seeks to increase capability at Kenepuru Hospital.

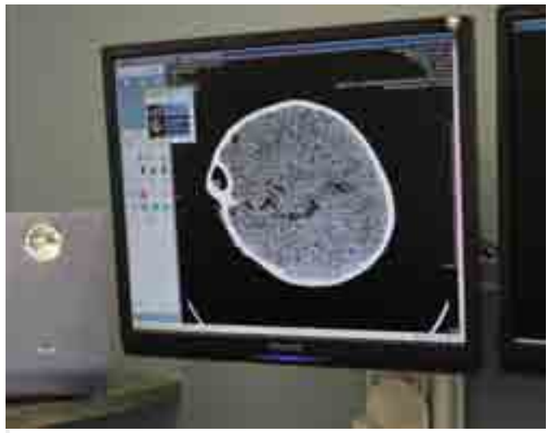
The service has developed a new pathway for direct access to carpal tunnel surgery. The pathway was implemented in July 2014 and, it removes the need to come to the hospital for a First Specialist Appointment (FSA), for some patients prior to being placed on the waiting list for surgery, reducing the overall wait time for surgery.

UROLOGY

Increasing demand for Urology Services has resulted in the recruitment of an additional urologist due to start in February 2015. In order to improve coordination of the urology waiting list, a part-time nurse coordinator was appointed in June 2014.

NEUROSURGERY

The service established a new international resident rotation agreement with the University of Pennsylvania Health System this year. This mutually beneficial arrangement will increase the seniority of the neurosurgery registrars and thus the quality of the service provided to patients. It will also provide the residents with the opportunity to experience neurosurgery as practiced in New Zealand.



"My son was delivered into your care from Masterton Hospital. He arrived on life support and was in isolation. From the moment you all began your care of him, our whānau experienced the most amazing, dedicated team work imaginable. You all need to be told how incredible you are. Your skill, your empathy and most of all your genuine kindness and love shone through. We thought he was going to die. And I believe that may have been your belief also. But despite the odds, you pulled him through. Please believe that you are all, without exception, extra-ordinary people. A blessing to all who come into your lives."

Intensive Care Unit (ICU)

INTENSIVE CARE UNIT (ICU)

The Intensive Care Unit had another busy year with an increase in occupancy. However, what has been encouraging is the length of stay for patients stabilised over the last 18 months. There are various reasons why we have achieved this improvement, most notably is the timeliness wards take to have their patients back when clinically ready from ICU.

ICU continues to actively foster and support on-going training and development for both medical and nursing staff. Four senior ICU registrars gained their specialist intensivist qualifications, while 10 registered nurses achieved proficient or expert status on the Professional Development and Recognition Pathway. In addition, two registered nurses graduated with Masters Qualifications during the year.

Research involvement and capability continues to grow with the service contributing to 20 clinical trials. These include two international studies that were initiated and led by Wellington ICU. One of which, 'the SPLIT trial,' has now enrolled 348 Wellington patients. Dr Paul Young received a $1.2 million grant from the Health Research Council of New Zealand to run a randomised controlled trial. Wellington will be the lead site for this cluster trial into the impact of selective decontamination of the digestive tract in ICU patients.

Wellington ICU has supported the objectives of the National Trauma Network. A 'Major Trauma NZ Symposium' was hosted and we have started scoping work to identify where clinical improvement can be made through better coordination of this patient group.

The work of the ICU procurement and practice groups was successful in finding efficiencies in 2014. For 12 consecutive months the cost of ICU pharmaceuticals was under budget and at year end had a $140,000 positive variance (savings target was $32,000). A multi-disciplinary team approach to appropriate selection and removal of unsupported prescription options were among the ways this was achieved. A significant saving was also made with blood products with a $90,000 positive variance.

Sterile production centre

STERILE PRODUCTION CENTRE

Continued improvements have been made as a result of the Sterile Services Quality Improvement Project.

These include:

- Installation of ultrasonic decontamination units for improved instrument cleaning.
- Installation of a central dosing system for the disinfectants used in the Getinge washers. Reducing manual handling and costs.
- Purchase and installation of a Reverse Osmosis Water System. Providing final rinse water in the washing process that will improve the longevity of instrumentation.
- Re-organising of staff meetings and training to meet production requirements.
- Audit on most of the theatre instruments to identify those in need of replacing.

The Sterile Service team contributed to updating the work place values. Four key attributes - respectable, responsible, honourable and adaptable - were identified and each was accompanied by four specific functions.

The goal was set at the start of 2014 to achieve instrument turnaround overnight and apart from two instances this was achieved and has become the norm rather than the exception.

The quality improvement project is nearing completion with the only major piece of work outstanding - the upgrade of the Endoscopy Room. This will be the focus for 2014/2015.

ICU nurses provide 24/7 one-on-one monitoring of patients.

Theatres

CLINICAL SUPPLIES

Regular fortnightly meetings of the Clinical Supplies Steering Group continued in the operating theatre this year. A number of sub groups also worked on specific projects including sutures, laparoscopic equipment, drug carts, drapes, procedure packs, blood usage, management of orthopaedic kits, screws, nails and plates. There were also a number of product trials that have resulted in improved clinical treatment.

The total value of savings specifically relating to operating theatres this year was $1,052,193. Other savings were made in cross organisational initiatives such as improved wound care management, implementing the national protective clothing contract and the Venous Thromboembolism policy, the LNI respiratory contract and suction catheter changes.

The Group continues to operate this year and includes staff from Theatre, PACU, Sterile Supplies, Anaesthetics and the Theatre Store. A key focus going forward is to review procedural costs to establish where new opportunities for cost efficiency exist and can be implemented.

THEATRE UTILISATION

Theatre services continue to focus on supporting the delivery of surgery to both the region and sub-region populations. This translated into 8,065 elective procedures performed at Wellington and 3,042 at Kenepuru in 2013/14 - 168 and 50 more than the previous financial year respectively. In addition, Wellington Theatres supported 5,495 acute operations and 1,373 caesarean sections. Wellington Theatres exceeded the utilisation target by 1.9%, and both Wellington and Kenepuru Theatres overall utilisation was comparable to the 2012/13 financial year.

The overall uptake of resourced theatre sessions for Wellington was 92.1% with another 5.1% backfilled by another specialty. At Kenepuru, the overall uptake was 74.5% with 5.1% backfilled by another speciality.

"Fabulous attention, support and thorough explanations by all medical staff. A compliment to our public health system (better service and attention than I have received in the private medical system). Thank you."

Kenepuru Perioperative Unit

PERIOPERATIVE SERVICES

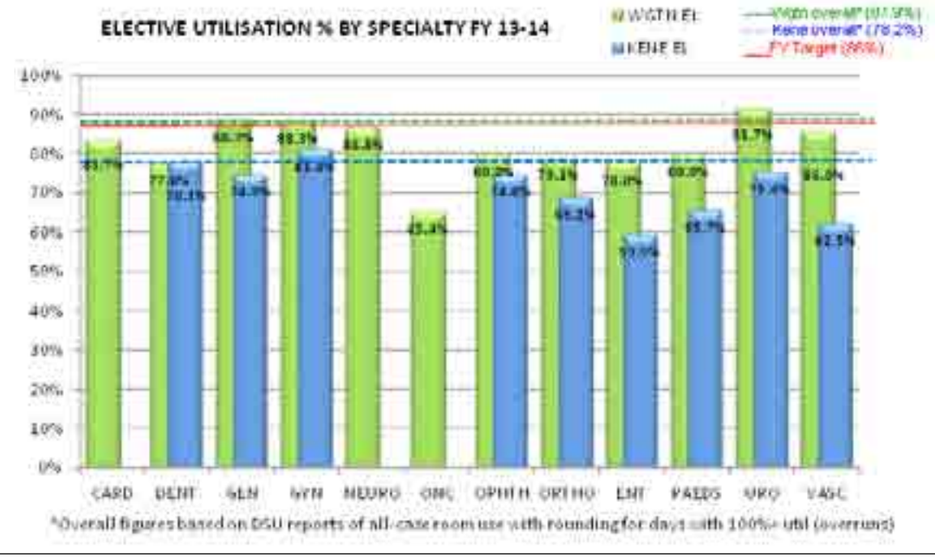
During 2013/2014 Perioperative Services continued to focus on improving patient flow, with the establishment of a Pre-assessment Productivity and Workforce Programme Working Group. The objectives of the group were to:

- improve the Pre-assessment Service so that it is patient focused and maintains patient safety
- improve the coordination of people and resource
- improve the operational management of the Pre-assessment Service
- support the team based approach to care and service delivery.

Post-Anaesthesia Care Unit (PACU) operated at capacity throughout the year with a total of 15,257 patients for the year. The average length of stay was 74 minutes which showed no significant change from the previous year.

There has been an increasing demand for peripherally inserted central catheters (PICC) line insertions with the number for the first six months exceeding 300. Because of this increase in demand, the service has outgrown the space allocated within PACU and will trial using the Theatre Procedure Room instead.

Utilisation sumary 2013-14



*Overall figures based on DSU reports of all case room use with roundingfor days with 100%+ util (overruns)

FIVE MINUTES IS A LIFETIME

A CCDHB anaesthetist has received the New Zealand Society of Anaesthetists' (NZASA) top research award for his study comparing methods of delivery of high pressure oxygen for Emergency Percutaneous Transtracheal Ventilation (EPTV).

Dr Colin Marsland, who picked up the Ritchie Prize, says the procedure is relatively unusual but life-saving for those patients who are not breathing and who can't be intubated or oxygenated.

"Currently EPTV sits at the very end of difficult airway algorithms. There's a significant risk of barotrauma, or overinflating the patient's lungs, with oxygen delivered at high pressure, so there was a need to work out how it could be done safely. This is particularly true when the proximal airway is completely obstructed and gas can't get out."

The study, which builds on work pioneered at the Royal Perth Hospital, showed patients with complete proximal airway obstruction could be safely oxygenated for up to five minutes with just a single transtracheal 'breath' from different ventilation devices, he said: "That is a lifetime in these kinds of extremely stressful situations, both for the patient and the clinicians looking after them.

"That extra time means you can do so much more for the patient, for instance the anaesthetist may be able to secure their airway from above using specialised equipment. It's the difference between having to make an emergency neck incision and being able to simply and safely secure their airway."

Colin's research has been submitted to the British Journal of Anaesthesia and he has also picked up a visiting lectureship in New Zealand for 2014.

This year's NZASA Awards were almost a clean sweep for the department with Dr Phillip Quinn also picking up the Poster Prize for "Hyperoxia During Cardiopulmonary Bypass: A Systematic Review."

"Extremely helpful, caring and concerned staff members made my stay so comfortable – a suggestion would be ice cream and ice blocks morning, noon and night."

Mental Health Service

Anaesthesia

ANAESTHESIA AND PAIN MANAGEMENT

2013/14 has been a challenging year for the Department of Anaesthesia and Pain Management, mainly due to an increasing workload. However, with a high degree of cooperation and a desire to meet the needs of our patients there has been an increase of 400 patients cared by anaesthesia services.

Session utilisation rates consistently average above 85% in Wellington. Acute workload has impacted on elective numbers, with the total allotted acute time being consistently occupied between 65-70% of the time since September 2013.

The department continues to provide an extremely high level of training and education to its trainees. The implementation of the ANZCA new curriculum in 2013 has seen a number of SMOs take on new roles within the department and all SMOs are now expected to do on-line workplace based assessments of trainees.

With five teaching streams now in operation, trainees are provided with a continual learning experience which is reflected in finals exam pass rates exceeding 90%. More importantly than the end result, is that specialists are not only sought after by CCDHB but many other departments throughout New Zealand and Australia. The department's Finals Exam Preparation Course continues to be oversubscribed with many past trainees now returning to be part of the faculty for this course.

There have been a number of meetings this year between the departments of anaesthesia at CCDHB, Hutt and Wairarapa DHBs. The meetings have allowed the further development of closer ties with the other departments and commitment has been given to the development of common processes, protocols and guidelines, equipment purchasing and generally closer relationships.

RESEARCH AND AWARDS

Research continues to grow with the enrolment of two multicentre trials – the BALANCE and METS trials.

At the 2013 Quality and Innovation Awards, Drs Sandy Garden and Phil Quinn won the Excellence in Collaboration and Integration Award for their project "TEAMS: Trauma in the Emergency Department – Advanced Multidisciplinary Simulation."

Earlier success was achieved at the Allied Health, Technical and Scientific Sub Regional Awards with Jim Hesketh being nominated for the Leadership Award and Sadun Kithalagoda winning the Excellence in Practice Award. Sadun's award was for an extended scope of practice becoming a certified PICC line inserter. Annie Bergemann won the prize for top Anaesthesia Technician in last year's exams.

Transit

FLIGHT RETRIVAL

Flight inter-hospital requests have continued at a steady pace. The CCDHB flight team has noted an increase of higher acuity patients requested for transfer. A total of 795 missions were completed by the flight team, 138 more missions than the previous year. Requests for transport increased by 264 requests to 1745.

The Wellington Free Ambulance liaison officer has been working closely with the renal dialysis department and IT to produce an electronic rostering system for dialysis bookings. This will provide a more accurate, timely system for roster changes which will positively affect those that need transport arrangements. This system will be launched in July 2014.

THE TRANSIT LOUNGE

The Transit Service continues to meet hospital demand, providing the safe transfer of patients within the hospital and inter hospital transfers. They have successfully provided after hours support with the night resource nurse role from 9.30pm-7.00am Monday to Thursday and 6.00pm-9.30pm three evenings per week.

This area continues to increase capacity but there is still room for more patients. A project looked at the flow of Kenepuru patients and prevention of late discharges. This resulted in a new process that improved orderly notification of the transfer and planning of workload and timely transfers. Changes started in April 2014 and the graph shows patients arriving in the Transit Lounge in a more timely fashion from May onward. This has led to an increase in bed hours saved as hospital beds have been freed up earlier.

Transit lounge

Emergency Department

Shorter Stays in Emergency Department: how we achieved 95%

Since the introduction of the health targets in 2010 CCDHB had found it difficult to achieve the shorter stays in ED target. Although a significant amount of work had been done to achieve the target it remained elusive to us while other DHBs of a similar size had managed to move closer to it.

In the past year we took a whole hospital approach to the problem and achieved the target for the first time in 2014, while also ensuring patients received care in a better, sooner, more convenient manner. By taking this joined-up approach not only did we improve against the target, it also meant patients were getting treatment faster and home as soon as possible. Below are some the contributing factors to our improved performance.

START

In May 2014 the Emergency Department piloted a new internationally accepted model of care called Senior Treatment Assessment Referral Team or START. The aim of the trial was to see whether this approach was possible and if it would improve patient care and flow through the department.

The trial ran for a week during the hours of 12.00pm-5.00pm on selected Triage 3 -5 patients. The team comprised of a Senior Medical Officer and senior nurse who would see patients as soon as possible, providing early senior assessment of patients (to identify potential serious illness), to initiate urgent treatment such as analgesia or antibiotics, obtain investigations such as ECG, blood tests, imaging, and to expedite referral to inpatient specialties as required.

Following this initial assessment, patients were either directed into the Emergency Department for further assessment, transferred to specialist assessment units such as Medical Assessment and Planning Unit and Surgical Assessment and Planning Unit, or on occasion discharged directly after the team's assessment.

The pilot showed an increase in the numbers of patients seen within recommended timeframes. This reduced delays for patients and also freed up space in ED for patients requiring emergency assessment.

The START team

"Having passed out in a cafe in Cuba Street I was taken to ED at Wellington Hospital and admitted to MAPU. I have never been admitted to hospital in my life before and was overwhelmed by the kind, professional support I received from all of the staff who attended to me. What an amazing place."

Emergency Department

THE ED GREEN ZONE

The Green Zone was introduced in the Emergency Department two years ago and has become an integral part of the daily function of the department. Although the patients seen within this area are not generally serious or cause bed blocks as they are rarely admitted, they do make up a significant proportion of the people who visit ED. On average 1100 patients or 22% of the total monthly presentations went through this minor care area, enabling us to keep more space free within the main treatment area for more serious cases.

This year we also introduced a dedicated registrar and clinical nurse specialist who focus only on patients within this area. Having dedicated clinicians has meant that we have been able to expand the scope of the patients seen within the area, while also increasing the number of patients seen.

PATIENT FLOW COORDINATORS

The role of the patient flow coordinator is crucial and one of the leading reasons for success in the acute flow management of patients from ED to the hospital. This year the role increased in scope with someone being present seven days a week, and four nights a week (Monday to Friday). The team has worked hard to build its profile and is now well known by all speciality registrars.

Along with assisting the Associate Charge Nurse Manager with the coordination of the department, they manage the acute flow of patients into the hospital from ED and home, booking beds, liaison with ward staff as well as operations and speciality teams. They also analyse presentation rates, breaches and report on any daily barriers to patient flow.

SHORT STAY UNIT

Members of the Short Stay Unit with Director of Nursing and Midwifery Andrea McCance (middle)

The Short Stay Unit is located opposite the Emergency Department and offers an additional observation space for patients who require a stay in hospital for not more than 24 hours.

In the past the unit had been used as an overflow for the hospital, however, last year it was agreed the unit's model of care would change to reflect the greater need for ED to observe patients for periods beyond six hours. As part of this change, the beds were redistributed with only Cardiology and Emergency Medicine having access to them. All medical patients were to use the Medical Assessment & Planning Unit for short stay admissions, while surgical services were to use Surgical Assessment & Planning Unit.

By taking a stricter admission approach, the unit has been able to meet its Key Performance Indicator of discharging 95% of patients home within 24 hours and has an average length of stay of 11 hours, with between 20 - 30 discharges a day.

This allows the unit to admit between 18 – 20 patients a day. Currently ED admits around 14 patients a day.

MEDICAL ASSESSMENT & PLANNING UNIT

The Medical Assessment & Planning Unit (MAPU) receives patients that have been referred by ED or GPs. Patients are assessed to see if they need to be admitted for longer term treatment or if the issue can be resolved in one to two days. Ideally patients tend to stay no longer than 48 hours in MAPU as they will either be admitted to another ward or discharged. MAPU staff treat a range of severity and complexity from blood clots to chest infections, rashes to collapses. Changes made to the unit's structure ensured patients only stayed for a short period, which has improved its patient flow. This included:

- improving the structure of the daily morning meetings
- emphasising to all staff the importance of delivering MAPU's vision and delivery of 24 hour assessment
- making patient flow more visible by permanently displaying the hospital occupancy.

Audits and evaluations on patient satisfaction and clinical standards have been used to guide the direction of changes and help us address the areas where improvements can be made.

MOVING THE HIGH DEPENDENCY BEDS TO 5 NORTH

Originally located within MAPU were four high dependency beds for patients who needed additional observation but not intensive care. In order to assist patient flow, these beds were relocated to Ward 5 South.

Moving the beds led to more space being available in MAPU for patients who require this kind of assessment. The move also meant staff from 5 North had to undergo additional training.

Short Stay Unit & MAPU charge Nurse Manager, Mikaela Shannon

POD D – CHANGES TO MODEL OF CARE

For patients requiring additional supervision due to them suffering delirium or dementia, Pod D was an initiative that looked at changing the model of nursing. This has led to increased supervision with registered or enrolled nurses carrying out more frequent assessments and ensuring patients get the right level of supervision.

MOVING GENERAL MEDICINE FORWARD

General medicine has the largest number of acute patient presentations a year, yet its model of care and structure had not changed for nearly 20 years.

With increasing demand in admissions – the specialty has seen admissions grow from 5,000 per year in 2004 to 9,500 last year – clinicians decided it was time for a change. Work began in December 2012 to redesign the service. The approach was to focus on a model of care that was:

- SMO led
- ensured manageable acute workloads
- made patient flow a priority
- focused on managing increased demand
- ensured patient safety was at the heart of everything we do.

The project was led by a working group of clinicians and staff from areas of the hospital including Allied Health, Nursing and Registrars, as well as staff from Kenepuru.

The group had been meeting on a weekly basis since early 2013 and started the change process by identifying what the problems were and what a new model of care might look like. "We started with broad principles and looked at different approaches by other DHBs and health systems from around the world," said Kyle Perrin, Clinical Leader for General Medicine.

"By looking at these different approaches we were able to create a model of care which we think will work for us, that will allow us to provide our patients the best possible care, while also strengthening our interactions with other specialties and primary care. We also needed to significantly improve our supervision and training of RMOs and we think the new model does that."

This new consultant-led service model has now been implemented to assertively manage acute events. Significant changes include:

- the presence of a consultant in MAPU until 8.00pm
- daily board rounding to address barriers to patient progress
- patients arriving before 8.00pm are now seen by a consultant within three hours
- the introduction of Expected Date of Discharge (EDD) and clinical criteria for discharge
- planned implementation to contact GPs prior to discharge as part of the handover model.

IV TO ORAL ANTIBIOTICS

A campaign was launched to promote a switch from IV antibiotics to oral at 72 hours if the patient meets specific criteria. The aim was to help rationalise the overall consumption of antibiotics, reduce the average duration of IV cannulation, reduce hospital length of stay and decrease the risk of infection.

Since the campaign was launched the percentage of patients on greater than three days of IV antibiotics has decreased by approximately 50%, which in turn means their length of stay in hospital has also been reduced.

Maternity

In 2013/2014, 3,648 women gave birth to 3,736 babies. This was a 3.6% decrease on the previous year. A total of 3,321 gave birth at Wellington (3,435 in 12/13), 215 at Kenepuru Maternity Unit (224 in 12/13) and 112 at Paraparaumu Maternity Unit (127 in 12/13).

There was an increase in the Caesarean Section (CS) rate from 31.1% (12/13) to 32.0% in 13/14.

Mode of birth	2012/13	%	2013/14	%
Spontaneous vaginal birth	2182	57.6	2111	57.9
Forceps	203	5.4	179	4.9
Ventouse	196	5.2	170	4.7
Manual rotation	0	0	1	0
Breech	27	0.7	21	0.6
Total vaginal	2608	68.9	2482	68.0
Emergency CS	745	19.7	736	20.2
Elective CS	433	11.4	430	11.8
Total CS	1178	31.1	1166	32.0
TOTAL	**3786**	**100**	**3648**	**100**

MATERNITY QUALITY SAFETY PROGRAMME

In 2012, the Maternity Quality Safety Programme was rolled out across all DHBs. The programme involves on-going review by local multi-disciplinary teams, including local midwifery and medical leaders. By working together with consumers, midwife LMCs and other community groups the programme has identified potential improvements to maternity services.

During the past year, service delivery has been strengthened by many quality and safety initiatives, including:

- An antenatal renal dilatation algorithm. This was developed in consultation with maternal fetal medicine specialists and neonatologists if a woman's antenatal ultrasound scan showed fetal renal dilatation. The algorithm clearly outlines the timing of postpartum referrals, possible procedures required and where the baby is best cared for in the immediate postpartum period.
- Following one of our midwives successfully completing the Immunisation Advisory Centre's (IMAC) vaccination training course, we now offer opportunistic immunisations to pregnant women attending outpatient antenatal clinics in Wellington. In the past year, 149 women between 20 and 38 weeks gestation were vaccinated against influenza and 70 against pertussis (whooping cough). We hope that by the end of 2014, every woman attending a secondary antenatal clinic or an acute assessment appointment between 20 and 38 weeks gestation will be given the opportunity to receive free influenza and pertussis vaccines.
- The Women's Health Service (WHS) annual clinical report has been produced at CCDHB since 2004. The report is critiqued by guest midwives and doctors who explore the data presented and suggest areas for improvement. A copy of the annual clinical report is available to interested parties via the DHB website www.ccdhb.org.nz/news/publications.
- In the Perinatal and Maternal Mortality Review Committee's Seventh Annual Report (2013) it was identified that all women should commence maternity care prior to 10 weeks gestation, as this will enable an:
  - opportunity to offer screening for congenital abnormalities, sexually transmitted infections, family violence and maternal mental health with referral as appropriate.
  - education around nutrition, smoking, alcohol and drug use, and other at-risk behaviour.
  - recognition of underlying medical conditions, with referral to secondary care as appropriate.
  - identification of at-risk women (maternal age, obesity, maternal mental health problems, multiple pregnancy, socioeconomic deprivation, maternal medical conditions).
- In response to this we launched an awareness campaign entitled "Pregnant? 5 things to do within the first 10 weeks." The campaign used community newspapers, local cinemas, commercial radio, Māori and Pacific radio, street posters, Go Wellington buses and general practice surgeries to share the message. It also used free resources such as social media, the intranet, internal communications, external website and poster boards throughout the DHB.
- A pulse oximetry pilot study began at Wellington Hospital this year. All babies aged between four and 24 hours will, with maternal consent, have pulse oximetry performed. A small probe is placed on the baby's right hand for approximately 30 seconds, then on either foot for the same period of time. A baby is considered to have passed when both the hand and foot readings are at or above 95%, with less than 3% difference in the readings. This simple test may help detect critical cardiac defects and respiratory problems in the first few days of life that are too subtle to notice on initial clinical examination but can lead to a baby becoming critically unwell. Pulse oximetry monitoring will be available in all postnatal facilities by August 2014.
- From 2014, well newborn babies of diabetic mothers no longer required admission to Neonatal Intensive Care Unit. These babies were cared for on the postnatal pod with their mother to protect, support and promote breastfeeding. Comprehensive management plans have been developed and from 36 weeks pregnant women with diabetes are encouraged to express breast milk antenatally.

MIDWIFERY

Four midwives started the Midwifery First Year of Practice Programme in 2013. These programme positions are protected and available to graduate midwives annually. The purpose of the programme is to support newly qualified midwives and enable them to develop and consolidate their midwifery knowledge and practice in a supportive environment within a hospital setting. During this period valuable experience is gained as the midwives work across the scope of practice, in primary, secondary and tertiary level maternity services.

The quality and leadership programme is a national course that provides a career pathway for core midwives, helping to identify and prepare midwives for leadership roles. The three domains are: competent, confident and leadership. Midwives wanting to progress from one domain to another submit portfolios which are assessed by trained assessors.

Within the 2013/2014 period 10 midwives revalidated or progressed to the leadership domain and seven midwives revalidated or progressed to confident domain.

"I want to congratulate the lovely ladies who helped me that day to breastfeed. I had a rough time with breastfeeding due to my baby being in neonates for two weeks so we didn't get the chance to practise after I started using a shield. I wasn't going to go to the clinic but I'm so glad I did. I felt welcomed straight away. It was so busy when I was there but the ladies still come over to give me one on one help and made sure I was OK. Ever since that day I have never used the breast shield again which feels like absolute freedom. As a mum this is an invaluable service."

Porirua Breastfeeding Clinic

Women's Health

RANZCOG ITP TRAINING

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists offer postgraduate training in obstetrics and gynaecology. In 2014 the Wellington HS Integrated Training Programme was audited and received three years' accreditation. This is the first time the service has achieved this.

TE MAHOE

Te Mahoe has undergone a downsizing from a five day a week to four days due to a significant reduction in demand. Te Mahoe provides comprehensive pregnancy counselling as well as first and second trimester terminations for women between five and 19 weeks gestation who reside in the Capital & Coast and Hutt Valley DHB areas.

Te Mahoe is also contracted to provide services to Whanganui, Mid-Central, Tairawhiti, Hawke's Bay, Wairarapa and Nelson-Marlborough DHBs. The Te Mahoe social work / counselling team provide pre-counselling and post treatment counselling to individuals, couples, family and whānau.

WOMEN'S ACUTE ASSESSMENT UNIT

The acute assessment unit provides acute care to women who are not pregnant and those who are pregnant but less than 20 week's gestation. Women seen by the unit are treated and assessed for various conditions including; undiagnosed abdominal pain, Bartholin's abscess, acute dysfunctional uterine bleeding, postoperative complications, suspected or confirmed ectopic pregnancy, hyperemesis gravidarum and miscarriage management.

A small number of women require inpatient admission but many are managed by regular outpatient review or day case surgery. Women requiring urgent after hours assessment are seen in the gynaecology ward.

The acute assessment unit is staffed by two nurses/ midwives, a house officer and a registrar. A change to the Resident Medical Officers roster means that a registrar is allocated to the acute assessment unit from Monday to Friday, and helps triage referrals sent to the service from GPs, LMCs and other services within the hospital linked to early pregnancy or gynaecology issues.

"Great service by all doctors, nurses, midwives, and support staff. Staff always checked we understood. Staff always checked we were okay. Staff were all friendly."

Maternity

GYNAECOLOGY SERVICES

Developing gynaecology clinical pathways was one of the priorities for 2013/14. These were developed in conjunction with the Service Integration and Development Unit and the GP liaison Medical Officer. Clinical pathways are guidelines to assist General Practitioners to treat women with common gynaecological conditions and to facilitate effective and complete referrals to the Women's Health Service.

Obstetric Anal Sphincter Injuries Service (OASIS) commenced in 2013. This new clinic coordinates postpartum outpatient follow-up and assessment with appropriate clinicians, for women who had experienced difficult labour resulting in a medical intervention.

In order to manage the acute flow in the Assessment Service, the new medical staff roster has an allocated registrar from 8.00am-5.30pm Monday to Friday working alongside a senior clinician in the acute assessment service. This has reduced interruptions to the work flow of the on-call obstetric registrar and allowed GPs, LMCs and the Emergency Department easier access for acute patient triage.

Visitors bring smiles to patients at Wellington Children's Hospital.

Children's Health

CHILD DEVELOPMENT SERVICE

The Child Development Service has been consolidating learnings from a large project completed last year designed to match demand with capacity. This resulted in reduced waiting times for children and we have concentrated this past year on maintaining that. We have continued to work with GP practices to share information and ensure appropriate sharing of information at discharge. We have engaged with the Hutt Valley Child Development Service to coordinate in-service trainings and sharing of resources.

A new Pathways Coordinator position has been developed to manage the in-take of work, ensuring referrals are appropriate. This position also oversees some of the pathway work within the Service.

New initiatives this year include the Service developing group work for children and seminars for families. These have been particularly effective in the feeding groups run for children who are tube fed. The groups are aimed at children and their carers to work on feeding skills, while maximising a clinician's time and giving both children and parents encouragement and learning.

The seminars were for children with severely restricted diets due to them having an autistic spectrum disorder. We also ran a series of seminars for families where an autistic spectrum disorder was diagnosed and children had some behavioural or sensory issues that could not be addressed in other services.

INFECTION CONTROL

Within the inpatient paediatric service, significant work has been done to reduce the risk of exposure to hospital acquired infection. Ward 1 and 2 work closely together to manage surgical admissions and ensure children coming to the hospital for surgery are cared for in a safe environment with the highest quality of care.

Staff also worked closely with infection control to improve the protocols for nursing children with both suspected and confirmed bacterial and viral infections. The changes in criteria determining which ward children are admitted to have reduced cross infection rates.

PAEDIATRIC ONCOLOGY

The Wellington service continues as a level 4 shared care service with Canterbury DHB as our tertiary partner. With a change in registrar roster we have more registrars working in paediatric oncology. This has meant medical staff are more familiar with the patient group and service. Recently we have introduced a rotation programme for nurses between the general ward and oncology unit. This allows nurses to spend eight weeks working within the paediatric oncology service. This will increase the nurse's skills and knowledge in caring for oncology patients and support delivery of quality care outside of normal working hours. These initiatives are supported by the National Child Cancer Network who reviewed our shared care service level agreement in March 2014.

PAEDIATRIC EARLY WARNING SCORE

Since January 2013 we have been considering adopting a paediatric early warning score chart to provide early recognition of a child's health deteriorating. Various options were discussed and a multi-disciplinary working group was established to look at how the Christchurch tool could be best adapted to meet the needs of our service. In February the tool was trialled and further refined based on user feedback. Audit and review of the tool is ongoing but anecdotally early warning score has been well received and appears to have had a positive impact on patient safety.

EATING DISORDER PROGRAMME

The inpatient eating disorder programme was developed in 2007 and since then we have seen the number of admissions steadily rise from nine a year to an average of 15. Age ranges from 9 to 15 years of age. The eating disorder programme uses a multidisciplinary approach with weekly meetings attended by young people and their families to plan each stage to achieve desired outcomes. All members of the ward team work with young people with eating disorders.

In response to the growing demand for the programme and requirements to provide a safe service, both for patients and staff, the programme has undergone a review this past year. In collaboration with our community partners, who manage the outpatient programme, we have reviewed criteria for admission, discharge and the pathways through the programme. As a result we now have a five stage programme, instead of seven, with a reduction in the average length of stay from 10-12 weeks to seven weeks. The programme now reflects the young person and family's needs whilst respecting their time and desired outcomes.

NEONATAL INTENSIVE CARE UNIT (NICU)

The Neonatal Intensive Care Unit had another busy year looking after more than 900 babies, while continuing to support ongoing education for its staff. It also runs two neonatal courses: Neonatal Nursing for the less experienced staff and Complex Care Neonatal Nursing for staff with at least two years' experience. Additional regional study days are held throughout the year. This provides an opportunity to increase knowledge and job satisfaction, as well as increase confidence and safe practice, and improve collegiality among hospitals.

This year we started an initiative with Plunket to provide parenting classes for families in NICU and the antenatal pod. If an infant has particularly complex needs they may be in NICU for several months and it is an ideal opportunity to strengthen a family's skills.

A focus this year has been on reducing length of stay in NICU through a range of initiatives including stronger links with regional hospitals, data analysis and discharge planning, particularly for infants with complex social needs.

REGISTRAR CHANGES IN CHILD HEALTH SERVICE

A new acute paediatric registrar roster was introduced in December 2013. This was after several years of work by the registrars who recognised that the existing roster was inconsistent with the care provided in other centres of a similar size. Prior to the introduction of this roster Wellington was the only hospital of its size without registrars on night shifts. House surgeons, sometimes with limited experience, were covering Wellington general paediatrics by themselves from 11.00pm-8.00am. The new roster involved an increase in the number of registrars by two and included subspecialty registrars in non-acute positions in the after-hours roster.

Night shifts are now covered by registrars and the acute service has more appropriate cover during the day to deal with the high volumes of work. This has led to improved patient safety. The house surgeons feel less stressed and more supported. The feedback from both registrars and house surgeons has been very positive as has the feedback from senior nursing and medical staff. We have been able to increase the number of outpatient clinics and as a result can see more First Specialist Appointments, and with the ever increasing numbers of referrals this is good news for pediatric patients.

Changes have also been made to the supervision of registrar clinics with registrars now having clinics alongside consultants with greater real-time oversight and feedback. This will improve training, quality and efficiency. Further improvements have been made in the RMO training with bi-weekly teaching sessions including weekly emergency scenario simulations.

The children's service is involved in two large multi-centre global drug trials. One of the studies is on a medication to improve cognitive performance in people with Down Syndrome and the other is an exciting anti-RSV nucleoside for infants with bronchiolitis.

VIOLENCE INTERVENTION PROGRAMME (VIP)

Over the past 12 months, the focus for VIP has been on building a training investment to implement family violence screening in various service areas. The initial focus has been on Child Health where significant increases in screening activity have been recorded from January to June 2014. Standardised documentation has been developed but further work is required to improve management reporting practices. Experience from Child Health has provided valuable lessons to support implementation to other directorates.

The CCDHB family violence policy has been reviewed and now consists of a suite of policies including family violence, child abuse and neglect, partner abuse intervention and elder abuse and neglect.

Solid progress has been made on the Child Protection Alert System (CPAS) policy and associated procedures. The CPAS policy has been signed off and associated processes will be reviewed prior to certification. CCDHB expect to be able to place national child protection alerts as part of the national programme in September 2014.

Two child protection-focused multi-disciplinary team meetings have been regularly held throughout the year. One has provided a conduit to ensure appropriate support and services are provided for Vulnerable Pregnant Women. A dedicated Child Protection Team has been formed to consider child protection matters on behalf of the DHB.

GENETICS

Wellington Regional Genetics Laboratory has seen an 18% growth in referrals in 2013/14 with the most significant changes being an increase in DNA based technologies. Chromosome microarrays - a high resolution chromosome test - is now offered prenatally through the maternal fetal medicine network nationally. In source partnerships with Southern Community Laboratories and Waikato Laboratory have become a sustained source of increased laboratory revenue.

There has been increased collaboration between Genetic Health Service New Zealand's three service hubs as well as the weekly teleconferences with the clinical leadership team. Increased demand for genetic assessment and growing wait lists remains a significant challenge for the service. GHSNZ is working closely with planning and funding teams from the provider DHBs as well as the National Health Board to provide a plan to address the backlog of cases as well as a strategy to improve the management of genetic tests generated outside the service.

Nursing

A key focus this year for nursing has been developing the nursing workforce and finding better ways to prepare them for future challenges within health care. These challenges include changes in population demographics as the New Zealand population ages, in technology, in the demographics of the nursing workforce, in consumer expectations and changes in the way health care may be delivered. Our challenge as nurses and within nursing leadership is how to meet these changes so that we are consistently delivering high quality and safe care to our patients.

Reunion of Wellington Hospital Nursing Class of 1973 with Andrea McCance, Director of Nursing and Midwifery.

The focus within the Surgery, Women and Children's Directorate has been on developing our capacity to employ and support new graduate nurses which will be an ongoing theme for the coming year. Changes in the past year include:

- finding unique placements for graduate nurses such as outpatient settings
- a new model of orientating new graduates so that they are better supported by the Nurse Educators in clinical areas
- positions have been 'ring fenced' so that they are available at each intake.

Another important part of workforce development is how we continue to support and grow our existing nurses. This will be a focus in the future as we continue to support nurses in developing their portfolios, completing post-graduate education, growing into leadership roles and taking on projects. The implementation of Trendcare in the coming year will enable patient acuity to be factored into the day-to-day workload of nurses and enable nursing roster models to reflect the acuity of their area of work.

At the heart of what we all do is ensuring patients receive high quality, safe, seamless care. There has been much work within nursing over the last year to meet this goal, including implementing the patient admission to discharge plan. This provides a tool for staff to carry out accurate assessments and develop a plan of care in partnership with their patient.

Another practice change was to peripheral intravenous (IV) line dwell time. Traditionally IV lines were routinely removed every four days. Intravenous lines can now stay in as long as there are no signs of complications and they are still being used, reducing the discomfort for patients.

Targeted approach to caring for the elderly

Caring for the elderly represents a large patient group that is seen in many settings and services. Previously patients have not been identified as "frail" but recent studies have shown the benefit of identifying this condition, primarily because frail older patients often require a different level of support and care compared to those who are not frail.

Frailty is clinically described as a decline in multiple body systems due to ageing which results in vulnerability to changes in health status. People with frailty have an increased risk of falls, disability, long term care and death.

In the past these types of patients have been challenging to care for in both the hospital and community setting. With this in mind the Medicine, Cancer and Community Directorate spent time planning a number of projects to better support the assessment, planning, treatment and on-going support for the frail older person.

The goals of the programme are to provide early identification of the frail older person, specialist assessment and care planning at the hospital front door providing effective alternatives to hospital care where appropriate. In the case where a person is admitted, the programme aims to deliver good care and good discharge planning. When that person is discharged back into the community the programme will deliver early specialist led assessment and a treatment plan to support the person where they live.

A CAREFUL APPROACH IN EMERGENCY DEPARTMENT

One part of this project will see Wellington ED initiate a frailty screening tool from the end of July 2014. This quick screening tool will be used on anyone over the age of 75 and allow for the early identification of patients who are vulnerable to sudden changes in their health, which may be caused by small events such as a minor infection or change in medication. Patients identified as frail are then referred to the CAREFul Team (Caring for the At Risk Elderly person who is Frail).

The CAREFul team is a multi-disciplinary team of a nurse, pharmacist, geriatrician and physiotherapist. This team works in collaboration with one another and ED to create care plans for those being admitted and discharged home. This can include consultations and referrals from specialist services, for example physio, geriatricians and rehab to outpatient community support and in home services.

The objective is that patients will receive a geriatric assessment and plan as close to their admission as allows. This assists in identifying patients who can avoid a hospital admission and coordinating community support and follow-up.

Having a team focusing on frail older conditions will improve the overall quality of care of frail older patients within our services.

ASSERTIVE MANAGEMENT

Another part of the programme has seen Kenepuru Community Hospital engaged in a series of quality improvements to implement assertive patient management principles. This had led to an overall reduction in bed days. The aim is to:

- remove all unnecessary waits in hospital
- standardise processes
- improve patient safety by reducing harm events in hospital
- improve patient's knowledge of their condition and hospital stay.

We aim to ensure that all staff involved in frail elderly care are aware of their health, functional status, treatment plan and progress against the plan. This project aims to engage all staff in the identification of barriers or delays to delivering the care required for a patient to be discharged.

To achieve the project objectives all members of the clinical teams need to be involved in proactively progressing patient care plans to achieve timely discharge.

COMMUNITY BASED CARE WITHOUT THE WAIT

The Community Teams are aligning their work to eliminate waiting lists by scheduling patients' appointments close to the receipt of the referrals. This will enable timely response to referrals and supporting discharge.

Occupational therapist Helen Clarke providing an in-home cognitive assessment service for her patient.

In particular there has been a shift to assessing patients in their own home on discharge rather than assessing their needs in a hospital setting. This has been named 'the discharge to assess process'. It is early days but the process appears to be enabling patients to get back to their lives in their own homes earlier than previously. Both inpatient and community teams are involved in this work.

This coming year Compass Health PHO and CCDHB are starting projects to support clinical staff across primary and secondary services to deliver care in a more joined up and integrated manner. The focus will be on sharing information, proactive care planning and delivering community based care without the wait.

There are a number of health pathways implemented or under way including cellulitis, sepsis, chest pain (suspected acute coronary syndrome) and more will be developed in the coming year.

Allied Health also underwent a review of how referrals to the community Older Adult, Rehabilitation and Allied Health (ORA) teams went this year which has led to a significant reduction in waiting times for patients waiting to see our Wellington teams. This was achieved by piloting a new model that allows more resources in order to manage referrals from other community teams.

"An informed discussion and interview which allowed us to make some positive changes to my life. We were unaware of who could provide additional assistance for care in our area. Most helpful, informative, sensitive and caring."

Care Coordination

Clinical nurse specialist James Robertson and infection control nurse Viv McEnnis

Infection Prevention and Control

The Infection Prevention & Control (IP&C) service won the 2014 National Hand Hygiene Quality Improvement Award for a DHB with more than 300 beds. This is an excellent achievement and the team thoroughly deserved this accolade.

Infection Prevention & Control, together with the Occupational Health Service, have spent the past year focussed on imbedding their programmes into the organisational culture so they become part of everyday staff behaviour. Some of the key achievements this year were:

- staff influenza vaccination rate = 57% approx. (this is an interim figure with the final rate calculated August 31st)
- orthopaedic surgical site infection process figures showed 96 -100% compliance.
- the Central Line Acquired Bacteraemia zero programme continues to be a success with the DHB continuing to have only 1-2 cases per year in the Intensive Care Unit.
- the Neonatal Intensive Care Unit and Renal Service continued to have extremely low incidence and rates of line infections.
- isolation signage and provision of additional training and education on isolation practices were all updated.
- the installation of alcohol based hand rub at the foot of every bed.

Radiology

Better, sooner, more convenient health care delivery has been a key driver for radiology this past year with staff reviewing and redesigning the CT modality or imaging. This re-engineering has led to increased efficiencies and greater throughput of scans with an 11% increase in activity so that around 350 people are scanned every day.

Sub-regional work has seen the formation of a 3DHB radiology working group which is starting to develop common protocols and polices. The delivery and implementation of a regional computerised information system, including patient archiving, (RIS/PACS) will enable closer and more efficient working across Wairarapa, Hutt Valley and Capital & Coast DHBs.

Staff across the sub-region were consulted about formalising a 3DHB approach to radiology. Feedback is now being considered, as a pathway forward is developed concerning the overall management structure of a 3DHB radiology service.

Another successful accreditation visit by International Accreditation New Zealand (IANZ) saw minimal recommendations which confirmed our commitment to improving quality standards and initiatives.

Radiology team

Pharmacy staff busy making the aseptic cytotoxic drug

Pharmacy

In January this year the Pharmacy Service started preparing all chemotherapy drugs onsite instead of outsourcing the majority of aseptic cytotoxic drug preparation to a commercial company in Auckland.

This involved the acquisition of an additional isolator, some facility modifications and the recruitment and training of additional staff. This has made a significant difference to patients as this group have conditions that can change rapidly. Having the in-house facility means the department is able to be more responsive to patient needs. Another benefit of the facility in-house is reducing waste to nearly zero as these drugs have a short shelf life.

This has been a very successful project with positive feedback from clinical oncology staff.

In addition to making things better for patients, the pharmacy has also made significant savings. Total expenditure on medicines compared to the same time last year shows a decrease in drug expenditure of $965,307. It is estimated for the first six months of this year the in-house manufacture of cytotoxic drugs has made net savings of around $475,000 and is significantly contributing to the overall drop in DHB drug spend. There is no doubt that a significant portion of this is also due to decreased expenditure on antibiotic drugs, a spin-off of the now well established antimicrobial stewardship programme.

A new clinical pharmacy service for the Emergency Department was implemented and very well received by staff. After a year the service is now well established and the role continues to evolve with benefits seen in terms of problem solving medication related issues and contribution to improving patient safety and the patient journey.

Pharmacy team

Daily Medical Board Round

Internal Medicine

A new consultant-led service model for Internal Medicine has been implemented to assertively manage acute events. Significant changes include:

- the presence of a consultant in MAPU until 8.00pm
- daily board rounding to address barriers to patient progress
- patients arriving before 8.00pm are now seen by a consultant within three hours
- the introduction of Expected Date of Discharge (EDD) and clinical criteria for discharge
- planned implementation to contact GPs prior to discharge as part of the handover model.

Clinical input and evidence are the drivers behind these 'best practice' changes. Underpinning them is the point that National Health Service improvement advisors Dr Ian Sturgess and Liz Sargeant made during their presentations to CCDHB staff last year – that frail elderly people are at risk of significant harm from acute hospital admission.

Cancer Services

The Ministry of Health cancer wait time target of four weeks from decision to treatment has been consistently achieved in the past 12 months. The Faster Cancer Treatment 62-day indicator will become the cancer health target in October 2014 and planning is well underway across a number of DHB services in preparation of this.

The cancer multi-disciplinary meetings continue to grow with 12 tumour streams now running regular meetings as part of the Faster Cancer Treatment Programme. We have recently appointed two Cancer multi-disciplinary meeting coordinators to assist with the day-to-day running and administration associated with these meetings, maintain consistency across the different tumour groups and facilitate on-going improvements.

The three Cancer Nurse Coordinators are now 12 months into their roles and have helped develop some necessary pathways for bowel and lung cancer patients who are referred to the service. Work will continue over the next 12 months to formalise these pathways and increase the level of coordination put into individual patient journeys. The Cancer Nurse Coordinators have also assisted the Central Cancer Network retrospectively audit patient journeys against the national tumour standards, for both bowel and lung, identifying areas for improvement at a local and regional level.

ANTIMICROBIAL STEWARDSHIP GROUP

The Antimicrobial Stewardship Group was established in 2012 to ensure antibiotics were being prescribed and used appropriately to combat antibiotic resistance and ensure safe prescribing.

Antibiotic resistance compromises clinicians' ability to treat even the simplest infections and it is growing rapidly around the world. Wellington Hospital received international attention in November 2013 as it encountered the first New Zealand patient who had been colonised by a bacterium resistant to all-known antibiotics.

Since a peak of nearly $1,850,000 spent on antimicrobial agents in 2010/2011, the Antimicrobial Stewardship Group has driven savings of at least $220,000 in annual expenditure on antibiotics. It is a multi-disciplinary group, and its members include representation from infectious diseases physicians, microbiologists and pharmacy.

Through regular educational materials, for example Antibiotic of the Month campaign, significant declines in the use of intravenous antibiotics have been seen. Campaigns such as the 'IV-to-Oral Switch', promoting the use of oral antibiotics over intravenous (IV) antibiotics when safe, saw a 50% drop in the percentage of patients on IV antibiotics over three days.

Updated antibiotic guidelines were released in September 2013. These were accompanied by lanyard reference cards, which were given to all junior doctors. New guidelines for Surgical Prophylaxis were also developed and released in February 2014.

"From start to finish staff were professional, caring and compassionate. I felt safe and understood at every stage of a very difficult process."

Te Mahoe

CULTURAL EXCHANGE OF PACE FOR JUNIOR DOCTORS

Two Wellington Registered Medical Officers (RMOs) will finish their second postgraduate year (PGY2) in London thanks to an international exchange programme unique to CCDHB.

For the past four years CCDHB has hosted three to four British doctors a year on their postgraduate equivalent Foundation Year 2 (F2).

Now our RMOs are getting a taste for life in busy hospitals like Hammersmith and Charing Cross, thanks to a placement at the coveted North West Thames Foundation School.

Access to workign in Britain for foreign RMOs has been highly restricted over the past three decades until the idea of a reciprocal exchange grew from a discussion between Wellington Hospital Postgraduate Mentor Dr Peter Roberts, former London Deanery head Professor Liz Pace and Associate Dean, Professor Ian Curran.

PGY2 trainees have a reputation as "a bit of a lost tribe", Peter says. "The second postgraduate year is a major span in the two year bridge between being a medical student, and a specialist trainee. These people are finding their feet in medicine, so they should be receiving a wide range of supervised experiences."

More than five years' worth of extensive discussions and negotiation between a number of bodies, from the Imperial NHS Trust, and the NZ and UK Medical Councils, to immigration services had to be undertaken in order for the reciprocal exchange to succeed.

"Liz and I wanted to know what effect it would have on our organisations' cultures. Our hope is that we can measure any change in local culture to see what can be done to improve healthcare practice in both countries."

Postgraduate Mentor Dr Peter Roberts with Londoners Dr Chris Lutterodt, Dr Lauren Ewington, Dr Annika Kaura, and Interim CEO Debbie Chin. The exchange doctors spent their four months making the most out of the opportunity to learn healthcare in a different setting.

Kenepuru & Kāpiti

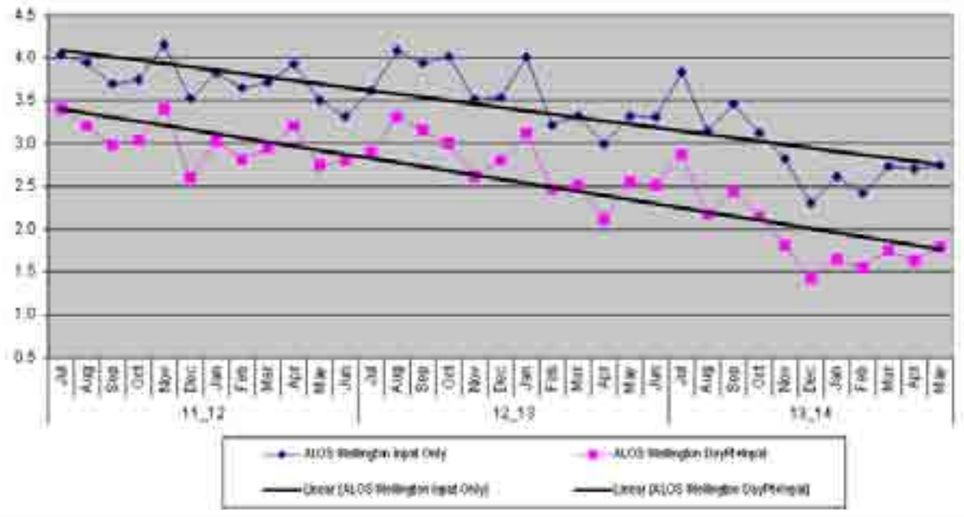
KENEPURU COMMUNITY HOSPITAL

Kenepuru Community Hospital has undertaken a series of service improvements around assertive discharge planning, multi-disciplinary communication, and a reduction in the use of 13 beds. This has required a 'cultural shift' on our behalf, in order to recognise the harms that frail elderly patients face in hospital, for example falls and hospital-acquired infections.

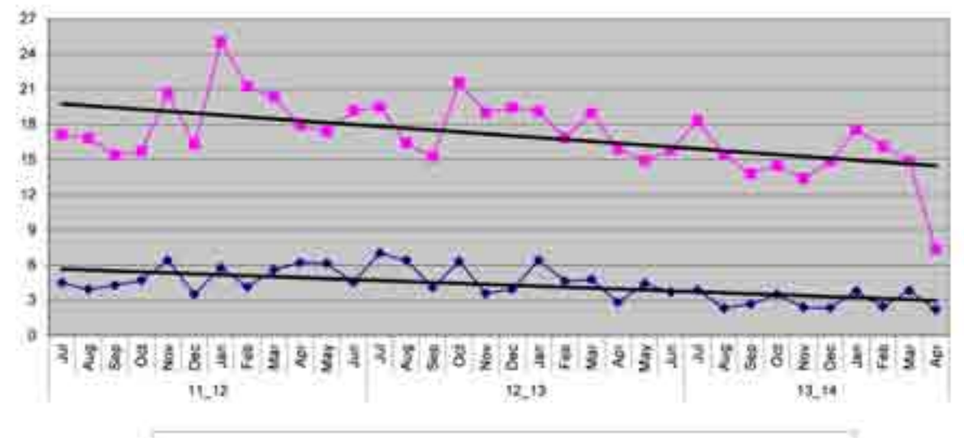
So far, these efforts have shown encouraging results, evident in the following graphs which look at trends of average length-of-stay (ALOS) in our hospitals.

Mums with babies born at Kenepuru Hospital.

ALOS of internal medicine inpatients + daypatients in Wellington (not transfered to Kenepuru)



Comparison of inpatient ALOS for internal medicine patients discharged from Wellington to Kenepuru



KENEPURU INPATIENT WARDS

Rapid improvement events for Wards 4 and 5 resulted in a number of initiatives being implemented. These include:

- a focus on assertive case management during board rounds
- My Ticket Home initiative providing better information for patients/families/whānau about the reason for admission and expected date of discharge
- enhanced multi-disciplinary care planning and documentation, especially around supported discharge models
- SMO rounds in Wellington for first assessment, care planning and decision on transfer – this ensures that appropriate patients are transferred, handovers are decreased (therefore decreasing risk) and their care planning begins at the first opportunity available.

KĀPITI HEALTH CENTRE TURNS 10

A Minister, a mayor, and the maternity unit's first mum came together with staff on 1 November to celebrate a decade of good health at the Kāpiti Health Centre.

Tania Yip was the first woman to use the new birthing unit in 2003 and was joined by her daughter Pearl, who also celebrates her 10th birthday this year.

Celebrating Kāpiti's 10th birthday was Otaki MP Nathan Guy and Kāpiti Mayor Ross Church with Pearl, who was the first baby born at the maternity unit.

"Health care on the coast has always had a strong community base, and it has been a source of that community since the opening of the Paraparaumu Maternity Hospital in 1958," CCDHB Chair Dr Virginia Hope said at the event.

"Since then the people have changed, and so has the health service. Ten years and one day ago today, the opening of the Kāpiti Health Centre brought many services under one roof to accommodate the coast's future health needs."

As a clinically-integrated health centre, Kāpiti was well-ahead of its time when it came to international best practice, she said, with specialist clinics, community nursing, mental health, and Māori health providers all hosted on site as well as maternity.

Mental Health, Addictions & Intellectual Disability

THE THERAPEUTIC GAINS OF GARDENING

A 'garden group' of eight clients with an intellectual disability has converted half of the Porirua Hospital's bowling club's pristine green into a full-scale vegetable garden. The garden group grow produce, harvest it, and prepare meals with the help of on-site staff.

Day Programme Support Worker John-Paul (JP) Magill says the hardest thing is getting the clients to weed, "but they love working with tools and doing the lawns. They love lawn mowing, so we bribe them with it but we do it together. I get down on my hands and knees with them".

The garden has enabled the group to all gain NZQA Level 1 Horticulture qualifications from Whitireia, and one of the dedicated supervisors is also a qualified chef, who assists them in preparing meals as part of their therapy, Te Korowai Whariki.

"It's about giving them a purpose to what they're doing – we want them to cook for each other as part of a communal thing. It's all about promoting healthy eating, it has literally taken us years to get them to eat vegetables," operations manager Rosanne Johnson says.

While the group have helped out with some tree planting around the Kenepuru grounds, their next big project is restoring the ornamental garden that runs alongside the bowling green.

RELOCATION AND REFURBISHMENT

Two significant changes to the Intellectual Disability Service has seen Hikitia Te Wairua, the national youth ID unit, opened in December 2013 on the Kenepuru Campus. This unit caters for up to eight patients. The other change was the refurbishment of Te Aruhe, previously the youth ID unit. From February 2014, Te Aruhe is now the national long stay cottage for three clients. Both units are working well.

A number of adult teams in the past 12 months have been relocated into more easily accessible, earthquake safe and therapeutically conducive environments. Feedback from consumers, their whānau and staff has been very positive.

SERVICE CONTRACTS

The Directorate continued to secure new contracts this year, including the Behaviour Support Services for the National ID Service. This reflects the confidence the Directorate has enjoyed with the Ministry of Health and is due to the quality and commitment of our staff to deliver quality, patient focussed services. The additional revenue that follows new contracts continues to improve the financial sustainability and service improvements. Funding was also secured for the development of a Legal Compendium detailing the history of the implementation of criminal procedure and intellectual disability legislations alongside relevant case law.

The ID Service has a contract with 'Joining The Dots Advocacy', which provides services for people in the intellectual disability inpatient unit. The main components of the service are to provide advice to clients, attend unit meetings and, in conjunction with management, assist in resolving issues which have been raised by clients.

RESEARCH

Research has been a big focus of the service this year. The Good Life project, which is a therapeutic model for secure services, has been introduced to an inpatient unit with results presently being analysed. The project is a rehabilitation framework that suggests all human beings (including those with mental disorders who have offended) seek certain goods - for example, inner peace, relationships, happiness, community, excellence in work - and that problems arise when unhelpful means are used to obtain these goods. The task of rehabilitation is to provide individuals with the skills and opportunities to obtain these goods by helpful rather than unhelpful means.

In conjunction with the University of Otago, Te Korowai Whariki researchers are attempting to address two important health issues for clients – weight gain and bowel problems. The researchers are using radiopaque markers to analyse the effects of different antipsychotics on the bowel – this is the first time this type of research has been conducted in the world.

The Stepping Stones Programme, formulated by two psychologists in the Intellectual Disability area, was awarded the Team of the Year in the 3DHB Allied Health, Technical & Scientific Awards in August 2013, with two articles in the national Te Pou publication in July 2013.

BRIGHTENING UP HANIA STREET

Visitors to mental health services based at Hania Street now have something else to smile about, thanks to the creative aptitude of some local street artists.

Registered Nurse Dion Howard, who works with the Child Adolescent Mental Health service based at Te Whare Tipu (the House of Growth) on Hania Street, says the refurbished premises in the Life Centre building are good, "but we're still tucked away in the middle of an industrial zone."

He saw an opportunity in the grey wall of the neighbouring Honda Wellington workshop, so he approached street artists BMD to paint a mural that would appeal to all ages.

"Physical environments are really important for young people, or people of any age, in fact," he said.

In spite of that growing appreciation for public painting, "they don't always get the best response when they approach landlords to paint over their blank walls," Dion said.

However, Honda Wellington was already paying for petty tagging to be removed on a monthly basis, and was quick to come around after his initial approach, he said.

The entire mural emerged over the course of two days and clients have voiced their approval, with one saying "how awesome it was, and because of that, less likely to be tagged over. Which is great feedback," he said.

Hania Street gets a lot of general foot traffic and it was great to see the delight on people's faces, Dion said.

The mural was jointly-funded with leftover fundraising money, and the support of Resene Paints, the Emerging Artists Trust (EAT) and BMD themselves.

TE ARA PAI (STEPPING STONES TO WELLNESS)

Te Ara Pai (Stepping Stones to Wellness) is a new initiative which started in 2013 and has proved successful.

Highlights include:

- increased collaboration between non-government organisations
- better support for clients to maintain their housing, with less homelessness and eviction issues
- supporting a large number of clients getting into their own home rather than living in supported accommodation, and
- clients enjoying a greater sense of community by being closer to their home.

The project will continue to streamline and better support what has already been put in place.

In the Addictions Service, the Choice & Partnership Approach has been introduced. This is a systematic methodology for organising services based on capacity and demand science and 10 High Impact Changes for Mental Health Services. Clients are provided with more choice and services and are in turn able to maximise resources and access more convenient healthcare delivery.

As an internal mechanism, a Directorate wide restraint and seclusion group was set up to oversee the use of these two elements in clinical practice. One of the outcomes is to promote the use of seclusion and restraint prevention tools and alternative strategies.

FUTURE DIRECTION

The beginning of 2014 saw the start of the 3DHB integration of the Mental Health, Addictions and Intellectual Disability (MHAIDS) Directorate – these are services presently operating in Capital & Coast, Hutt Valley and Wairarapa DHBs. The first stage involved the appointment of a General Manager MHAIDS 3DHB reporting directly to the two Chief Executives.

Work on the business model and single service operational structure has started and due to be completed by December 2014. The entire change process is underpinned by the Triple Aim of improving preventative health and empowered self-care; provision of relevant services closer to home; and quality hospital care including highly complex care for those who need it.

"I received excellent service over a period of one week and the different staff members and students were very friendly, professional and provided me with excellent care and endless smiles and humour. They helped me to improve my state of mind with a lot of respect, humour and interest in my person."
Regional Acute Day Service – Mental Health

The Te Ara Pai (Stepping Stones to Wellness) Team

Quality Improvement & Patient Safety

The Quality Improvement and Innovation Awards were held for the second year in November 2013. The awards consisted of eight categories aimed at recognising, rewarding and publically acknowledging CCDHB staff and community based services that have created excellent quality improvements and innovations.

With 33 applications received from hospital, primary care and Non-Government Organisations (NGO) staff there were plenty of examples of the amazing quality improvement work across the sector.

The Supreme Award went to Kāpiti Youth Support. This dynamic, innovative service strives to provide the best care and support to young people at the same time as reducing disparity amongst its community. The region has gone through considerable growth during the past few years and demand for their services for increased. They have also seen a need for greater diversity of services due to the increasing number of young people presenting with complex needs.

All the 2013 winners were:

- Commitment to Quality Improvement Award: 'A Journey toward patient centred e-health', Island Bay Medical Centre
- Excellence in Innovation Award: Child Development Service Improvement Project, Rachel Prebble, Child Development Service
- Excellence in Collaboration & Integration Award: Trauma in ED – Advanced Multidisciplinary Simulation, Dr Sandy Garden and Dr Phil Quinn
- Team of the Year Award – Kāpiti Youth Support
- Health Workplace Award – Mana Recovery Trust, Ngo Mental Health Services
- Leadership Achievement Award – Jane MacGeorge, Director of Clinical Services, Mary Potter Hospice
- CEO's Award – Dr Kyle Perrin
- Supreme Award – Kāpiti Youth Support

EMPLOYEE ENGAGEMENT

CCDHB's Employee Engagement and Patient Safety strategy includes a survey of all staff as one measure of the organisation's culture and is used to identify areas of strength and areas for improvement. The DHB uses the University of Texas Safety Attitudes Questionnaire. The questionnaire asks about six elements of safety culture: teamwork, safety climate, job satisfaction, stress recognition, perception of management and working conditions.

Staff were surveyed in August 2013 with a response rate of 58.9%. This compares favourably with other NZ surveys which average about a 30% response rate and shows 2/3 of CCDHB staff were motivated to have their say with clear evidence of an improvement for perceptions of management and working conditions.

HEALTHY LIVING

Following on from this research into weight gain, clients are becoming more aware of the need for healthy living and Ruaumoko, the Māori Mental Health Centre, has taken the lead with activities such as climbing Colonial Knob, as well as offering regular 5, 7 or 10km walks and an event called "The Great Race Relay".

Supreme Award winners – Kāpiti Youth Support

ADVANCE CARE PLANNING

Advance Care Planning is a process of discussion and shared planning for future health care and is particularly relevant to those who have long-term conditions. Advance Care Planning involves the patient, those close to the patient and clinician/s having discussions about diagnosis, prognosis, and future treatment possibilities within the context of understanding the patient's preferences.

During the past 18 months CCDHB has been developing an Advance Care Planning (ACP) Framework. This has involved developing ACP guidelines, and supporting work carried out at a national level as well as working with Primary Care.

The development of an effective Advance Care Planning model across CCDHB is starting to enable systematic changes in how we provide the most effective and targeted health care to patients when they become seriously unwell, including in their last years and months of life. Key achievements over the past 18 months have been:

- fourteen CCDHB staff attended the National Cooperative Training Programme and are now building conversations regarding ACP into their daily practice.
- the Renal Service has concurrently been developing a Supportive Care Programme and ACP is a component of this.
- ACP guidelines have been developed, endorsed and approved.
- a Primary Care Pilot was undertaken looking at ACP within the primary care setting.

Overall, the Advance Care Planning framework development has started to enable discussions with patients and families about what the most effective and targeted health care they would prefer during their last years and months of life.

'CHALLENGING CONVERSATION' MEETING

"I write to you with appreciations following the meeting held between our family and all key members of the … Department. I especially want to acknowledge every action and follow-through since our meeting and the work already in-progress within your department to improve your services to all. As a result of our meeting with you, we are pleased to advise that it provided us with closure. Firstly - that you were all willing to meet with us meant everything. (I really want to stress to you how important it was to us - it meant the world). We felt as though we as a family were being listened to and that your department cared about our wellbeing."

– Letter from a family member after a "challenging conversation" meeting.

PREVENTING PATIENT FALLS

Falls prevention has always been a focus in the DHB with a culture for reporting fall incidents as a mandatory reportable event. In 2013 the Falls Prevention Group took part in the Health Quality Safety Commission's National Reducing Harm from Falls Programme. This was a patient-centred system that signalled the level of mobility assistance a patient needed, supported by a patient's involvement in keeping safe when mobilising. The system reinforces the message "It's OK to ask for help".

The six DHBs in the Central Region trialled the signalling system resources that are now part of the standardised falls prevention approach that has been achieved across adult inpatient areas as part of the falls prevention programme. The end result was increased staff and patient awareness around the risks of falling.

During the past 12 months there has been a 10% improvement sustained in the fall rate per 1000 bed days rolling average. It is our aim to continue to make improvements during the coming year.

PATIENT SAFETY

"Zero Patient Harm" and "Patient and Whānau Centred Care" are specified priorities for the DHB with each priority supported through a range of safety and improvement programmes. The DHB continues to align this work with the NZ Health Quality and Safety Commission's work programmes and work closely with our colleagues in other DHBs.

Our Patient Safety Officer provides expert advice and leadership across the organisation to management, services and staff. We routinely share learnings from our reviews of adverse events with the aim of building knowledge, improving safety and preventing harm.

A strong focus in the past year has been on the experience of patients and whānau when things go wrong. Cases where there had been delays in notifying family about a patient's sudden deterioration were used to highlight to staff the impact delays can have on time with loved ones and on subsequent grief and coping. The importance of checking contact details on every admission in an age where people change such things regularly was emphasised.

CCDHB recognises that excellent communication is a critical skill for health care professionals. We offer staff access to a series of five half day workshops, each focused on development of skills in a different aspect of communication. One of the workshops is now included within the first year doctors teaching programme and helps equip them for the challenging conversations they need to have in their work.

CONSUMER EXPERIENCE

This year we took a major step forward in the way we collect feedback from our consumers about their experience by emailing the patient satisfaction survey to those who provided us with an email address.

So far 12,000 patients have been sent the survey, with approximately 25% returned each week. The information is then used to help us improve our inpatient experience and quality of care. Patients are also given the opportunity to ask for contact from the Patient Experience Facilitator if they wish to provide further feedback.

We continue to receive valuable information from our own complaints and compliments. All compliments received by the Quality and Risk Unit are sent to the areas concerned, while a selection are also published in the bi-monthly in-hospital newsletter Changing Times. This means that all staff can read some of the compliments we receive.

This year also saw the establishment of a Consumer Council. This provides a point of contact and feedback from a consumer and health service user perspective across the DHB. The Consumer Council is part of our DHB focus on patients and whānau centred care and offers consumers input in to many activities including service planning and development, and improvement and safety activities.

Māori Health

With the development of annual Māori health plans, there has been a significant amount of work, regionally and nationally, to provide monitoring and reporting against these indicators. Annual Māori health plans include 12 national indicators and 15 associated targets. In the past year we have worked across the organisation to identify areas of success and areas requiring accelerated performance.

CCDHB has created a Whānau Ora collaboration which includes leaders from each PHO, Regional Public Health and Māori providers to work with the Integrated Care Collaborative (ICC). The aim is to develop a Māori voice so it can have a greater contribution to the wider ICC programme.

CCDHB continues to provide a range of tailored training opportunities to build staff capability in dealing with cultural sensitivity. With the successful implementation of the in-house Tikanga training module, CCDHB has been approached by external organisations to provide this training, including 4th year medical students at the University of Otago, Wellington School of Medicine.

DNA review of Child Health Outpatient Clinics & Related Services

The Māori Health Development Group and the Child Health Service initiated a systems review of Child Health outpatient clinics and related support services to better understand outpatient clinic attendance in order to improve it.

This review included interviewing whānau, administrators, clinicians and GPs, and was part of a national Ministry of Health sponsored health literacy project. It built on our previous work aimed at increasing clinic attendances and plain English usage.

Missed clinic appointments or DNA (Did Not Attend) can have a severe adverse effect on the health and recovery of patients. Many reasons for non-attendance at children's outpatient clinics were identified. The review found that accessing children's outpatient services often placed family and whānau in unfamiliar health processes and new environments, and involved multiple health services such as primary care, in-patient and out-patient services. This led to coordination and communication challenges for services and families.

Implementing findings for system improvement is now underway. These are around improving communication, navigation and access issues, meeting the needs of patient and whānau, management and leadership issues. Implementation is likely to take a layered approach, acknowledging that improving clinic attendances requires a multi-prong approach.

Legal Services

Legal Services continued to provide advice to staff and proactively manage legal risk throughout the year. Another successful Privacy Awareness Week was held, aimed at raising awareness of the importance of keeping data secure and using it responsibly, especially when searching records. Feedback on the campaign was very positive with the Privacy Quiz proving popular with staff.

The Legal team were finalists in the New Zealand Law Awards. This was a big achievement for such a small team with one of the voters commenting:

"A fantastic team that work together with a solutions-focused outcome in an industry with extremely complex clinical health issues dealing with a wide range of people such as coroners, medical practitioners, administrators, funding organisations, service providers and patients."

Research Office

In its fourth year of operation, the Research Office has consolidated its role of guiding research activities in the DHB. Associate Professor Andrew Harrison was appointed as Clinical Leader, Research in November 2013, providing a link with the University of Otago Wellington and Hutt Valley DHB. The Research Governance Group comprised of senior staff from across the DHB who are active in research, and provides oversight for the activities of the Research Office.

In the past 12 months the Research Office has awarded nine grants to DHB staff to assist them with their research. A mechanism for approving low-risk projects that are outside the scope of the Health and Disability Ethics Committee has been initiated. The Clinical Trials Unit has continued to undertake sponsored research, mainly in rheumatology and income from these trials is used to support the activities of the Research Office.

Learning & Development

The Learning & Development group leads the strategic direction for education, learning and development at CCDHB, and works across the 3DHBs to ensure that staff potential is maximised through a high quality learning and development service.

This year L&D has initiated a number of service improvements, including:

- upgraded assessment and quiz based software to produce more engaging and interactive e-Learning packages, which staff can complete at their own convenience.
- the second Clinical Educators Forum ran over 10 months and was well-attended. From this, a new workshop called Creating Great Learning was produced and will focus on using a structured approach to design, develop and deliver effective courses and programmes.
- the group led an extensive project in collaboration with health professionals and the Ministry of Health to identify key competencies for nurses in the new Cancer Nurse Coordinator role. A matrix and workbook was produced from this project and is now in use by DHBs across the country.

Emergency Management

At the end of May, Capital & Coast ran an 'Emergo' mass casualty exercise where 60 casualties from a transport crash were processed through the hospital. Staff from various services throughout the hospital took part.

The Emergo Training System, developed at the University of Linkoping in Sweden, is an interactive simulation tool that uses whiteboards and magnetic symbols to represent casualties, current patients, staff and resources. A large bank of 'casualties' with various injures is available, along with protocols giving outcomes based on the treatment provided during the exercise. Real time management is used and trained senior Emergo instructors from DHBs and St John facilitate the exercise.

The main purpose of the exercise was to test the Wellington Regional Hospital Mass Casualty Plan, along with individual service plans such as the Emergency Department.

The exercise facilitator said it was clearly evident that CCDHB is well prepared and would respond well to any mass casualty incident.

Emergency Management also provided an urgent response to the two Seddon Earthquakes in late July 2013. This required a quick review of all CCDHB buildings to ensure operational safety of staff and patients. Facilities staff had to inspect enclosed basements and rooftop plant rooms while significant movement from aftershocks was still occurring at regular intervals. It is positive to note that emergency procedures worked well during this time.

Procurement & Supply Chain Services

During the past year Procurement & Supply Chain Services have continued to focus on seeking sustainable growth across actual and annualised savings as it builds alignment to national and other collaborated initiatives while still maintaining a local flavour for regional and sub-regional projects.

Procurement & Supply Chain Services will continue their current direction of developing a proactive and collaborative culture across Wairarapa, Hutt Valley and Capital & Coast DHBs. From 1 July, 2014, the national shared services platform and residual services left within the DHBs will be better served with a culture that supports a sharing of commercial knowledge, sector experience, and aligned growth.

'Emergo' mass casualty exercise

Building more innovative business relationships with major suppliers and distributors is a key priority and work steadily continues towards the nationalisation of Procurement and Supply Chain services. This work will ensure the DHB gets value for money from its spending on supplies and health services. In the past year actual savings were $7 million with an annualised impact of $11.5 million. Actual savings are $2 million above what was achieved in 2012-13 with a similar increase for annualised savings.

The majority of these savings came through internal DHB projects carried out in collaboration with both non clinical and clinical services. Other avenues for savings were initiated through national and regional initiatives. It is anticipated these savings will grow throughout 2014-15 as financial benefits from the nationalisation of procurement services, and alignment of residual procurement across the sub-regional DHBs comes into effect.

Other areas of savings have been achieved through:

- Clinical Product Advisors working closely with all clinical services to standardise medical consumables and finding less expensive but clinically acceptable alternative products.
- regular screening CCDHB departmental imprest levels. This has resulted in $274,000 of unused product being returned to Main Store and departments subsequently credited.
- alignment of pricing across Wairarapa, Hutt Valley and Capital & Coast DHBs for products from the top 25 suppliers. This resulted in $125,000 of savings.

Payroll

A key area of focus for Payroll has been the Roster-to-Pay project, which started in August 2012. This integrated solution utilises existing functionality such as the HR/Payroll kiosk to provide staff with greater visibility of rostered hours, online timesheets and pay processed.

The process surrounding Roster-to-Pay includes electronic rostering, which once published automatically informs a staff member's personal kiosk and electronic timesheets. Staff members complete their timesheets online via their personalised kiosk. Managers then approve timesheet, which then automatically feeds into the payroll system for payment.

In addition to providing the mechanism for completing e-timesheets, the project has configured award interpretation rules for six MECAs including Security Food Workers, NZNO, PSA Nursing, PSA Admin, PSA Allied and MERA's (midwives). This has resulted in more transparency for staff and managers of rostered and worked hours, a consistent interpretation and application of MECAs, as well as the elimination of manual timesheets and printed payslips as these are available online.

Following a successful six month pilot the new system is being rolled out to more areas and as at 30 June 2014 approximately 1500 of the 2369 staff identified are completing electronic timesheets online. Feedback from staff and managers has been positive, most notably staff appreciate the visibility and transparency the e-timesheets provides. The project is due for completion in September 2014.

Under the watchful eyes of technology specialist Peter Watts and specialist anaesthetist Dr Nicola Moore, a group of anaesthetic registrars practice their response to a sudden anaphylactic shock on the simulation centre's new METI Human Patient Simulator.

TWO OF A KIND

The Wellington Hospital's Simulation & Skills Centre welcomed two new additions to its stable of plastic patients, one of which is considered a New Zealand-first.

The centre's Team Leader Rebecca Kay said the CAE Healthcare Human Patient Simulator and the PediaSIM mannequins plug directly in to anaesthetic machines, and are specifically designed for anaesthesia, respiratory and critical care.

"Anything you would see in a human plugged into a machine is what you'll see with one of these plugged in."

The PediaSIM mannequin is the first of its kind in New Zealand and will be used to enable staff to train for paediatric crises during surgery, she said. "We can now begin providing paediatric anaesthesia training, which is something we've never been able to do before, so it's really good for our staff."

The mannequins automatically respond to the administration of anaesthetic gases, oxygen therapy and medications, and have been described as "the Cadillac of patient simulators" by a simulation specialist at the New York College of Osteopathic Medicine.

The new mannequins also ensure the centre can continue its external anaesthetic training courses, which draw attendees from around Australia and New Zealand.

The state-of-the-art duo are worth just under half a million dollars, and Rebecca said the Simulation & Skills Centre was very grateful to the Wellington Hospitals Foundation (WHF), who have worked really hard to make this happen, as well as the Anaesthetic Trust and CCDHB.

This year the centre also created a replica emergency resuscitation bay for internal training with the ED department, which allows for multi-disciplinary training without interrupting the daily work of the ED department.

WHF Chair Bill Day with Simulation & Skills Centre Clinical Leader Dr Deborah Forsyth

STATEMENT OF SERVICE PERFORMANCE

Impacts and Outcomes

As the major funder and provider of health, wellbeing, and disability services in our district, we work to make and maintain positive changes in the health of our population. Our decisions about which services to fund and deliver have a significant impact on the health of our population and contribute to the effectiveness of our entire health system.

We can measure our progress toward improving the health of our population on three different timescales: long-term outcomes (5-10 years), medium-term impacts (3-5 years), and shorter-term outputs (1 year). When we make progress on our short-term outputs (described in the following Statement of Service Performance), over time we can expect to see improvement in our medium-term impacts, which in the long term will lead to progress toward our outcomes.

In 2013/14, the three sub-regional DHBs agreed to focus on four long-term outcomes:

- Reduction of health disparities/improved health equity
- People are healthier and taker greater responsibility for their own health
- Improving the health and wellbeing of our region's children
- Optimising the health, well-being, and independence of our region's older people

We can measure our progress toward these outcomes by monitoring our population's health status and the environment in which they live. As such, in our 2013/14 Statement of Forecast Service Performance we identified impact measures related to each outcome, and we now report against these below. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas the DHB is making a positive difference and in which areas the DHB should seek to improve.

It is important to note that these outcomes are progressed not just through the work of the DHBs, but also through the work of all of those across the health system and wider health and social services.

Measures that also appear in the Māori Health Plans for the sub-regional DHBs are denoted with a †.

POPULATION HEALTH OUTCOME: REDUCTION OF HEALTH DISPARITIES/IMPROVED HEALTH EQUITY

There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and the current models of care. Māori and Pacific have consistently worse health outcomes, and patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

Patients experiencing disability can also have trouble finding services that are accessible and responsive to their needs. With an ageing population, the number of patients experiencing disability will increase and we need to deliver services that meet patients' needs. Low income and poor housing also contribute to poor health outcomes, so those living in deprived areas require services that are low-cost and easily accessible.

Measures – The DHB measures progress through:

A reduction in ambulatory sensitive hospitalisations (ASH) rates†

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include skin infections, dental conditions, asthma, pneumonia, cardiovascular disease, and diabetes.

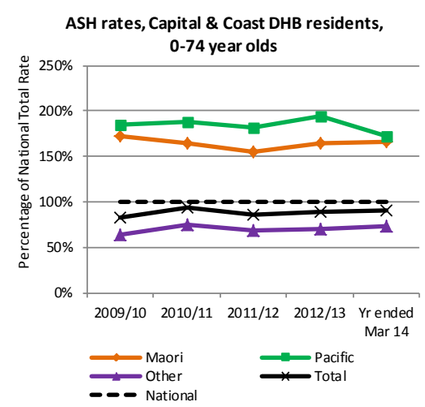
ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

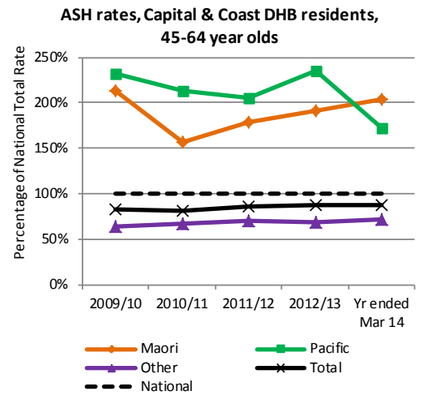
Our overall ASH rate is lower than the national ASH rate. However, Māori and Pacific continue to have higher ASH rates than other ethnicities.

ASH rates are affected by a wide range of services and programmes in the social sector, including housing and education. In addition to the outputs described in the following Statement of Service Performance, recent initiatives in the sub-region that will reduce ASH rates include:

- A sub-regional equity report, which contains a suite of equity indicators, including ASH rates. By improving our monitoring of disparities, we will be able to more effectively plan activities and reduce existing disparities.
- A project that aims to reduce the number of people who do not attend (DNA) outpatient appointments, as Māori and Pacific have higher DNA rates than other ethnicities.
- The Porirua Social Sector Trial, which aims to reduce the ASH rates and ED admissions of Porirua residents. The trial will achieve these aims through collaboration between various social services, including housing, education, police, and health services.

This measure links to the Prevention Services and Early Detection & Management output classes





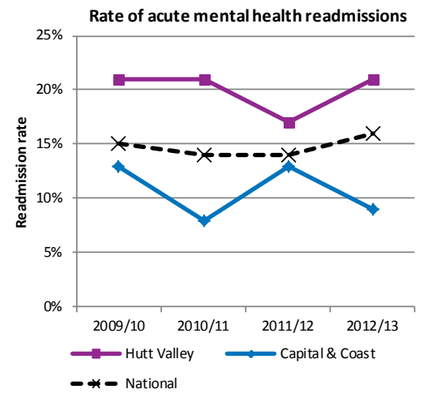
A reduction in the rate of acute mental health readmissions

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to support the person out of hospital.

A decrease in the rate of acute mental health readmissions reflects good continuity of care across the health system.

Capital & Coast DHB's readmission rate is lower than the national average. Because the readmission rate is affected by small changes in the number of yearly readmissions, four years is not enough data to establish a trend.

This measure links to the Intensive Assessment and Treatment Services output class.



Note: Wairarapa DHB is not shown as it does not operate an inpatient unit. 2013/14 data not available at time of publication.

POPULATION HEALTH OUTCOME: PEOPLE ARE HEALTHIER AND TAKE A GREATER RESPONSIBILITY FOR THEIR OWN HEALTH

Capital & Coast DHB and our partners, including Regional Public Health and local PHOs, continue to advocate for healthy lifestyles. By investing in preventative measures and promoting positive health choices, we expect that people's health will improve over time, which will reduce pressure on healthcare services and reduce hospital admissions.

Measures – The DHB measures progress through:

An increase in the proportion of "Never Smoked" responses from Year 10 students

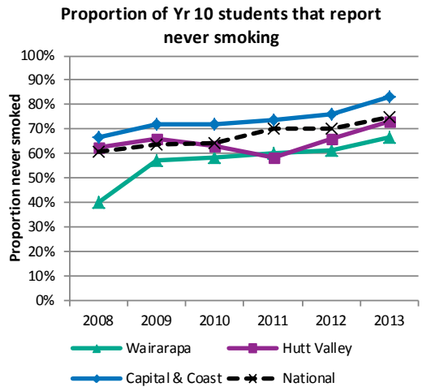
Over 95% of smokers have started smoking by 18 years of age, so reducing the number of young people taking up smoking will greatly reduce smoking rates in the future.

An increase in the number of young people that have never smoked is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risky behaviour.

Nationally, the number of Year 10 students who report never smoking has increased. Capital & Coast DHB's rate continues to be higher than the national rate, which is good.

The smoking cessation advice provided in primary care and hospitals helps to reduce smoking rates. Smoking education in RPH's school visits can increase the number of young people who have never smoked.

This measure links to the Prevention Services output class.



Source: Action on Smoking and Health Survey, www.ash.org.nz

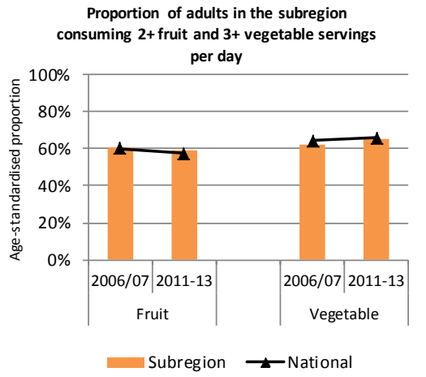
An increase in the percentage of adults consuming 2+ fruit and 3+ vegetable servings daily

Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against a number of risk factors and conditions, including high cholesterol, high blood pressure, obesity, CVD, and diabetes. These nutrition-related risk factors jointly contribute to two out of every five deaths each year.

Fruit and vegetable intake in the sub-region is not significantly different from the national average, and has not significantly changed from 2006/07 to 2011-13.

Regional Public Health services' school visits include nutrition education and RPH also runs a school vegetable garden programme. These initiatives will help to increase the consumption of fruit and vegetables in the sub-region.

This measure links to the Prevention Services output class.



Sub-regional figures. Source: NZ Health Survey

Measures – The DHB measures progress through:

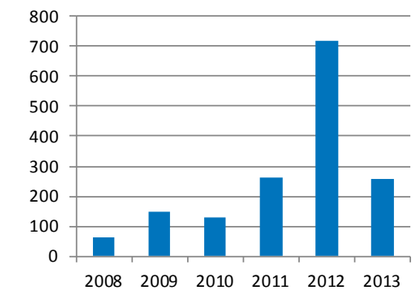
A decrease in the number of vaccine preventable disease notifications

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

Pertussis outbreaks in the region in recent years have caused an increase in vaccine preventable disease notifications. However, the number of notifications is beginning to return to previous levels in 2013. In the longer term, with increased immunisation, we expect the number of vaccine preventable disease notifications will decrease.

This measure links to the Prevention Services output class.

Number of vaccine-preventable disease notifications in Capital & Coast



Source: Environmental Science & Research, www.esr.cri.nz

A decrease in the breast and cervical cancer registration rate (rate per 100,000)

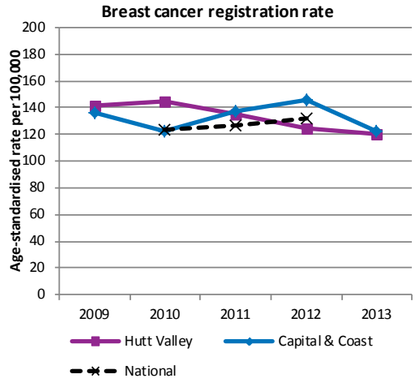
Breast screening for women over the age of 40 years significantly reduces their chance of dying from breast cancer [1]. Increased accessibility of breast screening services may increase breast cancer registration rates but will reduce breast cancer deaths.

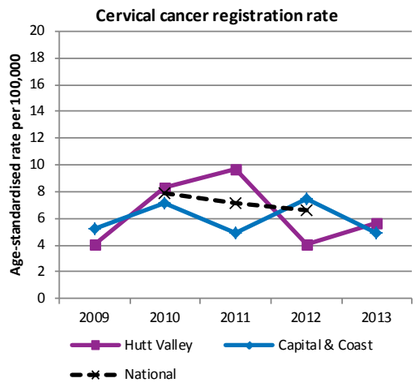
Cervical screening reduces the chance of developing cervical cancer by about 90%. Increased accessibility of cervical screening services will reduce cervical cancer registration rates.

Nationally, the breast cancer registration rate is increasing slightly, and the cervical cancer registration rate is decreasing. Rates in Capital & Coast DHB are comparable to the national rates. Because the cancer rate is affected by small changes in the number of yearly readmissions, four years is not enough data to establish a trend for the individual DHBs.

To achieve equity in screening rates, the screening service runs 'Priority Women Days' on Saturdays when Māori and Pacific women and women who are overdue for screening are booked in.

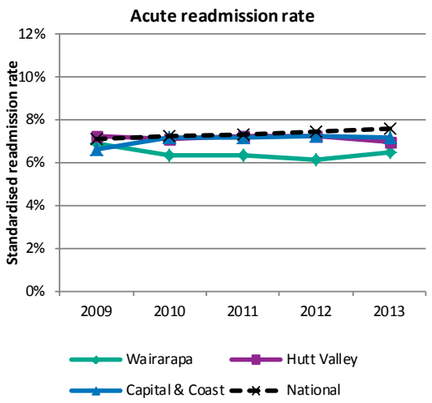
This measure links to the Early Detection and Management output class.





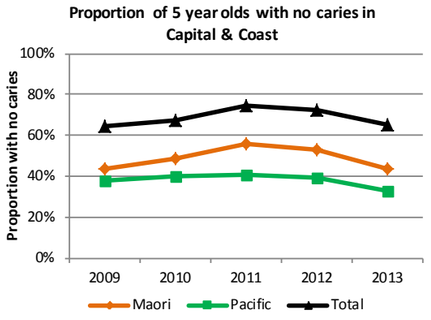
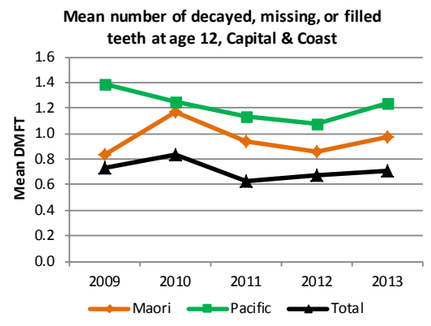
Source: NZ Cancer Registry, provisional data

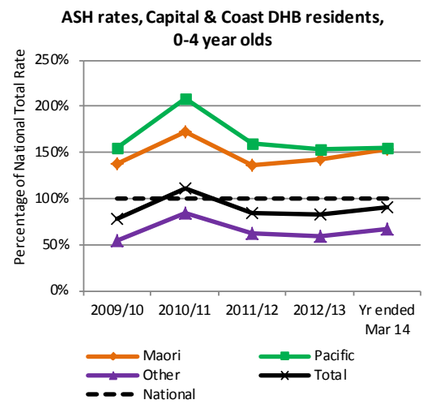
Note: Wairarapa DHB is not shown as the number of cancer registrations is very low and therefore the rate is unreliable.

Measures – The DHB measures progress through:	
A reduction in the rate of acute readmissions, Total A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital. Nationally, there has been a reduction in the rate of acute readmission since 2011/12. Capital & Coast residents have a similar rate of readmission to hospital than the national rate, and this rate is remaining stable. This result is in conjunction with the average length of stay in our hospital facilities decreasing, which shows that the effectiveness and efficiency of hospital treatment is increasing. This measure links to the Intensive Assessment and Treatment Services output class.	

POPULATION HEALTH OUTCOME: IMPROVING THE HEALTH AND WELLBEING OF OUR REGION'S CHILDREN

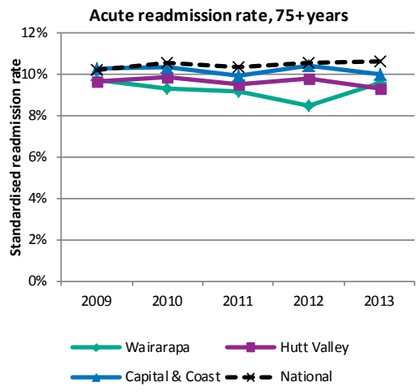
Healthy behaviours in childhood and the teenage years can affect health outcomes in adulthood. Health promotion and prevention can be particularly focussed on children and youth to ensure long term health gains for our population.

Measures – The DHB measures progress through:	
Oral health ▪ An increase in the proportion of children caries free at age 5 ▪ A decrease in the mean number of decayed, missing, or filled teeth (DMFT) at age 12 Regular dental care has lifelong benefits for improved health. Māori and Pacific children are more likely to have decayed, missing, or filled teeth, and improved oral health is an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Water fluoridation helps to maintain oral health, prevents tooth decay, and reduces health inequalities. There is evidence of this within our sub-region; Māori children in non-fluoridated areas of Kāpiti have twice as many decayed, missing, or filled teeth, as Māori children living in areas with community water fluoridation. For this reason, the sub-regional DHBs and Regional Public Health supported community water fluoridation in 2013/14. The mean number of decayed, missing or filled teeth has increased over the last three years in Capital & Coast. In addition, disparities between Māori and Pacific and other ethnicities still exist. The oral health team is working closely with early childhood services and medical centres to find and enrol children younger than five years to the school dental service, which should improve oral health outcomes. This measure links to the Early Detection & Management output class.	 

Measures – The DHB measures progress through:	
An increase in the percentage of children immunised at 8 weeks	Immunisation rates for this age group are currently not reported by the National Immunisation Register.
A reduction in ambulatory sensitive hospitalisations (ASH) rates† Capital & Coast DHB's 0-4 year old ASH rate is below the national average. However, Māori and Pacific continue to have higher ASH rates than other ethnicities. The local newborn enrolment project is currently developing a single system in each of the three DHBs that enables enrolment of newborns to primary care, oral health and Well Child Tamariki Ora services. The project also includes the development of information for parents and providers about the importance of newborn enrolment and the process for enrolling. In addition, following the government policy to provide free after-hours care to children under six from July 2012, consultations for under sixes across all general practices in the sub-region have been made free. This measure links to the Prevention Services and Early Detection & Management output classes.	 Note that in 2010/11 there was an artificial increase in admissions in the 0-4 age group due to administrative changes. This was remedied in 2011/12.

POPULATION HEALTH OUTCOME: OPTIMISING THE HEALTH, WELL-BEING, AND INDEPENDENCE OF OUR REGION'S OLDER PEOPLE

It is important to ensure that health services meet the increasing need of our ageing population. The proportion of Capital & Coast DHB residents who are 65 years or older is projected to increase from 12% in 2014 to 16% in 2025. Thus, it is important that the DHB provides services that are responsive to older people's needs. By ensuring that health services are responsive to the needs of our older population, we can help older people to maintain their independence and to remain at home for longer.

Measures – The DHB measures progress through:	
A reduction in the rate of acute readmissions, 75+ A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported once they are out of hospital. Capital & Coast DHB's 75+ acute readmission rate is slightly lower than the national rate. This measure links to the Early Detection & Management and Rehabilitation & Support output classes.	

Measures – The DHB measures progress through:

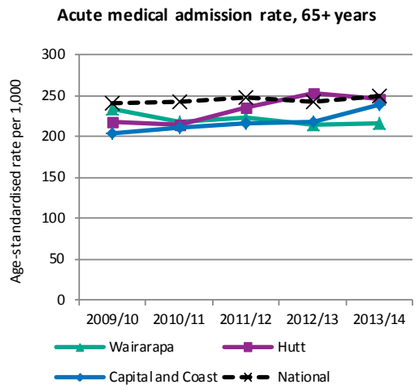
A reduction in the rate of acute medical admissions for 65+

Acute admission rates are influenced by a broad set of strategies, including prevention and treatment in primary care, and alternative models of care.

Unplanned acute admissions are an indicator of the quality of acute care (in the hospital and/or the community), and access to and the quality of health and disability services.

Capital & Coast DHB's rate of acute medical admissions has been lower than the national average in previous years, but increased in 2013/14, and is now comparable to the national rate. However, the recent establishment of HealthPathways, which describe the route a patient takes as they move through the health system and receive healthcare, should reduce the acute admission rate in future years. HealthPathways will increase collaboration between health services which will result in better quality of care for our population.

This measure links to the Early Detection & Management and Rehabilitation & Support output classes.



A reduction in the rate of admissions as a result of a fall, 65+

Falls are a common indicator in the health of older persons sector, both nationally and internationally. Reducing the rate of falls will promote and protect good health and independence, as older people will be able to do more things for themselves and remain in their own homes for longer. It will also reduce the demand on other services that provide treatment or interventions for falls.

The three DHBs joined with the Health and Safety Quality Commission in 2013/14 to implement a Falls Collaborative (as part of the Commission's Reducing Harm from Falls programme) with aged care facilities across the sub-region. This programme supported aged care to introduce and implement Quality Improvement projects to reduce the incidence of falls within facilities. The formal programme has finished. It has been independently evaluated and as a result the Commission is developing a set of tools and templates to support best practice in falls risk assessment and individualised care planning. The three DHBs will be involved in the promotion of these resources.

This measure links to the Rehabilitation & Support output class.

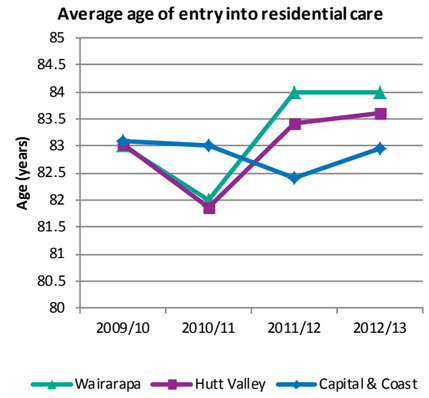
Measures – The DHB measures progress through:

An increase in the average age of entry into residential care

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study [2] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

Increasing the average age of entry into aged residential care indicates that our health services are providing for our older population's needs. There was a decrease in the average age of entry in 2011/12, but otherwise the age remains stable at approximately 83 years.

This measure links to the Rehabilitation & Support output class.



Source: Regional benchmarking. 2013/14 data not available at time of publication.

Statement of Service Performance

FOR THE YEAR ENDED 30 JUNE 2014

In the Statement of Service Performance, we evaluate our performance (outputs) against the targets we set in our 2013/14 Statement of Forecast Service Performance. We choose outputs that will make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. The outputs here provide a picture of the health service activity across the whole of the Capital & Coast health system.

To give a representative picture of our performance, the outputs are grouped into four 'output classes' that fit logically with the stages across the continuum of care (see Figure 1: Scope of DHB Operations – Output Classes in the Continuum of Care):

1. Prevention Services;
2. Early Detection and Management Services;
3. Intensive Assessment and Treatment Services; and,
4. Rehabilitation and Support Services.

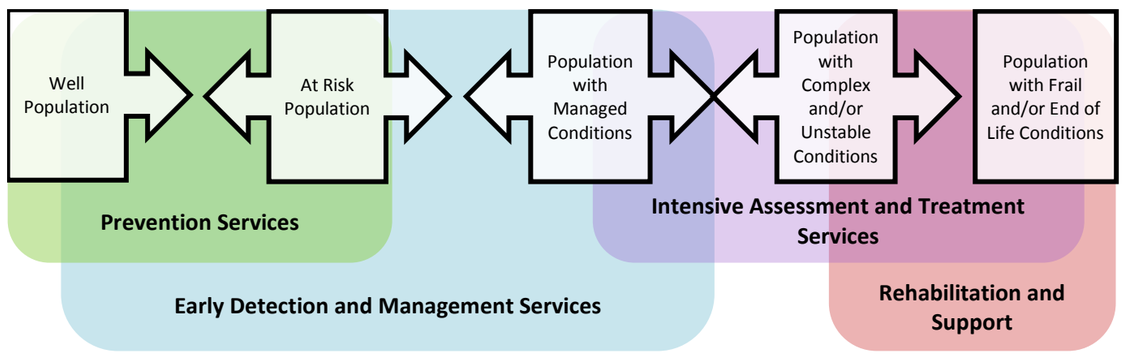


Figure 1: *Scope of DHB Operations – Output Classes in the Continuum of Care*

PREVENTION SERVICES (PUBLIC HEALTH SERVICES)

Public health services are publicly funded to protect and promote the health of our population or of identifiable sub-populations (e.g., Māori, or children under 5). Public health services improve and maintain the health and wellbeing of the population through population-wide physical and social environment interventions, and enabling and empowering community resiliency. Notably, public health services are different to 'curative' services which repair health dysfunction and disability and support rehabilitation.

Public health services include:

- Health promotion to prevent illness and to achieve equity in health status;
- Statutorily-mandated health protection services to protect the public from toxic environmental risks and communicable diseases; and,
- Individual health protection services, including immunisation and screening services.

EARLY DETECTION AND MANAGEMENT (PRIMARY AND COMMUNITY HEALTH SERVICES)

Primary and community healthcare services are delivered by a range of health and allied-health professionals in various private, not-for-profit, and government service settings. These services include general practice, community, and Māori and Pacific health services, community pharmacy services, and child and adolescent dental and oral health services. These services are usually accessible from multiple health providers and from a number of different locations within the district.

INTENSIVE ASSESSMENT AND TREATMENT (HOSPITAL SERVICES)

Hospital services are publicly funded and are delivered by a range of secondary, tertiary, and quaternary providers. These services are usually integrated with 'facilities' (hospitals) so specialised clinical expertise and equipment are conveniently provided in the same place, as hospital services are usually highly complex and provided by a variety of health care professionals who work closely together.

Hospital services 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; and
- Emergency Department services including triage, diagnostic, therapeutic, and disposition services.

REHABILITATION AND SUPPORT (SUPPORT SERVICES)

Support services are delivered following a 'needs assessment' by Needs Assessment Service Coordination (NASC) Services. These services include palliative care, home-based support, and residential care.

INTERPRETING OUR PERFORMANCE

To provide a representative picture of our performance, it is important to measure more than the number of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time.

Because of this complexity, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T

The tables on the following pages show our performance against our targets. Our performance has been categorised according to the table below:

Performance	Definition
Achieved	Target has been achieved.
Partially Achieved	For targets with multiple components, some targets have been met but not all.
Not Achieved	Target has not been met.

In addition, we've used the following symbols:

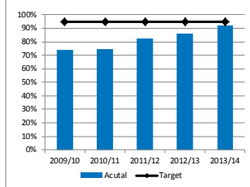
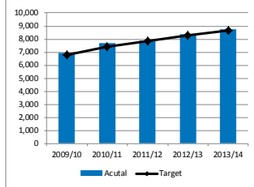
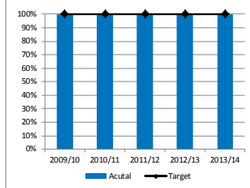
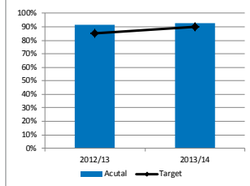
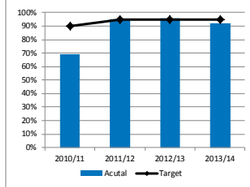
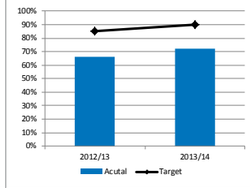
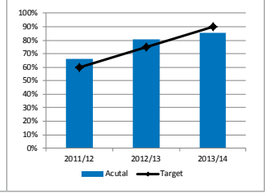
Symbol	Definition
†	Appears in the Māori Health Plan for Capital & Coast DHB.
*	New measure in 2013/14. Our 2012/13 performance has therefore not been audited by Audit New Zealand.

FINANCIAL PERFORMANCE ($000s)

Revenue	2012/13	2013/14 Budget	2013/14 Actual
Prevention	7,768	8,731	8,991
Early Detection and Management	183,476	179,281	177,733
Intensive Assessment and Treatment	667,115	657,744	692,992
Rehabilitation and Support	100,861	106,410	95,940
Total	**959,220**	**952,166**	**975,657**

Expenditure	2012/13	2013/14 Budget	2013/14 Actual
Prevention	7,871	8,731	9,003
Early Detection and Management	183,481	180,513	177,741
Intensive Assessment and Treatment	678,407	661,855	698,828
Rehabilitation and Support	100,235	107,067	95,981
Total	**969,994**	**958,166**	**981,554**

Minister's Health Targets

Health Target	Description and 2013/14 Result	Trend
Shorter stays in Emergency Departments 	95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours. 2013/14 Result: 92% **Output Class: Intensive Assessment and Treatment**	
Improved access to elective surgery 	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year. Target was 8,630 discharges in 2013/14. 2013/14 Result: 8,734 **Output Class: Intensive Assessment and Treatment**	
Shorter waits for cancer treatment 	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. 2013/14 Result: 100% **Output Class: Intensive Assessment and Treatment**	
Increased immunisation 	85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014. 2013/14 Result: 93% **Output Class: Prevention Services**	
Better help for smokers to quit 	95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. 2013/14 Result: Hospital: 92% Primary Care: 72% **Output Class: Prevention Services**	**Hospital:**  **Primary Care:** 
Better diabetes and cardiovascular services 	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. 2013/14 Result: 85% **Output Class: Early Detection and Management**	

Performance Highlights

Capital & Coast DHB continues to provide high quality and timely services to our population. In 2013/14:

- Capital & Coast DHB and Regional Public Health met all of the health promotion targets.
- Capital & Coast DHB continues to achieve the immunisation health target, with 93% of eight month olds having received their scheduled immunisations.
- Capital & Coast DHB PHOs have increased performance on the CVD health target from 76% in 2012/13 to 85% in 2013/14, which equates to approximately 4,200 more people receiving an assessment.
- Capital & Coast DHB met the Before School Check screening target, with 91% of children receiving a check.
- Capital & Coast DHB exceeded the elective surgery health target with 8,734 elective surgeries delivered to the DHB population, which equates to 374 more surgeries than in 2012/13.
- Capital & Coast DHB achieved 95% on the Shorter Stays in Emergency Departments health target in quarter four of 2013/14. Compared to the previous year, in 2013/14 over 6,000 more patients who presented at ED were admitted, discharged, or transferred within six hours.
- Wellington Cancer Centre continues to provide a high quality service with 100% of patients ready for treatment receiving radiotherapy or chemotherapy within four weeks.
- Access to specialist mental health services in Capital & Coast DHB continues to increase, particularly for children and youth. The percentage of the population accessing specialist mental health services has increased from 3.19% in 2012/13 to 3.27% in 2013/14.
- The percentage of residential care providers meeting three year certification standards has increased from 84% in 2011/12 to 94% in 2013/14.
- People in Capital & Coast DHB continue to be less likely to be admitted to hospital for an avoidable condition compared with the rest of the country.

Prevention services

HEALTH PROMOTION SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of schools and early childhood services receiving health promotion visits (RPH)[3]	V	290*	**138**	186	✓ Achieved
The number of new client referrals to school health nurses (RPH)[4]	V	Unavailable[5]	**650**	1234	✓ Achieved
Local Measure: Minimum number of house insulation installations for low income residents with long-term respiratory or circulatory conditions	C	403*	**200**	451	✓ Achieved
The percentage of infants exclusively and fully breastfed at 6 months[6]†	C	34%	**27%**	32%	✓ Achieved

Capital & Coast DHB met all of its health promotion services targets in 2013/14. Topics covered in the health promotion visits included health issues (e.g., oral health, skin infections, gastroenteritis, rheumatic fever, chicken pox, and head lice), nutrition, physical activity, school gardens, road safety, and bullying.

IMMUNISATION SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of eight month olds fully vaccinated	C	92%	**90%**	93%	✓ Achieved
The percentage of enrolled people over 65 years vaccinated against flu [7]†	C	69%	**75%**	65%	✗ Not Achieved
High need		66%	**75%**	64%	✗ Not Achieved
The percentage of Yr 7 children vaccinated in schools[8]	C	64%*	68%	67%	✗ Not Achieved
The percentage of Yr 8 girls vaccinated against HPV [8, 9]	C	**6**0%*	60%	64%	✓ Achieved

Capital & Coast DHB continues to meet the eight month old immunisation health target in 2013/14. Although the Year 7 vaccination target was not achieved, approximately 13% of the combined HVDHB and CCDHB Year 7 population were vaccinated in primary care. Māori and Pacific rates for Year 8 HPV vaccinations exceeded the target by achieving 71% and 73% respectively.

SMOKING CESSATION SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of hospitalised smokers receiving advice and help to quit †	C	96%	**95%**	92%	✗ Not Achieved
Health Target: The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking †	C	66%	**90%**	72%	✗ Not Achieved

Capital & Coast DHB did not meet the hospital health target in 2013/14. However, the DHB has adopted a multi-pronged strategy which should result in improvements in 2014/15.

Although Capital & Coast DHB did not meet the general practice health target in 2013/14, performance increased by 6%. PHOs are continuing to emphasise the importance of clinicians giving cessation advice when they see a smoker in their practice.

Early Detection and Management

PRIMARY CARE SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The number of DHB domiciled population enrolled in a PHO[10]	V	278,176*	**280,345**	280,161	✗ Not Achieved
Māori		28,348*	**29,750**	28,834	✗ Not Achieved
The percentage of the PHO enrolled population enrolled in Care Plus [10]	C	6%	**5%**	6%	✓ Achieved
The GP and nurse utilisation rate - High need	C	1.13	**>1.16**	1.14	✓ Achieved
Health Target: The percentage of the eligible population assessed for CVD risk in the last five years †	C	76%	**90%**	85%	✗ Not Achieved
The percentage of diabetics receiving an annual check	C	86%	**60%**	88%	✓ Achieved
Local Measure: The percentage of practices with a diabetes care improvement plan	Q	Measure established 2013/14	**100%**	62%	✗ Not Achieved

While the target for the Capital & Coast population enrolled in a Primary Healthcare Organisation was not achieved, the proportion of the population enrolled has remained the same, with 93% of the projected total population and 87% of the Māori population enrolled. 84% of the Capital & Coast enrolled population is enrolled with Compass Health (Capital & Coast), 5% with Cosine, 5% with Well Health, and 4% with Ora Toa, and 2% with other PHOs.

Although Capital & Coast DHB did not achieve the CVD health target, performance improved each quarter, and there was an overall improvement of 9% on the 2012/13 year, which equates to approximately 4,200 more people receiving an assessment. The PHOs have used a variety of strategies to support practices to increase performance toward the target. These include IT support, workforce support, and a rewards and recognition programme.

SCREENING SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of eligible children receiving a Before School Check	C	77%	**90%**	91%	☑ Achieved
High need		82%	**90%**	83%	☒ Not Achieved
The percentage of eligible women (25-69) having cervical screening in the last 3 years [11] †	C	80%	**≥80%**	79%	☒ Not Achieved
Māori		59%*	**80%**	60%	☒ Not Achieved
Pacific		63%*	**80%**	62%	☒ Not Achieved
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years †	C	69%	**70%**	69%	☒ Not Achieved
Māori		63%*	**70%**	63%	☒ Not Achieved
Pacific		65%*	**70%**	64%	☒ Not Achieved

Capital & Coast DHB has achieved the Before School Check target for the total population but not the high need population. Part of the cervical screening service involves following up people who have not had a cervical screen in the last five years. Focused initiatives to support primary care include data matching, and 'priority women days' for which priority women (Māori, Pacific, or overdue for screening) are booked into a Saturday clinic for breast and/or cervical screening. A current shortage of Medical Radiology Technologists (MRT) is placing strain on breast screening services, and we are actively recruiting for MRTs. We will continue work to improve Māori and Pacific screening rates.

ORAL HEALTH SERVICES

Measure	Type of Measure	2012 Performance	Target [12] 2013	Target [12] 2014	2013 Performance	Achievement
The percentage of children under 5 years enrolled in DHB funded dental services	C	41%	**65%**	**85%**	42%	☒ Not Achieved
The total number of dental examinations by the dental service for children 0-12, CCDHB population	V	28,734*	**29,047**	**29,364**	26,196	☒ Not Achieved
The percentage of adolescents accessing DHB funded dental services	C	71%	**74%**	**85%**	73%	☒ Not Achieved

The oral health team are working closely with early childhood services and medical centres to find and enrol children under 5 years to the school dental service.

A lack of clinical resource in the service currently contributes to the shortfall in dental examinations. An open recruitment drive is in place to employ staff to the service. The service continues to prioritise examinations for the children most overdue.

Intensive Assessment and Treatment Services

MEDICAL AND SURGICAL SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	86%	**95%**	92%	☒ Not Achieved
Quarter 4		88%		95%	☑ Achieved
Health Target: The number of surgical elective discharges	V	8,360	**8,630**	8,734	☑ Achieved
The average length of stay for inpatients (days) [13] Acute	T	3.84	**4.30**	3.62	☑ Achieved
Elective		3.22*	**3.21**	3.17	☑ Achieved

Although Capital & Coast DHB did not meet the shorter stays in ED health target for the 2013/14 year, we met the target in Quarter 4, with 95% of patients admitted, discharged, or transferred from ED within six hours. We expect this achievement to continue into the 2014/15 year. The average length of stay for inpatients continues to decrease in 2013/14.

QUALITY MEASURES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of "DNA" (did not attend) appointments for outpatients	Q	6%*	**6%**	6%	☑ Achieved
Māori		12%*	**12%**	12%	☑ Achieved
Pacific		11%*	**10%**	11%	☑ Achieved
The ratio of first specialists assessments (medical & surgical) to follow up appointments	Q	1: 2.7*	**1: 2.8**	1: 2.7	☑ Achieved
The percentage of mothers breastfeeding on discharge [14]	Q	83.0%*	**83.5%**	83.0%	☒ Not Achieved
The number of central line acquired bacteraemia (CLAB) infections in ICU	Q	1	**0**	2	☒ Not Achieved
The rate of falls per 1000 bed days	Q	1.01*	**<3.06**	0.93	☑ Achieved
The rate of medication errors per 1000 bed days	Q	0.85	**<1.95**	0.89	☑ Achieved

Capital & Coast DHB continues to provide high quality and timely care to patients. In 2013 the Health Quality & Safety Commission (HQSC) introduced a campaign that focusses on improving patient safety in medications, falls, health acquired infections, and perioperative harm. Our medication error and fall rates are now significantly lower than they were in 2011/12.

CANCER SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
Health Target: The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	100%	✓ Achieved

MENTAL HEALTH AND ADDICTIONS SERVICES

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people accessing secondary mental health services[15]	C	3.19%	**3.08%**	3.27%	✓ Achieved
The percentage of people accessing secondary mental health services, 0-19[15]		3.66%	**3.58%**	3.90%	✓ Achieved
Māori		5.45%	**3.58%**	5.58%	✓ Achieved
The percentage of people accessing secondary mental health services, 20-64[19]		3.37%	**3.20%**	3.41%	✓ Achieved
Māori		7.10%	**3.20%**	7.04%	✓ Achieved
The percentage of long term clients who have up-to-date relapse prevention plans	Q	91%	**95%**	85%	✗ Not Achieved
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	87%	**95%**	90%	✗ Not Achieved
The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	90%	**95%**	90%	✗ Not Achieved

Access to mental health services in Capital & Coast continues to increase, particularly for children and youth. We are focused on improving the quality of relapse prevention planning (wellness plans), and wellness plans are now updated at least once every six months. We expect performance to increase over the next year as a result of this change.

Rehabilitation and Support

Measure	Type of Measure	2012/13 Performance	Target 2013/14	2013/14 Performance	Achievement
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	Q	99%	**>95%**	100%[16]	✓ Achieved
The number of total assessments (including new and review)[17]	V	5,147*	**5,000**	5,912	✓ Achieved
The number of people receiving home and community support services	V	2,870*	**2,900**	3,000	✓ Achieved
The number of respite days [18]	V	4,551*	**5,594** [19]	4,131	✗ Not Achieved
The number of subsidised aged residential care bed days	V	541,198*	**547,300** [19]	551,067	✓ Achieved
The percentage of residential care providers meeting three year certification standards[20]	Q	90%	**95%**	94%	✓ Partially Achieved
The number of disability newsletters published	V	6*	**3**	4	✓ Achieved
Number of Disability Forum meetings (sub-regional and local)	V	2*	**2**	2	✓ Achieved
Number of children and young people with a primary care transition plan from Child Development Services	V	Nil	**30**	23 (27 eligible children)	✓ Partially Achieved

Two of 34 facilities in Capital & Coast DHB do not have a 3+ year certification. The target is partially achieved because the number of facilities is not high enough to note a 1% difference. There are now five facilities with a four year certification. The three sub-regional DHBs collaborated in a disability plan in 2013. As a result of this collaborative approach, the first 3DHB intersectoral forum around disability issues was held in 2013/14.

Footnotes

1. Nelson HD, Tyne K, Naik A, et al. Screening for Breast Cancer: Systematic Evidence Review Update for the US Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (US); 2009 Nov. (Evidence Syntheses, No. 74.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK36392/
2. Hambleton, Penny, Sally Keeling, & Margaret McKenzie (2008). "Quality of Life is...:The Views of Older Recipients of Low-Level Home" Support." Social Policy Journal of New Zealand (33).
3. Hutt Valley and Capital & Coast populations.
4. This measure was originally "The number of new client referrals by school health nurses". This wording has since been revised as we are measuring referrals to the public health nursing service, not volume of referrals by the nursing service to other providers.
5. This measure changed in 2013/14 from the number of visits to the number of referrals. The 2012/13 number of visits was 1355. In 2013/14, the average number of visits per open referral was 4.93.
6. Plunket data.
7. As flu vaccinations are seasonal, result is as at July 2013 (for 2012/13) and July 2014 (for 2013/14)
8. Performance aligned to school year: January to December 2012 (2012/13) and January to December 2013 (2013/14)
9. Fully vaccinated Dose 3
10. PHO enrolment as at 1 July 2013 (for 2012/13) and 1 July 2014 (for 2013/14).
11. National Screening Unit data. Note that the National Screening Unit revised the original measure from 20-69 year olds to 25-69 years old to align with international best practice. The national targets (to which our targets are aligned) have remained the same.
12. Oral health measures are reported on a calendar year, so the Ministry of Health requests that we specify targets for each year.
13. Ministry of Health reporting operates a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
14. Fully or exclusively breastfeeding.
15. Ministry of Health reporting operates a quarter in arrears, so data is for 12 months ending March 2013 (for 2012/13) and March 2014 (for 2013/14).
16. As at 31 March 2014
17. Includes the ORA team, NASC and home-based providers. Provisional data for one HCSS provider is included in this total. As the providers have equal number of clients the provisional figure is based on the other HCSS providers. It is expected that these volumes should be similar.
18. Excludes bulk-funded beds.
19. These targets are based on historic trends and are not aspirational. There are no assumptions around whether an increase/decrease is desirable or not. Performance on these targets will vary from year to year depending on a number of factors (e.g., socio-demographic and economic profiles).
20. Excluding new providers and facilities as these are required to have a one year certification

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2014.

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

We have audited:

- the financial statements of the Health Board on pages 92 to 135, that comprise the statement of financial position as at 30 June 2014, 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 performance information of the Health Board that comprises the statement of service performance on pages 77 to 87 and the report about outcomes on pages 70 to 77.

UNMODIFIED OPINION ON THE FINANCIAL STATEMENTS

In our opinion the financial statements of the Health Board on pages 92 to 135:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2014; and
  - financial performance and cash flows for the year ended on that date.

QUALIFIED OPINION ON THE PERFORMANCE INFORMATION

Reasons for our qualified opinion

Performance information from third party health providers

Some significant performance measures of the Health Board, (including some of the national health targets) rely on information from third-party health providers, such as primary health organisations. The Health Board's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board for the year ended 30 June 2013, which is reported as comparative information, was qualified for the same reason.

Performance information about smokers seen in hospital are offered advice and support to quit

Our audit of the reported performance for the national health target "smokers seen in hospital are offered advice and support to quit" identified errors which indicate that the reported results are likely to be materially overstated. We are unable to quantify the extent of any overstatement.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reasons for our qualified opinion" above, the performance information of the Health Board on pages 70 to 87:

- complies with generally accepted accounting practice in New Zealand; and
- fairly reflects the Health Board's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:
  - its service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
  - its actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 31 October 2014. 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 performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of

material misstatement of the financial statements and performance information, 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 performance information 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.

Our audit of the financial statements involved 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; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

Our audit of the performance information involved evaluating:

- the appropriateness of the reported service performance within the Health Board's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

RESPONSIBILITIES OF THE BOARD

The Board is responsible for preparing financial statements and performance information 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 and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and performance information, whether in printed or electronic form.

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 performance information 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.

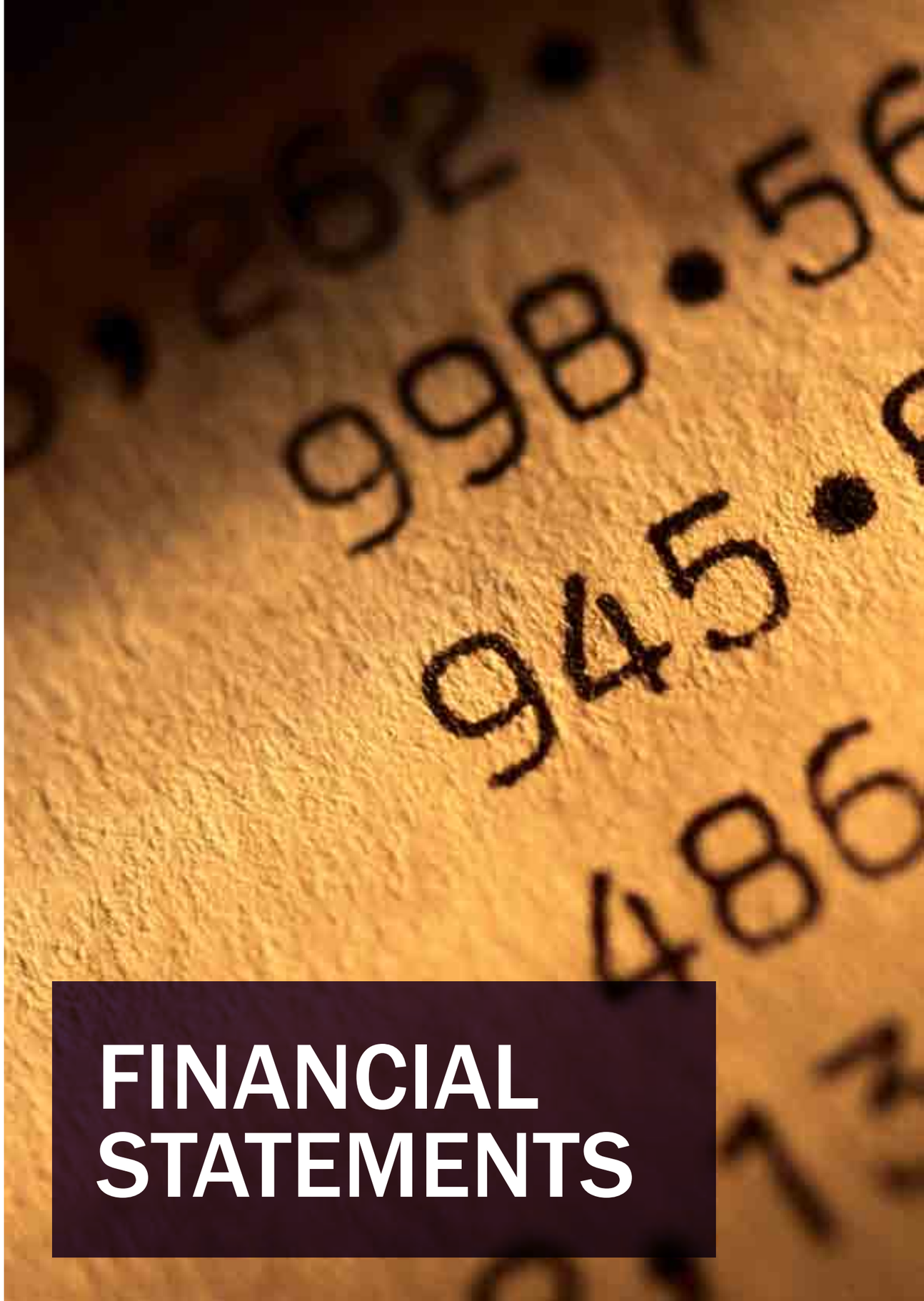
INDEPENDENCE

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

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

Kelly Rushton
Audit New Zealand

On behalf of the Auditor-General
Wellington, New Zealand



FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2014
in thousands of New Zealand Dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Revenue	1	975,657	952,166	938,919
Reversal of impairment previously recognised	6	-	-	20,301
Total income		**975,657**	**952,166**	**959,220**
Clinical supplies		110,685	103,880	110,718
Employee benefit costs	2	409,095	397,180	391,450
Infrastructure and non-clinical expenses		55,540	50,591	50,115
Other operating expenses	3	4,717	4,525	11,230
Outsourced services		20,693	18,775	21,222
Payments to other district health boards		67,215	67,588	65,570
Payments to non-health board providers		253,952	253,169	250,529
Capital charge	4	8,578	8,643	9,408
Finance costs	5	16,573	16,595	17,890
Depreciation and amortisation expense	6,7	34,508	37,220	41,862
Total expenses		**981,556**	**958,166**	**969,994**
Surplus/(deficit) for the year		**(5,899)**	**(6,000)**	**(10,774)**
Other comprehensive income				
Revaluation reserve movement		-	-	1,585
Other comprehensive income for the year		-	-	**1,585**
Total comprehensive income for the year		**(5,899)**	**(6,000)**	**(9,189)**

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 2014
in thousands of New Zealand Dollars

	Crown equity	Other reserves: Revaluation reserve (land)	Other reserves: Retained earnings	Total equity
Balance at 1 July 2012	421,655	22,021	(312,455)	131,222
Repayment of equity	(3,484)	-	-	(3,484)
Total comprehensive income of the year	-	1,585	(10,774)	(9,189)
Balance at 30 June 2013	**418,171**	**23,606**	**(323,229)**	**118,548**
Balance at 1 July 2013	418,171	23,606	(323,229)	118,548
Contribution from the Crown	6,000	-	-	6,000
Repayment of equity	(3,484)	-	-	(3,484)
Total comprehensive income for the year	-	-	(5,899)	(5,899)
Balance at 30 June 2014	**420,687**	**23,606**	**(329,128)**	**115,165**

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 2014

in thousands of New Zealand Dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Assets				
Current assets				
Cash and cash equivalents	11	12,097	85	74
Trade and other receivables	10	44,145	42,421	42,765
Inventories	8	8,184	8,019	8,019
Trust and special funds	12	7,116	6,962	6,960
Total current assets		**71,542**	**57,487**	**57,818**
Non-current assets				
Property, plant and equipment	6	518,738	521,283	532,053
Intangible assets	7	10,316	7,051	5,918
Investments in joint ventures	9	3,955	-	1,934
Total non-current assets		**533,009**	**528,334**	**539,905**
Total assets		**604,551**	**585,821**	**597,723**
Equity				
Crown equity		420,687	428,668	418,171
Revaluation reserve		23,606	23,606	23,606
Retained earnings/(losses)		(329,128)	(336,233)	(323,229)
Total equity		**115,165**	**116,041**	**118,548**
Liabilities				
Current liabilities				
Trade and other payables	16	81,580	57,405	64,077
Borrowings	13	71,248	76,094	37,442
Employee entitlements	14	59,859	59,571	59,524
Provisions	15	350	2,296	300
Patient and restricted funds	17	174	-	166
Total current liabilities		**213,211**	**195,366**	**161,509**
Non-current liabilities				
Borrowings	13	269,107	268,454	311,454
Employee entitlements	14	6,787	5,960	5,960
Provisions	15	281	-	252
Total non-current liabilities		**276,175**	**274,414**	**317,666**
Total liabilities		**489,386**	**469,780**	**479,175**
Total equity and liabilities		**604,551**	**585,821**	**597,723**

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 2014

in thousands of New Zealand Dollars

	Note	2014 Actual	2014 Budget	2013 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		955,127	925,187	896,771
Other receipts		17,790	25,742	38,405
Cash paid to suppliers		(495,203)	(497,459)	(512,669)
Cash paid to employees		(407,935)	(397,180)	(386,265)
Cash generated from operations		**69,779**	**56,290**	**36,242**
Goods and Services Tax and other taxes (NET) (a)		494	-	(2,256)
Capital charge paid		(8,928)	(13,190)	(4,861)
Net cash flows from operating activities	11	**61,345**	**43,100**	**29,125**
Cash flows from investing activities				
Interest received		1,131	1,236	1,458
Acquisition of property, plant and equipment	6	(19,620)	(12,685)	(14,202)
Acquisition of intangible assets	7	(6,068)	(10,517)	(3,984)
Investment in joint venture		(2,021)	(2,452)	(1,234)
Appropriation from trust and special funds (b)	12	(146)	-	676
Net cash flows from investing activities		**(26,724)**	**(24,418)**	**(17,286)**
Cash flows from financing activities				
Contribution from the Crown		6,000	6,000	-
Borrowings raised		901	-	28,525
Repayment of borrowings		(79)	-	(28,000)
Repayment of equity		(3,484)	(3,484)	(3,484)
Repayment of finance leases		(253)	-	(278)
Interest paid		(16,573)	(16,917)	(17,890)
Net cash flows from financing activities		**(13,488)**	**(14,401)**	**(21,127)**
Net increase/(decrease) in cash and cash equivalents		21,133	4,283	(9,288)
Cash and cash equivalents at beginning of year		(9,036)	(2,076)	252
Cash and cash equivalents at end of year	11	**12,097**	**2,207**	**(9,036)**

(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 2014

in thousands of New Zealand Dollars

	Note	2014 Actual	2013 Actual
Legal proceedings against the DHB		200	372
Other contractual matters		125	1,076
		325	**1,448**

The DHB has been notified of 8 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2014 (2013: 5)

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 (2013: $nil)

STATEMENT OF COMMITMENTS

As at 30 June 2014

in thousands of New Zealand Dollars

	Note	2014 Actual	2013 Actual
Capital commitments		**7,164**	**4,470**
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,819	2,530
One to two years		2,055	1,306
Two to five years		1,675	1,641
		6,549	**5,477**

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

NOTES TO THE FINANCIAL STATEMENTS

in thousands of New Zealand Dollars

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, 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 2016.
- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope. The DHB anticipates that these standards will have no material impact on the financial statements in the period of initial application.

Basis of preparation

The financial statements for the year ended 30 June 2014 were approved by the Board on 31 October 2014.

The financial statements have been prepared for the period 1 July 2013 to 30 June 2014. Comparative figures and balances relate to the period 1 July 2012 to 30 June 2013.

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.

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 based on current trading terms and legislative requirements. 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 2013/14 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 28 August 2014 from the Ministers of Health and Finance which states that deficit support will be provided where necessary to maintain viability.

Deficit support of $6m was received during the current financial year.

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 and based on current trading terms and legislative requirements.

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 based on current trading terms and legislative requirements.

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.

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.

Addition to property, plant and equipment

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 60 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	3 years
▪ Licences	5 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 is a short term obligation and is 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 2014, indirect costs accounted for 1.54% of the DHB's total costs (2013: 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

Estimated impairment of non financial assets

Intangible assets, property, plant and equipment and investments in subsidiaries, associates and joint ventures are tested for impairment whenever there is any objective evidence or indication that these assets may be impaired. Refer Notes 7 and 9.

Lease 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

	2014 Actual	2013 Actual
Ministry of Health contract funding	748,225	710,656
Other government	17,153	17,527
Inter district flows (other DHBs)	192,481	187,196
Non government & crown agency sourced	16,667	22,082
Interest income	1,131	1,458
	975,657	938,919

2. EMPLOYEE BENEFIT COSTS

	2014 Actual	2013 Actual
Direct staff costs (excluding increases in employee benefit provisions)	383,772	365,558
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	12,239	12,533
Contributions to defined contribution plans	11,391	9,091
Increase/(decrease) in employee benefit provisions	1,693	4,268
	409,095	391,450

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

3. OTHER OPERATING EXPENSES

	Note	2014 Actual	2013 Actual
Impairment of trade receivables (bad debts)		142	-
Increase /(decrease) in provision of trade receivables (doubtful debts)	10	740	369
(Gain)/loss on disposal of property, plant and equipment		97	391
Impairment losses		-	6,562
Audit fees for financial statements audit		194	180
Fees for other assurance services		75	-
Board member fees	20	362	391
Rental and other operating expenses		3,107	3,337
		4,717	11,230

4. CAPITAL CHARGE

	2014 Actual	2013 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 2014 was 8 per cent (2013: 8 per cent)	8,578	9,408

5. FINANCE COSTS

	2014 Actual	2013 Actual
Interest on CBA loan	-	442
Interest on term borrowings	16,556	17,413
Interest on finance leases	17	35
	16,573	17,890

6. PROPERTY, PLANT AND EQUIPMENT

	Freehold land	Freehold buildings	Lease Improvements	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Cost							
Balance at 1 July 2012	24,120	451,776	370	69,389	34,703	18,661	599,019
Additions	-	15,240	9	6,687	2,317	15,225	39,478
Disposals	-	-	-	(577)	(11)	-	(588)
Impairment losses	-	(6)	(142)	(1,086)	(1,330)	-	(2,564)
Revaluations	1,585	(25,155)	-	-	-	-	(23,570)
Transfer to fixed assets	-	-	-	-	-	(25,404)	(25,404)
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-	-
Transfer between categories	-	3,398	39	7,022	(10,400)	-	59
Balance at 30 June 2013	**25,705**	**445,253**	**276**	**81,435**	**25,279**	**8,482**	**586,430**
Balance at 1 July 2013	25,705	445,253	276	81,435	25,279	8,482	586,430
Additions	-	12,564	348	3,790	1,407	23,541	41,650
Disposals	-	-	-	(243)	(14)	-	(257)
Impairment losses	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(22,010)	(22,010)
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-	-
Balance at 30 June 2014	**25,705**	**457,817**	**624**	**84,982**	**26,672**	**10,013**	**605,813**
Depreciation and impairment losses							
Balance at 1 July 2012	-	(23,982)	(138)	(24,297)	(16,312)	-	(64,729)
Depreciation charge for the year	-	(21,977)	(96)	(10,601)	(4,002)	-	(36,676)
Impairment losses	-	1	16	621	795	-	1,433
Disposals	-	-	-	191	6	-	197
Revaluations	-	45,457	-	-	-	-	45,457
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-	-
Transfer between categories	-	(1,436)	(14)	(3,242)	4,633	-	(59)
Balance at 30 June 2013	-	(1,937)	(232)	(37,328)	(14,880)	-	(54,377)

in thousands of New Zealand Dollars

6. PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	Freehold land	Freehold buildings	Lease Improvements	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Depreciation and impairment losses							
Balance at 1 July 2013	-	(1,937)	(232)	(37,328)	(14,880)	-	(54,377)
Depreciation charge for the year	-	(21,298)	(15)	(8,521)	(3,004)	-	(32,838)
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	140	-	-	140
Revaluations	-	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-	-
Balance at 30 June 2014	**-**	**(23,235)**	**(247)**	**(45,709)**	**(17,884)**	**-**	**(87,075)**
Carrying amounts							
At 1 July 2012	24,120	427,795	232	45,092	18,391	18,661	534,291
At 30 June 2013	25,705	443,316	44	44,107	10,399	8,482	532,053
At 1 July 2013	25,705	443,316	44	44,107	10,399	8,482	532,053
At 30 June 2014	25,705	434,582	377	39,274	8,789	10,013	518,738

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 21 June 2013 by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand 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 $25.7m.

The total fair value of buildings valued by the valuer amounted to $445.3m.

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
2013	Revaluation gain	20,301
	Revaluation loss carried forward	**(50)**

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 2013 net revaluation losses of $0.05m are carried forward to future years.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2014 was $16m (2013: $16m)

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 Māori 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 $0.007m (2013:$0.228m).

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $10m (2013: $8.5m) which includes $4.09m (2013:$3.84m) of refurbishment of existing buildings.

in thousands of New Zealand Dollars

7. INTANGIBLE ASSETS

	Software	FPSC Shared Services Rights	Licences	Total
Cost				
Balance at 1 July 2012	24,452	-	2,509	26,961
Additions	1,097	2,637	408	4,142
Disposals	-	-	-	-
Impairment losses	(14,873)	-	(453)	(15,326)
PP&E restatement	-	-	-	-
Transfer between categories	(59)	-	-	(59)
Balance at 30 June 2013	10,617	2,637	2,464	15,718
Balance at 1 July 2013	10,617	2,637	2,464	15,718
Additions	3,513	2,452	103	6,068
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories		-	-	-
Balance at 30 June 2014	14,130	5,089	2,567	21,786
Amortisation and impairment losses				
Balance at 1 July 2012	(13,433)	-	(1,137)	(14,570)
Amortisation charge for the year	(4,760)	-	(425)	(5,185)
Impairment losses	9,691	-	205	9,896
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	59	-	-	59
Balance at 30 June 2013	(8,443)	-	(1,357)	(9,800)
Balance at 1 July 2013	(8,443)	-	(1,357)	(9,800)
Amortisation charge for the year	(1,306)	-	(364)	(1,670)
Impairment losses	-	-	-	-
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2014	(9,749)	-	(1,721)	(11,470)
Carrying amounts				
At 1 July 2012	11,018	-	1,373	12,391
At 30 June 2013	2,174	2,637	1,107	5,918
At 1 July 2013	2,174	2,637	1,107	5,918
At 30 June 2014	4,381	5,089	846	10,316

7. INTANGIBLE ASSETS (CONTINUED)

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.

Finance, Procurement and Supply Chain (FPSC) shared services project

Health Benefits Limited (HBL) was established in July 2010. HBL is undertaking a Finance, Procurement and Supply Chain (FPSC) shared services project aimed at reducing costs in administrative support and procurement for the public health sector. The FPSC project is to be funded by the 20 DHBs across the country who will be the beneficiaries of these savings. As at 30 June 2014, the DHB has accrued $5.089m as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services.

The intangible asset has been tested for impairment during the year by CCDHB Board and management. Further it has also been tested by PricewaterhouseCoopers at the request of HBL. The CCDHB Board was concerned that there was an indication of impairment and has carried out appropriate investigation into this however at this stage on the information available no impairment is required at this point.

8. INVENTORIES

	2014 Actual	2013 Actual
Pharmaceuticals	1,828	1,548
Surgical & medical supplies	5,805	5,876
Other supplies	551	595
	8,184	8,019

The amount of inventories recognised as an expense during the year ended 30 June 2014 was $52.3m (2013: $52.2m). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2013: $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

	2014 Actual	2013 Actual
Uncalled ordinary share capital	-	-
Advance on redeemable preference shares	3,955	1,934
	3,955	1,934

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 2014, a further investment in financial year 2013/14 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. This agreement is subject to further negotiations with CRTAS.

The investment has been tested for impairment during the year by CCDHB Board and management. The CCDHB Board was concerned that there was an indication of impairment and has carried out appropriate investigation into this however at this stage on the information available no impairment is required at this point.

in thousands of New Zealand Dollars

9. INVESTMENTS IN JOINT VENTURES (CONTINUED)

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

	2014 Actual	2013 Actual
Non-current assets	1,937	786
Current assets	3,587	3,053
Non-current liabilities	-	-
Current liabilities	2,245	1,457
Net assets/(liabilities)	3,279	2,382
Income	4,044	3,296
Expense	3,993	3,294
	51	2

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. (2013: $nil)

The DHB's share in commitments

The DHB share of capital commitments for CRTAS is $0.5m (2013: $0.2m).

10. TRADE AND OTHER RECEIVABLES

	2014 Actual	2013 Actual
Trade receivables from non-related parties	3,873	4,506
Ministry of Health receivables	14,816	13,906
Other DHB recievables	8,614	7,126
	27,303	25,538
Accrued income	12,409	12,693
Prepayments	4,433	4,534
	44,145	42,765

Trade receivables are shown net of a provision for doubtful debts amounting to $0.8m (2013: $0.5m)

The carrying value of receivables approximates their fair value.

As at 30 June 2014, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below

	2014			2013		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	25,467	-	25,467	23,143	-	23,143
Past due 1-30 days	734	-	734	1,791	-	1,791
Past due 31-60 days	401	-	401	96	-	96
Past due 61-90 days	388	-	388	85	-	85
Past due > 91 days	1,132	819	313	912	489	423
Total	28,122	819	27,303	26,027	489	25,538

10. TRADE AND OTHER RECEIVABLES (CONTINUED)

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:

	2014 Actual	2013 Actual
Balance at 1 July 2013	489	882
Additional provisions made during the year	740	369
Provisions reversed during the year	-	-
Receivables written-off during period	(410)	(762)
Balance at 30 June 2014	819	489

11. CASH AND EQUIVALENTS

	2014 Actual	2013 Actual
Petty cash	13	13
Bank accounts	91	61
HBL call deposits	11,993	-
Cash and Cash equivalents (excluding Secured HBL loan)	12,097	74

Cash and cash equivalents include the following for the purpose of the statement of cash flows:

	2014 Actual	2013 Actual
Cash and Cash equivalents	12,097	74
Secured HBL loan (Note 13)	-	(9,110)
	12,097	(9,036)

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 $51.8m. (2013:$50.8m). The highest overdrawn bank balance during financial year 2013/14 was $31.4m.

in thousands of New Zealand Dollars

11. CASH AND EQUIVALENTS (CONTINUED)

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

	2014 Actual	2013 Actual
Surplus/(deficit) for the year	(5,899)	(10,774)
Add back non-cash items:		
Depreciation & amortisation	34,508	41,869
Revaluation gain	-	(20,301)
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	97	6,923
Interest income on financial assets	(1,131)	(1,458)
Add back items classified as financing activity:		
Interest expense on financial liabilities	16,573	17,890
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(1,380)	(2,976)
(Increase)/decrease in inventories	(165)	(1,244)
Increase/(decrease) in trade and other payables	17,501	(5,140)
Increase/(decrease) in employee benefits	1,162	4,376
Increase/(decrease) in provisions	79	(40)
Net movement in working capital	17,197	(5,024)
Net cash inflow/(outflow) from operating activities	61,345	29,125

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	2014 Actual	2013 Actual
Balance at 1 July 2013	6,812	7,490
Monies received	2,128	1,616
Interest received	264	298
Payments made	(2,243)	(2,592)
Balance at 30 June 2014	6,961	6,812
Patient funds		
Balance at 1 July 2013	148	144
Monies received	172	198
Interest received	2	2
Payments made	(167)	(196)
Balance at 30 June 2014	155	148
Total trust and special funds	7,116	6,960

13. INTEREST BEARING LOANS AND BORROWINGS

	2014 Actual	2013 Actual
Current		
Secured Ministry of Health loans	71,000	28,000
Secured HBL loans	-	9,110
Unsecured EECA loans	240	79
Finance leases	8	253
	71,248	37,442
Non-current		
Secured Ministry of Health loans	268,000	311,000
Unsecured EECA loans	1,107	446
Finance leases	-	8
	269,107	311,454

Secured loans

The DHB secured loans are from the Ministry of Health and Health Benefits Limited (Note 11). The details of terms and conditions are as follows:

Interest rate summary	2014 Actual	2013 Actual
Ministry of Health	2.74% - 7.13%	2.74% - 7.13%
Health Benefits Ltd	4.55% - 5.07%	4.25% - 4.67%
Finance leases	6.50%	6.50%
Energy Efficiency and Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	2014 Actual	2013 Actual
Within one year	71,240	37,189
One to two years	34,285	71,105
Two to five years	130,777	130,315
Later than five years	104,045	110,026
	340,347	348,635

in thousands of New Zealand Dollars

13. INTEREST BEARING LOANS AND BORROWINGS (CONTINUED)

Analysis of finance leases	2014 Actual	2013 Actual
Minimum lease payments payable		
Within one year	9	270
One to two years	-	9
Two to five years	-	-
Later than five years	-	-
Total minimum lease payments	9	279
Future finance charges	(1)	(18)
Present value of minimum lease payments	8	261
Present value of minimum lease payments payable		
Within one year	8	254
One to two years	-	7
Two to five years	-	-
Later than five years	-	-
Total present value of minimum lease payments	8	261

Term loan facility limits	2014 Actual	2013 Actual
Ministry of Health loan	339,000	339,000
Energy Efficiency and Conservation Authority (EECA)	1,347	525
	340,347	339,525

Security and terms

The loan facility is provided by the Ministry of Health. $311m facility limit expires in December 2021. $28m facility limit expires in April 2022. The loans are secured by a negative pledge. Without the Ministry'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 NZ Government does not guarantee term loans.

The total borrowings with the Debt Management Office is $339m. Of this $71m is maturing in April 2015 and will be refinanced at lower interest rates.

14. EMPLOYEE ENTITLEMENTS

	2014 Actual	2013 Actual
Current liabilities		
Liability for long service leave	2,010	1,840
Liability for sabbatical leave	290	280
Liability for retirement gratuities	1,000	1,030
Liability for annual leave	35,509	36,048
Liability for sick leave	1,727	1,653
Liability for continuing medical education leave and expenses	8,171	8,600
Salary and wages accrual	11,152	10,073
	59,859	59,524
Non-current liabilities		
Liability for long service leave	3,697	3,737
Liability for sabbatical leave	350	360
Liability for retirement gratuities	1,728	1,863
Liability for continuing medical education leave and expenses	1,012	-
	6,787	5,960

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% (2013:3.5%) and a discount rate ranging from 3.42% to 4.95% (2013: 2.53% to 6.00%) from 1-10+ years.

in thousands of New Zealand Dollars

15. PROVISION

	2014 Actual	2013 Actual
Current provisions		
ACC Partnership Programme	350	300
Provision for demolition	-	-
	350	300
Non current provisions		
ACC Partnership Programme	281	252

ACC Partnership Programme	2014 Actual	2013 Actual
Undiscounted amount of claims at balance date	515	441
Discount	18	14
Central estimate of present value of future payments	569	497
Risk margin	62	55
	631	552

The movement in provisions is represented by:

	ACC Partnership Programme
2013	
Balance at 1 July 2012	592
Additional provisions during the year for the risks borne in current period	271
Decrease in provisions relating to a reassessment of risks in a previous period	236
Subtotal	1,099
Amounts used during the year	547
Total liability	552
(Decrease) / increase in provision	(40)

	ACC Partnership Programme
2014	
Balance at 1 July 2013	552
Additional provisions during the year for the risks borne in current period	308
Additional provisions relating to a reassessment of risks in a previous period	321
Subtotal	1,181
Amounts used during the year	550
Total liability	631
(Decrease) / increase in provision	79

15. PROVISION (CONTINUED)

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

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 M Lardies, 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 2.50% for the year ending 30 June 2014. A discount rate of 2.95% has been used for the year ended 30 June 2014.

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	2014 Actual	2013 Actual
Trade payables to other related parties	20	5,407	5,153
Trade payables to non-related parties		14,146	4,177
GST and other taxes payables		11,796	11,302
Income in advance		899	1,027
Capital charge due to the Crown		4,197	4,547
Other non trade payables and accrued expenses		45,135	37,871
		81,580	64,077

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.

in thousands of New Zealand Dollars

17. PATIENT AND RESTRICTED FUNDS

Patient funds	2014 Actual	2013 Actual
Balance at 1 July 2013	148	144
Monies received	172	198
Interest received	2	2
Payments made	(167)	(196)
Balance at 30 June 2014	155	148

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 2014 are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as at 30 June 2014, both as an asset and a liability.

Holiday homes funds	2014 Actual	2013 Actual
Balance at 1 July 2013	72	67
Monies received	18	17
Interest received	2	2
Payments made	(17)	(15)
Balance at 30 June 2014	75	71
Hutt Valley DHB Portion ¼ of holiday homes total	19	18
Total patient and restricted funds	174	166

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.

18. OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2014 Actual	2013 Actual
Less than one year	2,819	2,530
Between one and five years	3,730	2,947
More than five years	-	-
	6,549	5,477

During the year ended 30 June 2014, $2.6m was recognised as an expense in the statement of comprehensive income in respect of operating leases (2013: $2.7m)

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:

	2014 Actual	2013 Actual
Less than one year	184	125
Between one and five years	626	697
More than five years	1,427	1,409
	2,237	2,231

During the year ended 30 June 2014, $2.2m was recognised as rental income in the statement of comprehensive income (2013: $2.3m)

The DHB has:

- a long term agreement with the University of Otago for the provision of medical consultancy services and facilities from which they operate these services.
- long term ground leases in operation where the lessee owns all the improvements.
- medium term leases (consulting rooms) in two separate health centres.
- 43 short term commercial leases, all subject to 6 month termination notice.
- 2 residential leases all subject to the Residential Tenancies Act.

in thousands of New Zealand Dollars

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 55.94% in 2014 (2013: 61.24%). 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 2014 was nil (2013: $nil)

Sensitivity analysis

If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $0.03m in 2014. (2013: $0.29m).

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 2014, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $3.4m (2013: $3.5m). 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 $0.00025m for the year ended 30 June 2014 (2013: $0.00042m).

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.

	2014 Actual							
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	
Loans:								
NZD fixed rate loan*	5.16	28,000			28,000			
NZD fixed rate loan*	3.43	6,000			6,000			
NZD fixed rate loan*	3.65	9,000				9,000		
NZD fixed rate loan*	4.04	34,000				34,000		
NZD fixed rate loan*	4.15	6,000					6,000	
NZD fixed rate loan*	3.72	25,000				25,000		
NZD fixed rate loan*	3.61	8,000					8,000	
NZD fixed rate loan*	3.51	34,000					34,000	
NZD fixed rate loan*	3.38	28,000					28,000	
NZD fixed rate loan*	6.37	62,000				62,000		
NZD fixed rate loan*	6.30	20,000		20,000				
NZD fixed rate loan*	7.13	12,000		12,000				
NZD fixed rate loan*	6.57	11,000		11,000				
NZD fixed rate loan*	6.95	19,400		19,400				
NZD fixed rate loan*	6.39	8,600		8,600				
NZD fixed rate loan*	3.57	28,000					28,000	
NZD secured loan	4.52	0					45	
NZD unsecured loan	0	1,347		240	285	777		
Finance leases*	6.50	8	8					
		340,355	8	71,240	34,285	130,777	104,045	

	2013 Actual							
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	
Loans:								
NZD fixed rate loan*	5.16	28,000				28,000		
NZD fixed rate loan*	3.43	6,000				6,000		
NZD fixed rate loan*	3.65	9,000				9,000		
NZD fixed rate loan*	4.04	34,000					34,000	
NZD fixed rate loan*	4.15	6,000					6,000	
NZD fixed rate loan*	3.72	25,000				25,000		
NZD fixed rate loan*	3.61	8,000					8,000	
NZD fixed rate loan*	3.51	34,000					34,000	
NZD fixed rate loan*	3.38	28,000					28,000	
NZD fixed rate loan*	6.37	62,000				62,000		
NZD fixed rate loan*	6.30	20,000			20,000			
NZD fixed rate loan*	7.13	12,000			12,000			
NZD fixed rate loan*	6.57	11,000			11,000			
NZD fixed rate loan*	6.95	19,400			19,400			
NZD fixed rate loan*	6.39	8,600			8,600			
NZD fixed rate loan*	2.74	28,000	28,000					
NZD secured loan	4.52	9,110	9,110					
NZD unsecured loan	0	525	26	53	105	315	26	
Finance leases*	6.50	261	126	127	8			
		348,896	37,262	180	71,113	130,315	110,026	

* These liabilities bear interest at fixed rates.

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.

2014	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
Creditors and other payables	81,580	81,580	81,580	-	-	-
Secured loans	339,000	392,803	86,644	45,507	150,063	110,589
Unsecured loans	1,347	1,347	240	285	777	45
Finance leases	8	9	9	-	-	-
Patient and restricted funds	174	174	174	-	-	-
Total	422,109	475,913	168,647	45,792	150,840	110,634
2013						
Creditors and other payables	63,267	63,267	63,267	-	-	-
Secured loans	348,110	410,043	53,042	14,645	225,375	116,981
Unsecured loans	525	525	79	105	315	26
Finance leases	261	279	270	9	-	-
Patient and restricted funds	166	166	166	-	-	-
Total	412,329	474,280	116,824	14,759	225,690	117,007

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.

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2014						
Cash and cash equivalents	12,097	12,097	12,097	-	-	-
Debtors and other receivables	44,145	44,145	44,145	-	-	-
Trust and special funds - bank	714	714	714	-	-	-
Trust and special funds – term deposit	5,800	5,920	5,920	-	-	-
Trust and special funds – debtors	464	464	464	-	-	-
Total	63,220	63,340	63,340	-	-	-
2013						
Cash and cash equivalents	74	74	74	-	-	-
Debtors and other receivables	42,765	42,765	42,765	-	-	-
Trust and special funds - bank	134	134	134	-	-	-
Trust and special funds – term deposit	6,350	6,438	6,438	-	-	-
Trust and special funds – debtors	242	242	242	-	-	-
Total	49,565	49,653	49,653	-	-	-

Maximum exposure to credit risk

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

	2014 Actual	2013 Actual
Cash and cash equivalents	12,097	74
Debtors and other receivables	44,145	42,765
Trust and special funds – bank	714	134
Trust and special funds – term deposit	5,800	6,350
Trust and special funds – debtors	464	242
	63,220	49,565

	2014	2013
Counterparties with credit ratings		
Cash at bank and term deposits	18,611	6,558
AA- (Standard & Poor)	18,611	6,558

Counterparties with no credit ratings	2014	2013
Secured HBL loan	-	(9,110)

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 US 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 2014 was $nil (2013: $nil), comprising assets of $nil (2013: $nil) and liabilities of $nil (2013: $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 2014 was $nil (2013: $nil) recognised in fair value derivatives.

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 2014 Actual	Fair value 2014 Actual	Carrying amount 2013 Actual	Fair value 2013 Actual
Trade and other receivables	10	44,145	44,145	42,765	42,765
Cash and cash equivalents	11	12,097	12,097	74	74
Secured loans	13	(339,000)	(342,998)	(348,110)	(363,021)
Unsecured loans	13	(1,347)	(1,347)	(525)	(525)
Finance leases	13	(8)	(9)	(261)	(279)
Trade and other payables	16	(81,580)	(81,580)	(63,238)	(63,238)
		(365,693)	(369,692)	(369,295)	(384,224)
Unrecognised (losses)/gains			(3,999)		(14,929)

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 2014 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2014 Actual %	2013 Actual %
Derivatives	N/A	N/A
Loans and borrowings	3.38, 3.43, 3.51, 3.57, 3.61, 3.65, 3.715, 4.04, 4.15, 5.16, 6.295, 6.37, 6.39, 6.57, 6.95, 7.13	2.74, 3.38, 3.43, 3.51, 3.61, 3.65, 3.72, 4.04, 4.15, 4.52, 5.16, 6.30, 6.37, 6.39, 6.57, 6.95, 7.13

20. RELATED PARTIES TRANSACTIONS

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 MNZM, is the Chairman of Hutt Valley District Health Board. She is also a Health Programme Leader in the Institute of Environmental Science and Research.
- Derek Milne is the Chair of Wairarapa District Health Board.
- Dr Judith Aitken is a member of the Greater Wellington Regional Council and Chair, Parliamentary Sector Advisory Board.
- Peter Douglas is a member of Hutt Valley District Health Board.
- Helene Ritchie is a Councillor at Wellington City Council.
- Darrin Sykes is a director of New Zealand Touch Board of Directors.
- David Choat is Senior Policy Analyst, Office of the Leader of the Opposition.
- Sue Kedgley is a member of the Greater Wellington Regional Council and a member of the Consumer New Zealand Board.
- Chris Laidlaw is a member of the Greater Wellington Regional Council.
- Nick Leggett is the Mayor of Porirua City Council, a chairperson of Wellington Regional Emergency Management Committee, and a member of Greater Wellington Regional Council, Wellington Regional Transport Committee, and Wellington Regional Strategy Committee.
- Roger Jarrold is a member of Auckland District Health Board Charitable Trust. He is also the Chief Financial Officer at Downer New Zealand Limited.

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

- Ashley Bloomfield is Trustee at AR and EL Bloomfield Trusts, and Fellow at NZ College of Public Health Medicine.
- Andrea McCance is Trustee at Mary Potter Hospice.
- 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.
- Debbie Chin is seconded from her role as CEO at Standards New Zealand

Remuneration

Key management personnel remuneration is as follows:

	2014 Actual	2013 Actual
Short-term employee benefits	3,057	2,876
Post-employment benefits	-	20
Termination benefits	-	-
Executive team	3,057	2,896
Board members	362	391
	3,419	3,287

Key management personnel include all Board members, the Chief Executive, and the other 13 (2013: 15) members of the executive management team.

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

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.

Board members			Board Fees		Committee Fees	
Current board members as at 30 June 2014			**2014**	**2013**	**2014**	**2013**
Dr Virginia Hope NZOM	Elected	Board Chair from 1 Dec 2010 Chair HAC to 30 Nov 2010 Deputy Chair DSAC from 1 Dec 2013	53	50	5	7
Mr Derek Milne	Appointed	Chair DSAC from 1 Dec 2013 Deputy Chair HAC from 1 Dec 2013	19	-	1	6
Dr Judith Aitken	Elected	Chair DSAC to 30 Nov 2010 Deputy Chair CPHAC to 30 Nov 2013	26	25	2	4
Mr David Choat	Elected	Member from 1 Dec 2010	26	25	2	2
Mr Peter Douglas	Appointed	Chair FRAC from 1 Dec 2013	26	25	2	4
Ms Helene Ritchie	Elected	Member from 2001	26	25	2	2
Mr Darrin Sykes	Appointed	Member from 1 Dec 2010 Deputy Chair FRAC from 1 Dec 2013	26	25	3	4
Ms Sue Kedgley	Elected	Member from Nov 2013	15	-	1	-
Mr Chris Laidlaw	Elected	Member from Nov 2013	15	-	1	-
Mr Nick Leggett	Elected	Member from Nov 2013	15	-	1	-
Mr Roger Jarrold	Appointed	Member from Dec 2013	15	-	1	-
Board members who left during the year						
Mr Peter Glensor	Appointed	Retired Sept 2013	13	31	3	6
Ms Barbara Donaldson	Elected	Retired Sept 2013	11	25	1	3
Ms Margaret Faulkner	Elected	Retired Sept 2013	13	25	4	7
Mr Keith Hindle	Appointed	Left Sept 2013	11	25	4	6
Mr Robert Frances	Appointed	Left Sept 2013	11	23	1	1
Crown monitor						
Ms Debbie Chin	Appointed	Appointed as Interim CEO Sept 2013	7	35	-	6
			328	339	34	52

Legend:

DSAC – Disability Support Advisory Committee

HAC – Hospital Advisory Committee

CPHAC – Community and Public Health Advisory Committee

FRAC – Finance Risk & Audit Committee

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

Committee members (other than Board members and employees)	2014 Actual	2013 Actual
Community and Public Health Advisory Committee		
Herani Demuth	-	-
Tavita Filemoni	-	-
Jack Rikihana	-	2
Disability Support Advisory Committee		
Nathan Bond	-	1
Sere Tapu- Ta'ala	-	1
James Webber (from March 2011)	-	1
Hospital Advisory Committee		
Tavita Filemoni	-	1
Lynn McBain	1	2
Karen Coutts	1	2
	2	10

Sales to related parties	2014 Actual	2013 Actual
Compass Health Wellington Trust	-	91
Compass Primary Health Care Network	-	3
Gillies McIndoe Research Institute	12	-
Mary Potter Hospice	19	46
Medical Research Institute of NZ	11	170
New Zealand Defence Headquarters	5	-
Ora Toa Health Service	1	14
Southern Cross Hospital	-	6
Spotless Services (NZ) Limited	-	272
The Health Roundtable	-	1
Victoria University of Wellington	213	-
Wakefield Hospital	-	6
Well Health	-	10
Wellington Free Ambulance	-	26
Wellington Hospitals & Health Foundation	55	121
Whitireia Community Polytechnic	463	-
	779	766

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

Purchases from related parties

	2014 Actual	2013 Actual
Age Concern New Zealand	1,001	991
Compass Health	54,577	51,147
Downer New Zealand Limited	146	-
Healthcare New Zealand	27	-
Mary Potter Hospice	5,282	4,828
MATPRO	-	40
Medical Council of New Zealand	85	1
Medical Research Institute of New Zealand	120	1
Metlife Care Palmerston North	1,136	1,196
Ora Toa PHO	4,638	4,771
Porirua City Council	117	-
Porirua Union and Community Health Service Inc	83	147
Southern Cross Hospital	-	4,255
Spotless Services	-	7,153
Te Runanga O Toa Rangatira Inc	-	1,620
Telecom New Zealand Limited	891	-
The Health Roundtable	249	51
The Royal Australasian College of Medical Administrators	-	2
Wakefield Hospital Limited	-	1,938
Well Health PHO	6,370	6,239
Wellington City Council	1,353	897
Wellington Free Ambulance	-	1,591
Wellington Hospitals and Health Foundation	425	200
Wellington Riding For The Disabled Association	146	6
Wellington Tenths Trust	175	188
Wesley Community Action	437	522
	77,258	87,784

Outstanding balances to related parties	2014 Actual	2013 Actual
Age Concern New Zealand	77	76
Compass Health	-	792
Compass Health Wellington Trust	-	277
Compass Primary Health Care Network	2,319	183
Mary Potter Hospice	404	-
Ora Toa PHO	324	159
Porirua City Council	60	-
Porirua Union and Community Health Service Inc	32	13
Southern Cross Hospital	-	104
Spotless Service	-	1,537
Telecom New Zealand Limited	378	-
Te Runanga O Toa Rangatira Inc	-	103
Wakefield Hospital Limited	-	36
Well Health PHO	521	285
Wellington City Council	40	81
Wellington Free Ambulance	-	121
Wellington Hospitals & Health Foundation	-	2
Wellington Tenths Trust	54	40
Wellesley Community Action	11	18
	4,220	3,827

Outstanding balances from related parties	2014 Actual	2013 Actual
Compass Health Wellington Trust	-	13
Gillies McIndoe Research Institute	12	-
Mary Potter Hospice	19	37
Medical Research Institute of New Zealand	-	1
Ora Toa PHO	1	4
Southern Cross Hospital	-	5
Spotless Service (NZ) Ltd	11	21
Victoria University of Wellington	101	-
Wakefield Hospital	-	5
Wellington Free Ambulance	-	20
Wellington Hospital and Health Foundation	52	108
	196	214

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

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.

	2014 Actual	2013 Actual
Purchases from CRTAS related entities	3,645	1,755
Sales to CRTAS related entities	-	39
Outstanding balances to CRTAS related entities	3,129	113
Outstanding balances from CRTAS related entities	-	17

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 (2013: $nil).

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 $740m (2013: $720m) to provide services to the public for the year ended 30 June 2014.

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.

	2014 Actual	2013 Actual
Purchases from government related entities	302,407	325,822
Sales to government related entities	207,063	216,913
Outstanding balances to government related entities	22,828	17,455
Outstanding balances from government related entities	29,542	33,170

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 2014	Number of Employees 2013
100 – 110	129	95
110 – 120	63	71
120 – 130	57	41
130 – 140	62	54
140 – 150	42	32
150 – 160	18	13
160 – 170	20	19
170 – 180	16	21
180 – 190	20	9
190 – 200	14	8
200 – 210	9	15
210 – 220	19	22
220 – 230	11	15
230 – 240	20	23
240 – 250	17	16
250 – 260	8	19
260 – 270	11	12
270 – 280	13	12
280 – 290	12	12
290 – 300	10	11
300 – 310	2	11
310 – 320	7	8
320 – 330	5	8
330 – 340	4	10
340 – 350	10	7
350 – 360	3	7
360 – 370	4	3
370 – 380	4	4
380 – 390	1	4
390 – 400	4	1
400 – 410	1	2
410 – 420	1	7
420 – 430	3	2
430 – 440	2	3
440 – 450	1	-
460 – 470	1	1
470 – 480	-	1
480 – 490	1	-
490 – 500	-	1
520 – 530	1	-
530 – 540	1	-
560 – 570	-	1
650 – 660	-	1
	627	601

in thousands of New Zealand Dollars

21. EMPLOYEE REMUNERATION (CONTINUED)

Of the 627 employees shown above, 419 are or were medical or dental employees and 208 are or were neither medical nor dental employees. This represents an increase of 26 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 1,435, compared with the actual total number of 627.

22. TERMINATION PAYMENTS

During the year ended 30 June 2014, 11 (2013: 4) employees received compensation and other benefits in relation to cessation totalling $0.3m (2013: $0.05m).

No Board members (2014: nil) received compensation or other benefits in relation to cessation (2013: nil).

23. EXPLANATIONS TO FINANCIAL VARIANCES FROM BUDGET

Explanations of significant variances from the Statement of Intent when compared to actual figures for the year ended 30 June 2014 are provided below.

Statement of comprehensive income

The DHB recorded a deficit of $5.9m compared with the budgeted deficit of $6m.

Revenue for 13/14 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:

- Personnel and clinical supply costs were above budget due to higher levels of activity that was not budgeted for and delays in the implementation of certain targeted savings initiatives.
- Increased outsourced services were contracted to meet health targets
- Increased infrastructure costs mainly related to higher levels of activity and additional spend on regional information technology improvements

Statement of financial position

Major variances were:

- Cash and cash equivalents were higher due to higher Government & Crown agency revenue and better cash management.
- Trade and other payables were higher due to correctly updating supplier payment terms and timing of supplier payments.

Statement of cash flows

Major variances were:

- Operating cash flows were favourable due to higher Government & Crown agency revenue coupled with reduction in operating payments.
- Cash flow from investing activities is higher than budget due to increased capital expenditure.
- Cash flow from financing activities are in line with budget.

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.

25. SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2014 Actual	2013 Actual	2014 Actual	2013 Actual	2014 Actual	2013 Actual	2014 Actual	2013 Actual	2014 Actual	2013 Actual
Revenue										
Crown	8,991	7,768	177,733	183,476	667,065	615,530	95,940	100,175	949,729	906,949
Other	-	-	-	-	25,928	51,585	-	686	25,928	52,271
Total revenue	**8,991**	**7,768**	**177,733**	**183,476**	**692,993**	**667,115**	**95,940**	**100,861**	**975,657**	**959,220**
Expenditure										
Personnel	-	-	-	-	403,810	387,121	5,285	4,329	409,095	391,450
Depreciation	-	-	1	1	34,509	41,861	-	-	34,510	41,862
Capital charge	-	-	-	-	8,578	9,408	-	-	8,578	9,408
Provider payments	8,454	7,247	159,002	160,184	65,877	57,755	87,834	90,912	321,167	316,098
Other	550	624	18,738	23,296	186,055	182,262	2,863	4,994	208,206	211,176
Total expenditure	**9,004**	**7,871**	**177,741**	**183,481**	**698,829**	**678,407**	**95,982**	**100,235**	**981,556**	**969,994**
Net surplus/(deficit)	**(13)**	**(103)**	**(8)**	**(5)**	**(5,836)**	**(11,292)**	**(42)**	**626**	**(5,899)**	**(10,774)**

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.

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2014 Actual	2014 Budget	2013 Actual	2014 Actual	2014 Budget	2013 Actual	2014 Actual	2014 Budget	2013 Actual	2014 Actual	2014 Budget	2013 Actual
Opening balance	(289,737)	(294,936)	(285,241)	(17,221)	(19,573)	(17,764)	(16,271)	(25,727)	(9,450)	(323,229)	(340,236)	(312,455)
Surplus/(deficit) for the year	(21,444)	(4,000)	(4,496)	61	-	543	15,484	(2,000)	(6,821)	(5,899)	(6,000)	(10,774)
Closing balance	**(311,810)**	**(298,936)**	**(289,737)**	**(17,160)**	**(19,573)**	**(17,221)**	**(787)**	**(27,727)**	**(16,271)**	**(329,128)**	**(346,236)**	**(323,229)**

CAPITAL AND COAST DHB attendance at board and committee meetings July 2013 – June 2014

JULY – DECEMBER 2013

Board member	Board (5 meetings)	CPHAC (5 meetings)	DSAC (5 meetings)	HAC (5 meetings)	FRAC (5 meetings)
Dr Virginia Hope	5	4	4	4	5
Peter Glensor	4	x	x	5	5
Judith Aitken	5	3	3	x	x
David Choat	5	x	x	4	x
Darrin Sykes	3	x	x	3	3
Peter Douglas	5	x	x	3	3
Margaret Faulkner	5	4	4	5	5
Barbara Donaldson	5	x	x	5	x
Keith Hindle	5	5	5	5	5
Helene Ritchie	5	x	x	3	x
Bob Francis	4	5	5	x	x

JANUARY – JUNE 2014

Board member	Board (6 meetings)	CPHAC (4 meetings)	DSAC (4 meetings)	HAC (3 meetings)	FRAC (4 meetings)
Dr Virginia Hope	6	3	3	3	4
Derek Milne	6	4	4	2	1
Judith Aitken	6	x	x	x	3
David Choat	5	3	3	x	x
Darrin Sykes	5	x	x	x	4
Peter Douglas	6	2	2	x	3
Sue Kedgley	6	x	x	3	x
Chris Laidlaw	3	3	3	x	x
Nick Leggett	6	x	x	2	x
Helene Ritchie	5	3	3	x	x
Roger Jarrold	6	x	x	x	3

Note 1: Changes to board members following the DHB elections in October 2013.

Note 2: 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.
x = not a committee member

Note 3: There was an additional (special) Board meeting held in June which resulted in 11 Board meetings for the year.


THANKS
m.I.m
EAT.
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