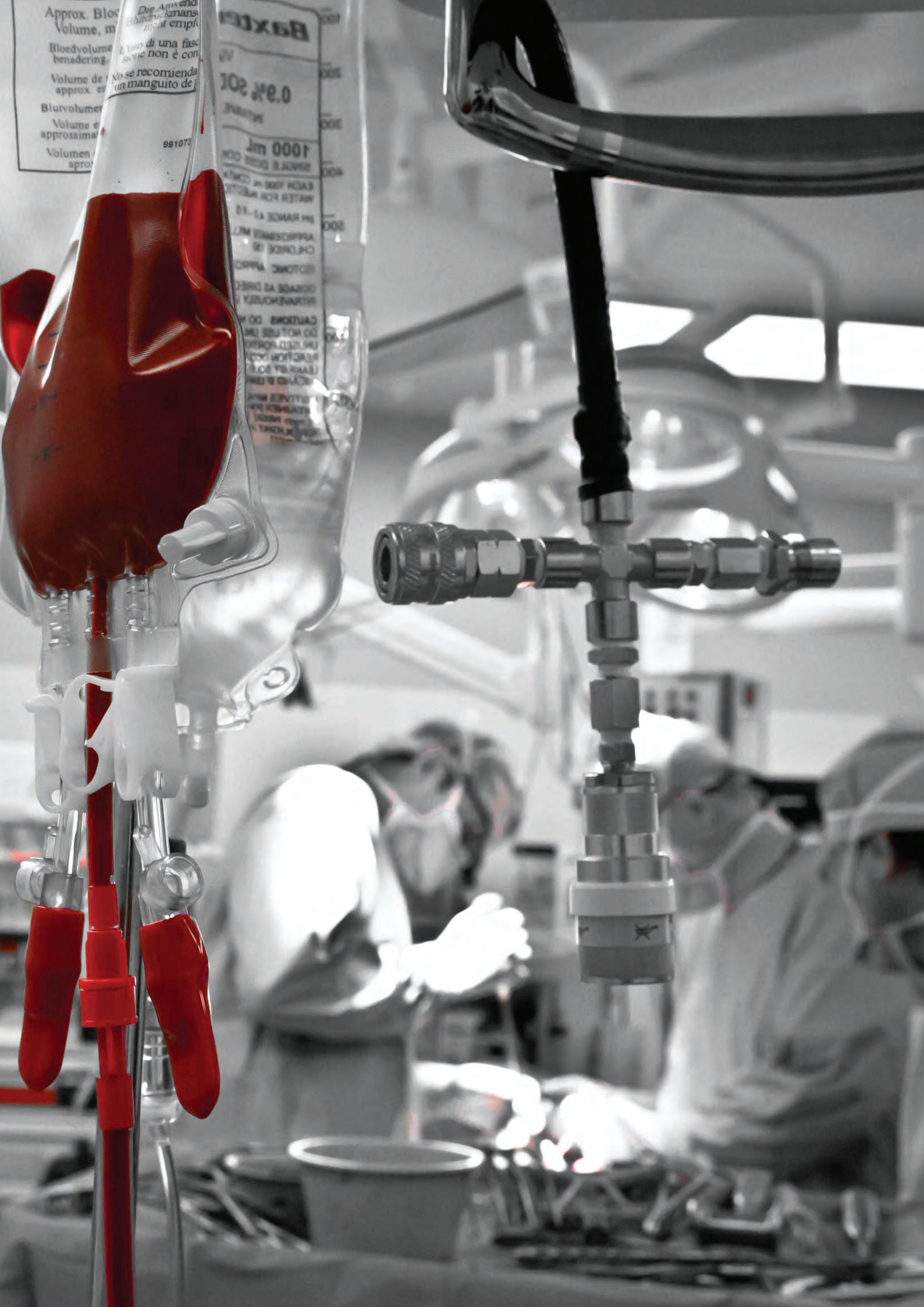
CAPITAL & COAST DHB

ANNUAL REPORT 2012/13

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 CCDHB medical photographer, Louise Goossens and the communications team.*

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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...

742 patients seen by a nurse in general practice

75 people get their eyes checked

11 babies are born

2546 patients seen by a GP

9.5kgs Milo made

4.1kg of coffee sipped

1,742 tea bags dunked

328 eggs cracked

185 people admitted to our hospital

1,679 patient meals served up

55kgs potatoes scrubbed

3,008 face cloths used

3,121 bath towels washed

55 patients undergo surgery

37.97 litres of hand soap lathered

32,561 metres of toilet paper used

9,196 number of items dispensed by community pharmacies

1,755 bed sheets used

2,076 pillow cases used

7,244 number of lab tests performed in both the community and hospital labs

(These are all daily figures)

Mary Bonner, CEO and Dr Virginia Hope, Board Chair.

Welcome

Message from the Chair and CEO

The 2012/13 year has seen Capital & Coast District Health Board focussed on improving the health of our population by developing stronger links with our community health partners and neighbouring DHBs. Through a better integration with primary care and a focus on maintaining a strong quality and safety culture we have been able to reduce waiting times and deliver more equitable access to services for our population.

Highlights of the past year include:

- improved access to elective services, completing 494 extra surgeries than the previous year;
- reduced waiting times for surgical treatments, including orthopaedic, cardio thoracic and vascular services;
- surgical safety check list audit saw our overall compliance increase to 98% making us top of all DHBs;
- increased access to cancer treatment and the introduction new cancer nurse co-ordinator roles to improve the experience for patients and their families;
- improved Emergency Department waiting times from 74% of patients being seen within six hours to 86%, which is on top of an 8% increase in attendances during the past year;
- introduced free health care for all children under 6, which resulted in significant reductions in hospital admissions;
- exceeded the Health Quality & Safety Commission's hand hygiene target with 75% compliance, rating CCDHB among the highest in New Zealand;
- increased our immunisation rates to 93% of two year olds, which includes 91% for Māori and 94% for Pacific.

BETTER CARE CLOSER TO HOME

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

Collaboration remains one of the key drivers for us this year and in the future. Through the Integrated Care Collaborative (ICC) we are working closely with our primary care partners to serve our community by delivering a whole system approach to care; approaches that are open, consensus based and clinically led.

Through projects such as the 'free under sixes' we are working to reduce the demand on departments such as the Emergency Department, by making it easier for parents to visit their general practice

or after hours care by removing cost barriers and therefore ensuring equitable access to services. The Shared Care Record was also launched in collaboration with General Practices, allowing hospital clinicians to access a summary record of patient information. Having access to this means hospital doctors can get a more complete view of that person's health history and easily see what medication they are taking and if there are any recent test results. This will ultimately mean shorter and safer patient journeys.

Work continues to enhance the service we provide to people with disabilities through improved understanding by clinical staff of disability support needs and in turn a safer patient journey. A new project will see the launch of the disability alert icon later this year which allows patients with disabilities to be easily identified before they come into the hospital. This, along with the health passport, means that the patient admission and discharge processes can be completed more accurately making it safer for our patients.

INVESTING IN THE FUTURE

This year has also seen the completion of major construction projects as well as the beginning of new ones. At the beginning of this financial year, we completed the refurbishment of our mental health facility in Wellington, Te Whare O Matairangi (TWoM). This has resulted in a spacious, modern respectful facility that has become a leading acute inpatient facility in the country.

At Kenepuru Community Hospital work began on the Renal Service's new Satellite Dialysis Unit in April. This 24 chair purpose-built unit will replace our current facility located in the BNZ Tower, which has nine chairs. It will be used by patients from across the three DHBs, providing a purpose built dialysis unit for our entire sub-regional community. The facility is expected to be completed by February 2014 and will provide a much needed capacity boost for non-acute dialysis services across the region.

Work is almost complete on creating a Surgical Assessment and Planning Unit, due to be open in September 2013. This 18 month project is expected to improve our acute surgical patients' journey as it reduces waiting times and a patient's length of stay.

CREATING SUSTAINABLE SERVICES

Developing sustainable health services that can support our ever-changing population has been a large focus of our strategic planning. In October 2012, the 3DHB Programme developed by Wairarapa, Hutt Valley and Capital & Coast DHBs was formally announced. This builds on the work of the shared Clinical Leadership Group and aims for a closer integration of operations and delivery of health care, to help ensure health services are delivered equitably and sustainably to our sub-region.

Partnership activity amongst the three DHBs is not new and 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. The intention of this programme of work has been to advance integration in these services and accelerate it across other specialties.

We see this as an evolutionary process, rather than a revolutionary one, that is being led by clinical need and benefit. Done right, all three District Health Boards firmly believe that greater integration will remove many of the artificial boundaries and barriers that hamper effective and safe healthcare delivery that at times frustrate both patients and clinical staff alike. It will lead to better use of the skills and time of our experienced and capable staff.

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. We also recognise the dangers of a large organisation losing focus on the patient and we want a strong patient-centred culture both emerging from and driving these changes.

WHOLE OF SYSTEM APPROACH

With the prospect of an ageing population supported by an ageing workforce, we recognise that joining together the DHBs is not enough and that a 'whole of system' view is needed.

Thinking of the region as one population and the potential access to the breadth of skill and expertise across the sub-region will not only create new opportunities but also real progress as we continue to work together across our three DHBs - a prospect all three boards are excited by. We have been inspired by the leadership and commitment from the Clinical Leadership Group. We are constantly humbled by the sheer will to do well and perform to higher and higher standards that exists throughout the three DHBs.

Of course it is our staff's commitment that makes all this possible. In the past year we saw many wonderful examples of innovation and dedication throughout the year, from Staff Recognition Awards through to the many projects highlighted in the Quality Improvement and Innovation Awards and the Allied Health Scientific & Technical Awards for the sub-region.

Finally, we would like to thank the Board and the staff for their continued support and commitment to the people of the region. Special mention must go to retiring Board members Barbara Donaldson and Margaret Faulkner, whose experience after many years on the Board will be missed. To deliver a first-rate health system you need to have a first-rate team and we believe that we have this and are on track to providing a sustainable service that can evolve with the growing demands of an ever changing population.

Dr Virginia Hope, Chair

Mary Bonner, CEO

Left to right: Catherine Epps, Executive Director of Allied Health, Technical & Scientific, Dr Geoff Robinson, Chief Medical Officer and Andrea McCance, Director of Nursing & Midwifery.

Message from the Professional Heads

The Professional Heads have written this annual report together as part of our vision of inter-professional collaboration, and drive for continuous quality improvement for the patients and families with whom we work with. We are passionate about improving and leading the way we deliver healthcare as the needs of our communities change.

As we reflect on last year, there have been many services across the DHB who have been able to implement and embed changes in the way they work. This is in order to continue to improve the way we deliver our services to patients/people while continuing to manage within the financial constraints that we have. Many of the professional groups have been able to take advantage of the opportunities to work more closely with their peers in primary care and/or across the other DHBs within our sub-region.

We are proud of the achievements of our workforce, and many have been celebrated and thanked. Recognising and acknowledging our successes is a key factor in ensuring that we continue to value the work that we each do to make a difference to our patients and populations. This year, the DHB has commenced the staff recognition awards to mark the staff who have worked for many years within our organisation. We have also engaged in many of the profession based celebration days such as International Nurses Day and others.

Many staff have also participated in service improvement processes in the last year (both formally and informally). The importance of using sound service improvement principles is well recognised, and so we are delighted that in the new financial year, the Executive Director for the Quality, Improvement and Patient Safety Directorate, will be a service improvement expert. We anticipate that the building of our service improvement culture will continue to help us work towards, and meet our health targets, as well as improving the way we deliver health care.

Last year, we referred to the number of clinicians who came together from across the health system to break down some of the traditional barriers within healthcare that our people and families experience. This has occurred in a number of different ways, and led by the Integrated Care Collaborative (ICC) and 3DHB projects. The improvements we have made in working with our colleagues in other parts of the health system will be further strengthened by the evolution of the ICC into the Alliance Leadership Team in the new financial year.

As a teaching hospital, our commitment to research, and to training a wealth of undergraduate and post graduate students, is well established. There are

also many links across the organisation into each of the four universities in and around Wellington, as well as the other training centres across New Zealand. The ongoing commitment to the training of our workforce; both present and in the future, remains a key driver to our success.

The Professional Heads continue to endeavour to be accessible and available to hear clinician and consumer feedback, as well as to guide and demonstrate strong clinical leadership. We value and appreciate the array of involvement from clinical staff at all levels across the DHB to ensure that clinical staff practice safe, high quality, and effective healthcare. Together we are contributing to, implementing, and in some cases driving international best practice for healthcare.

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

Dr Geoff Robinson,
Chief Medical Officer

Andrea McCance,
Director of Nursing & Midwifery

Staff Recognition Awards at Kenepuru Hospital

About CCDHB

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

Currently 298,600 people live within the Capital and Coast district, with two thirds of the population in Wellington City, 18% in Porirua and 14% on the Kapiti Coast.

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

CCDHB is the leading provider of specialist tertiary services for the upper South and lower North Islands, covering a population of about 900,000.

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

Community-based services provided include both general and specialist district nursing, specialist multi-disciplinary rehabilitation services, occupational therapy, speech language therapy, physiotherapy, dietetics, social work and home support services, mental health, alcohol and drug services.

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

The health of our population

Our DHB is the seventh largest in New Zealand and spans three territories; Wellington City, Porirua City and part of Kapiti Coast District. The actual combined population of these three districts is 298,600.

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

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

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

We have fewer than average Māori (11%) and higher than average Pacific (7%) and Asian (12%) populations. The Māori and Pacific populations are younger than other groups in the district, and comprise of more children and fewer elderly people.

Overall our district is relatively advantaged in terms of socio-economic 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 Kapiti. The proportion of Māori and Pacific will increase. Like the country as a whole, the population will age over the next 20 years with the number aged over 65 years expected to grow

by 78% and an expected two-fold increase in the population aged over 85 years.

Key health issues for this DHB include:

- Reducing the incidence of long-term conditions (such as cardiovascular disease, diabetes and respiratory conditions) and minimising the impact on people's daily lives. Māori and Pacific tend to have earlier onset of long-term conditions than other groups.
- The burden of cancer and reducing disparities in survival.
- Experience of mental illness and its unequal impact on younger, disadvantaged population groups.
- Addressing issues for children and youth, including oral health, respiratory, skin infections and injuries, mental health and youth suicide, as well as sexual health.
- Health of older people, including management of long-term conditions, cancer, musculoskeletal disease (for example, arthritis, osteoporosis), injury from falls, the impact of dementia, and home and community support needs.
- Responding to the needs of the 15% of the district population estimated to have a disability.
- For more detail on the health needs of our population see the 2012-2013 Annual Plan and the 2013-14 Statement of Intent.

About our Annual Report

This report presents Capital & Coast District Health Board's (CCDHB) performance for the year 1 July 2012 to 30 June 2013. 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) 2012/13, and provides a detailed account of how the health funding received by CCDHB has been managed. The SOI is an annual statutory document which determines our course of activities for the financial year including milestones and measures. It includes long-term goals and annual accountability objectives and is the formal accountability document between the Government and CCDHB.

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

STRATEGIC DIRECTION

OUR VISION

Better health and independence for people, families and communities.

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

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

- focusing on people through integrated care
- supporting and promoting healthy lifestyles
- working with our communities
- developing our workforce
- updating our hospitals
- managing our money

OUR VALUES

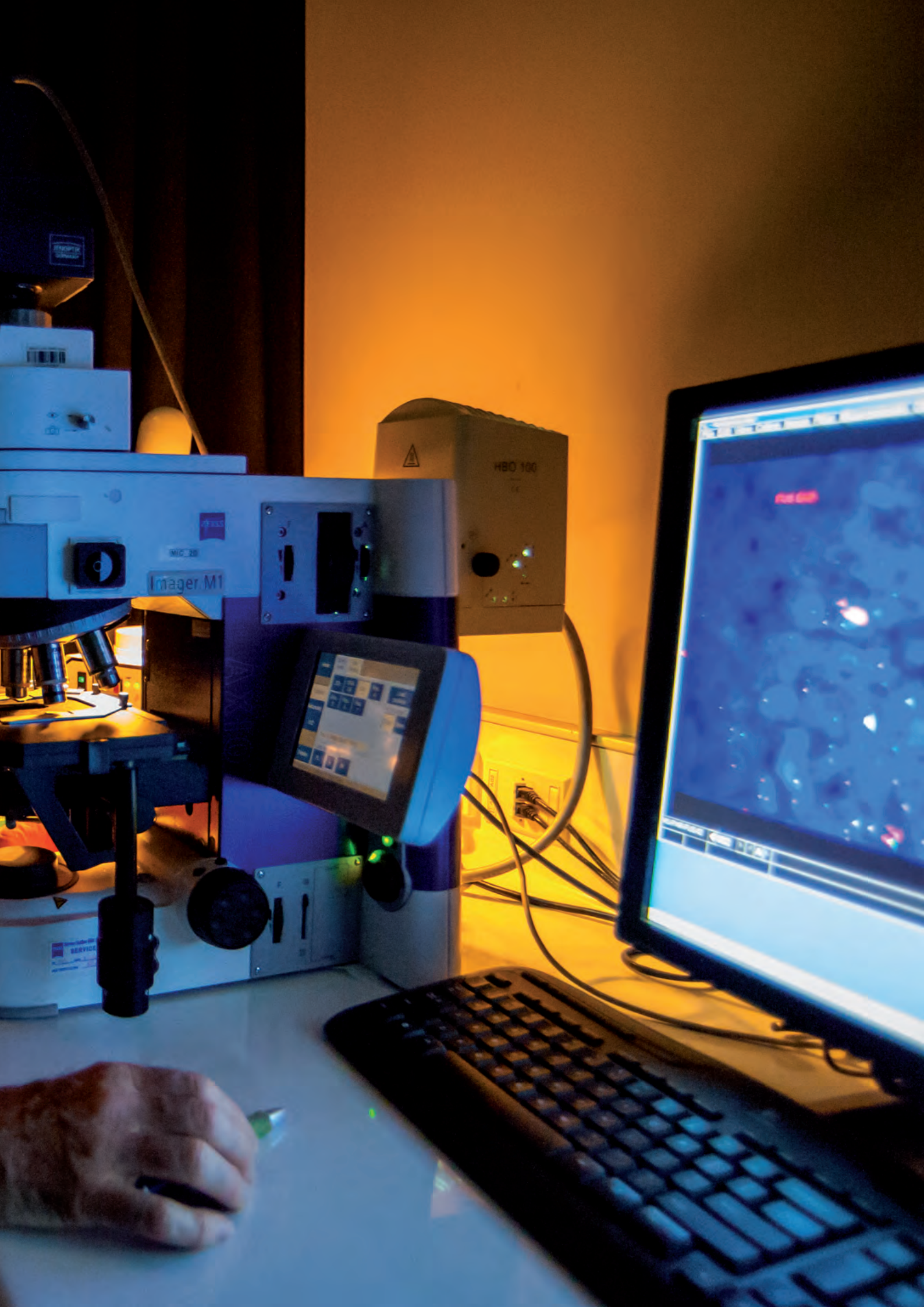
As a health care provider, we work according to core values:

- focusing on people and patients
- innovation
- living the Treaty
- professionalism
- action and excellence

STRATEGIC GOALS

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

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

The Board of Capital & Coast DHB is responsible for the governance of the organisation and is accountable to the Minister of Health. The governance structure for DHBs is set out in the New Zealand Public Health and Disability Act 2000.

The Capital & Coast DHB Board consists of 11 members who have overall responsibility for the organisation's performance. Seven Board members are elected as part of the three-yearly local body election process (held in October 2013) and four are appointed by the Minister of Health. A Crown Monitor was appointed in the 2007/08 year and replaced by a new Crown Monitor in November 2009.

OUR OBJECTIVES AS A DISTRICT HEALTH BOARD

The objectives of DHBs are described in section 22 of the New Zealand Public Health and Disability Act (NZPHD) 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.

CCDHB Committees

The Board delegates specific matters to the Chief Executive Officer of our DHB. The Board has established four committees 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 it was agreed that the Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC) would sit at the same time to achieve regional collaboration. 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, takes 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

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).

Attendance at Board and Committee meetings

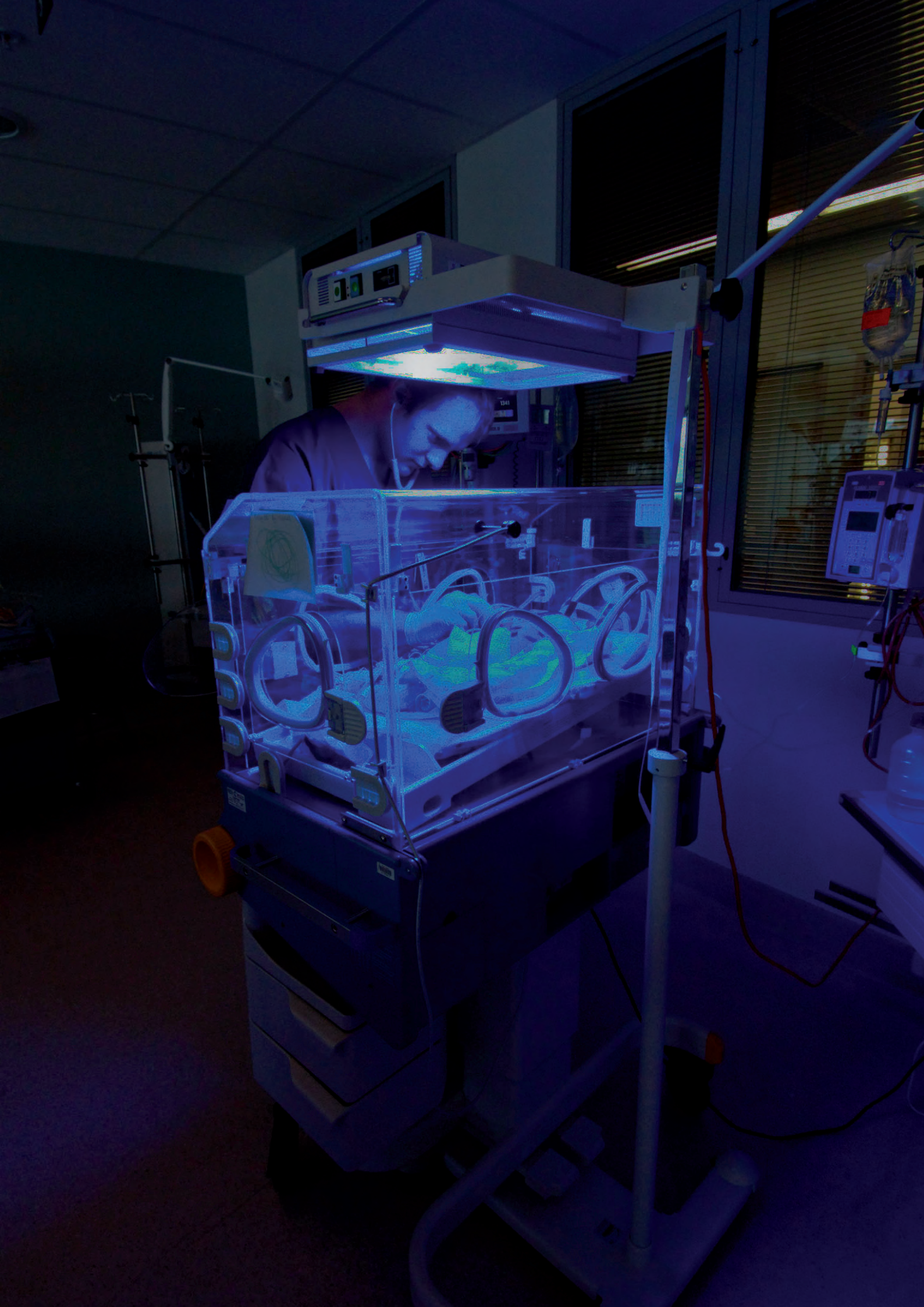
Board member	Board 10 meetings	CPHAC 10 meetings	DSAC 7 meetings	HAC 10 meetings	FRAC 10 meetings
Dr Virginia Hope	10	9	6	10	10
Peter Glensor	10	-	-	9	10
Keith Hindle	7	5*	5	10	10
Margaret Faulkner	10	5*	7	-	10
Helene Ritchie	9	3^	1	5*	-
Darrin Sykes	8	-	-	8	9
Barbara Donaldson	8	-	-	9	-
Judith Aitken	7	8	5	-	-
David Choat	9	3^	0^	5*	
Peter Douglas	7	-	-	10	6
Bob Francis	10	5*	5*	-	-

** Committee member from February 2013 ^ Ceased being member of the committee December 2012 - Not a member*

NOTES:

DSAC meetings were held quarterly to December 2012, then held monthly from February 2013, on the same day as CPHAC meetings. 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.

Dr Ashley Bloomfield being introduced at a Board meeting.



2012/2013 SPENDING ($M)

(Figures shown are for funder arm only)

204.85	75.90	253.39
Hospital - Medicine, Cancer & Community	**Hospital - Mental Health Services**	**Hospital - Surgery Women's & Children**
.93	11.89	54.14
Hospital - Clinical and Corporate Support	**Other Hospital Services**	Primary Health Organisations & GP Services
15.92	24.72	16.20
Community Laboratories (Paid to Hutt DHB)	Mental Health Services (Including inter-district)	Care Co-ordination and Home Based Services for the Elderly
62.09	45.68	56.55
Community Pharmaceuticals	Inter-District Outflows	Aged Residential Care

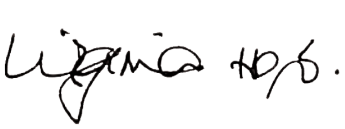
2012/2013 REVENUE ($M)

14.42	Other Elderley and Disability Support Services
34.83	Other Services
676.37	Ministry of Health
182.46	Other DHBs
5.84	Other Revenue
864.67	**TOTAL**

Statement of Responsibility

FOR THE YEAR ENDED 30 JUNE 2013:

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 2013, fairly reflect the financial position and operations of Capital & Coast District Health Board.



Virginia Hope
Chair
31 October 2013

Peter Glensor
Deputy Chair
31 October 2013

COLLABORATION HIGHLIGHTS

3DHB Health Service Development

A significant development in 2012/13 was the launch of the 3DHB Health Service Development (3DHB HSD) programme. This commitment to a partnered approach to health service delivery was led by the 3DHB Chairs through a number of presentations to staff across the sub-region.

The Sub-Regional Clinical Leadership Group (SRCLG) oversees the progress of the agreed work programme, which details both clinical workstreams and enablers aimed at delivering health services as a single sub-region. SRCLG is chaired by Dr Iwona Stolarek and includes clinical leaders, senior managers and the CEOs from the three DHBs.

A recent important addition to this group has been the three GPs from Primary Care; one from each of the DHB areas. Bringing Primary Care into our programme oversight strengthens our focus for a whole of system approach. Our service designs span the health continuum enabling the greatest gains to the patient and whanau experience, population health and clinical and financial sustainability, consistent with the Triple Aim Approach.

The focus on service integration is significant. Better co-ordination of services - especially between hospital and community-based care - is essential if we are to improve the experience of people when using health services.

Members of the Sub-Regional Clinical Leadership Group and Clinical Leadership Group. From left to right: Dr Ashley Bloomfield - Director of Service Integration and Development, Dr Iwona Stolarek - Hutt/Wairarapa DHB Chief Medical Officer, Carolyn Cooper - Executive-Director, People and Culture, Pete Chandler - Hutt/Wairarapa DHB COO, Graham Dyer - Hutt/Wairarapa DHB CEO, Bob Francis - Wairarapa Board Chair, Dr Virginia Hope - CCDHB Board Chair, Tony Bekker, Wairarapa GP, Mary Bonner, CCDHB CEO.

Previous page: *Dr Virginia Hope turning the sod of the new $5 million Satelite Dialysis Unit at Kenepuru with Porirua Mayor Nick Leggett*

Key steps undertaken by the Wairarapa, Hutt Valley and Capital & Coast DHBs to progress the eight key actions agreed for sub-regional service alignment in 2012/13 are:

- A sub-regional approach to planning and funding functions was developed following consultation. The three DHBs established a single Service Integration and Development Unit (SIDU) in December 2012, bringing together their planning and funding functions. This provides a single view across the population of the 3DHBs when deciding on the services needed to address health needs of different communities.
- A 3DHB chief executive forum was established, which is attended by the chair of the Clinical Leadership Group with executive and programme management support from SIDU.
- The appointments of a Director of People and Culture and a Chief Information Officer across the sub-region has enabled alignment of these core functions. An agreed approach has been established and implemented to sub-regional policy development, including human resource and clinical policy.
- In order to support a collaborative annual planning process and the bringing together of SIDU, Community and Public Health Advisory Committees (CPHAC) of the three DHBs sit together to oversee the work programme of SIDU and the sub-regional 3DHB work programme.
- To progress clinical services alignment across the three DHBs, work is being undertaken to align core components of the patient journey and service delivery. The objective is to enable service delivery to be seamless across the sub-region to improve the patient journey. Clinical services steering groups have progressed decisions on how best to manage patient flow, triage and service delivery, that will ensure we are meeting the needs of our sub-regional population. Our focus has included ENT, Child Health and Gastroenterology. The collaborative clinical leadership across the sub-region has enhanced our progress. New clinical workstreams are currently being reviewed for opportunities to develop a 'single service' approach.
- Significant work has been undertaken supporting the clinical workstreams to progress their identified priorities through utilisation of project management methodology. This framework has improved reporting and our ability to demonstrate progress to our Boards and wider stakeholders.

SUB REGIONAL PACIFIC STRATEGIC HEALTH GROUP

The Sub Regional Pacific Strategic Health Group is now in its second year of operation, and to date, the group has provided sound, relevant and timely advice to a range of CCDHB and HVDHB programmes and projects.

The group has also been utilised by the Associate Minister of Health's office to mobilise Pacific communities in the Whanau Ora space. It has been instrumental in negotiating with Pacific providers and communities to form the Central Region Pacific Health and Wellbeing Collective. This Collective has received funding from the Ministry of Health Pacific Unit for four years to develop their infrastructure and build links and pathways with mainstream services.

The Respiratory Physiology teams from Hutt Hospital and Wellington Regional Hospital are working togerther to improve services for their patients.

Better access for the region's respiratory patients

Respiratory services in the region are a good example of DHBs working together to make things better for patients. Previously, if you needed a specialist lung function tests, your GP referred you to Hutt Valley or Wellington Hospital according to the type of test you needed, regardless of where you lived or if you had a related outpatients' appointment at another hospital.

"We decided to work together to create a service across the three DHBs that was more convenient for patients, where they had access to the same standardised testing protocols and where service was consistently available," says Betty Poot, Clinical Nurse Manager Respiratory at Hutt Hospital.

There are now two Wellington and one Hutt respiratory physiologists who have 'special staff status' working between Wellington and Hutt Hospitals.

"The service has shared training support and supervision, which really helps to attract new staff and hold on to those we have," says Physiologist David Robiony–Rogers, Service Leader for Respiratory Medicine at Wellington Hospital. "Best of all, patients from Wairarapa, Hutt, Wellington and Kapiti are offered appointments at the Pulmonary Function laboratory that best fits their need; for example to match with an outpatient appointment or to reduce the distance they need to travel."

Radiology

Sub-regional, regional and national collaboration has continued to be a key focus for the Radiology Department during the past 12 months. The 3DHB Radiology Project was launched to review how Radiology Services can be delivered within the sub-region to provide a better, sooner and more convenient service to patients.

THE VASCULAR SERVICE

The Vascular Service has been working with Hawke's Bay and Mid Central DHBs to provide increased clinical support for the region. We have been providing the acute vascular service for Hawke's Bay since March 2013. There have been ongoing meetings with Hawke's Bay and Mid Central to progress an enhanced central region service.

Allied Health's 3DHB Trailblazer

Variety comes with the territory for Allied Health, Technical & Scientific Educator Suzy Stubbs, who works across the three district health boards. She divides her time between Wellington and the Hutt Valley during the week, with monthly visits to the Wairarapa.

An early challenge has been getting to grips with parallel educational opportunities that have developed independent of each other, and working within technological limitations where the three DHBs are not yet integrated.

Her current focus is on professional education that can be applied both sub-regionally and across the professional groups that fall under Allied Health, Technical & Scientific. This includes NZQA Level 3 training for Allied Health Assistants and clinical supervisory training for Allied Health staff. It also includes a joint initiative with the Otago School of Medicine, Rehabilitation Research and Teaching Unit - the Allied Health, Technical & Scientific Seminar Series.

Past training for Allied Health Assistants was "very much on the job, learn as you go", as there was no recognised qualification or standard for this workforce. "We're one of the first DHBs in New Zealand to introduce training to our Dental Assistants and Therapy Assistants," says Suzy.

Working across different systems remains challenging but recent projects such as Hutt's switch to Outlook was evidence of progress, she says: "I'd like to extend my reach online, initially by hosting joint sub-regional video conferences for the Seminar Series. This lets clinicians efficiently access educational opportunities wherever they are and breaks down travel time and cost barriers."

Suzy said working sub-regionally has made her job 'richer' due to the many different people and perspectives she meets along the way. "So far I've found that staff have been really receptive to finding ways to work collaboratively with their neighbours. It helps that we are making deliberate efforts to ensure each DHB has appropriate representation on steering groups and project groups to ensure all perspectives are heard."

Suzy Stubbs.

Ear, Nose and Throat (ENT)

The ENT Steering Group has had a considerable sub-regional focus during the past financial year, exploring how it can better meet the demand and needs of patients. Its focus has been on:

- exploring the approach to design and establishment of a sub-regional ENT service;
- completion and approval of ENT Clinical Pathways and development of an implementation plan for sub-regional roll-out;
- initiation of a sub-regional Specialist Voice Clinic pilot with clinics being held regularly;
- developing recommendations for a sub-regional approach to managing community paediatric ear health, following a sub-regional workshop with key stakeholders;
- preparation of an ENT Workforce Sustainability Business Case for the Sub- Regional Clinical Leadership Group.

ACCESS TO SUPPORT FOR PEOPLE WITH AUTISM

Following a Ministry of Health review of access to funded disability support services for people with Autism Spectrum Disorder (ASD), people with ASD are now eligible for some funded services through Capital Support.

Those that meet eligibility criteria can access behaviour support, carer support and respite services through the Capital Support Needs Assessment Service Co-ordination (NASC) services. Other services may be accessed following an exception process through the Ministry of Health. To date, Capital Support has received 23 referrals.

Respiratory

Respiratory has been working as part of the Integrated Care Collaborative (ICC) on providing increased support to Primary Care.

Informal development of this process has been led by the clinical teams and work will be done in the future to formalise this approach as the integrated 3DHB model is progressed.

The team at the launch of The Healthy Skin Initiative.

Proposed regional training for clinical physiology has progressed to the agreement stage around funding and support from the Central Region Training Hub. Once agreed, this will be based at CCDHB and run by Health Workforce New Zealand.

Pain Management Services

This year saw the establishment of an outreach clinic for Wairarapa DHB by the clinical leader, similar to the clinics provided to Hawke's Bay DHB. This took place alongside the Ministry of Health's updated pain specifications, a process that is ongoing.

Healthy skin in Greater Wellington

In September 2012 more than 40 representatives from a range of health and social sector organisations came together to celebrate the launch of a 60-page healthy skin protocol that had been signed off by the three DHBs and five Primary Health Organisations. The protocol was produced as part of the Healthy Skin in Greater Wellington initiative.

This initiative shows how, by proactively working with the community and across the health and social sector, we can make a significant difference in preventing illness, rather than treating it when it's too late.

The initiative was originally established by Keeping Well, the population health strategy for the Greater Wellington region to reduce skin infection for children. It has further grown with the support of Regional Public Health, culminating in the development of the Healthy Skin in Greater Wellington Road Map.

Additional resources have been developed, including a Healthy Skin Tool to help children and parents identify infections. The benefit for patients is that consistent messages about skin health are being used by the health sector and the wider community across the region.

The next steps are continuing education sessions on skin infections for primary care providers across the region.

Dr Adrian Gilliland at the Healthy Skin launch.

Information and Communication Technology (ICT)

Sub-regionally the 3DHB's ICT service provided initial capability support for the implementation of Service, Integration and Development Unit (SIDU) and have further progressed with the implementation of a Microsoft 3DHB Outlook service. Other 3DHB ICT collaborative project work underway, or completed, includes the replacement of systems involving Laboratory, Pharmacy, Blood Glucose Meters and e-tree.

A collaborative approach to sharing staff resources was formalised in May 2013 with the development of a 3DHB ICT service. A senior management structure and 3DHB ICT Steering Group was implemented to drive the next changes due during 2013/14.

This has involved three major programmes of work: convergence planning, the development of a common operating environment, and an infrastructure programme.

Procurement

Procurement has been working hard to align with national and other collaborated initiatives, while still maintaining a local flavour for projects applicable at both the DHB and sub-regional level.

Procurement & Supply Chain Services will continue their current direction of developing a proactive and collaborative culture across the sub-region's three DHBs. Both the intended 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.

Procurement support around major projects such as the 2012/13 Laboratory Information System collaboration between CCDHB and HVDHB, and CRISP programmes managed through the Central TAS agency has been provided.

Wellington Regional Breast Screening Service goes digital

Women in the Greater Wellington region now have access to a completely refurbished fully digital breast screening mobile unit.

The refurbishment was part of a larger project to move the Wellington Regional Breast Screening Service / BreastScreen Central from analogue film-based mammography to digital mammography and technology. State-of-the-art digital equipment was installed at Kenepuru Hospital and in the mobile unit as part of the Hutt Valley DHB Breast Centre.

"This signals the further strengthening of collaboration across the three DHBs, particularly as the mobile unit provides the only mammography service to the Wairarapa," said CCHDB and Hutt Valley DHB Chair, Dr Virginia Hope.

The digital upgrade – which reaches across the Greater Wellington region to approximately 2,500 women a month – has made a big difference for health professionals.

"Not only have the images improved compared to the old X-ray film, but it is much more convenient with everything available electronically and immediately," said Dr James Wellwood, Clinical Director, BreastScreen Central. For Kenepuru Hospital the digital upgrade means it can potentially double the capacity of women it screens on site.

"The new digital equipment will ensure that we can continue to deliver a first class service to our communities", said Mammographer Jackie Rushton. "The equipment is user-friendly which makes high quality service delivery easier."

Left to right: Yvonne Clarke (Charge MRT/Mammographer) demonstrates the mobile unit's new digital mammography machine to Hutt Valley and Capital & Coast DHB Board member Peter Glensor, Hutt Valley Board member Katy Austin and Capital & Coast and Hutt Valley Board Chair Dr Virginia Hope.

Progress – The new Dialysis unit "rising up out of the paddocks".

Renal – Satellite Dialysis Unit

The unit under construction is a purpose-built 24 chair facility that will replace the current nine chair unit located in BNZ Tower. This will provide patients across the 3DHB's with a much-needed capacity boost for non-acute dialysis services. An on-site unit at Kenepuru Hospital will also provide more convenient access to treatment for dialysis patients who live in Kapiti, Porirua City and the Hutt Valley.

The sod turning ceremony followed a tour of Kenepuru facilities by Porirua City Council and Kapiti District Council members, with Mayors Nick Leggett and Jenny Rowan in attendance to help Board Chair Virginia Hope with the turning of the sod.

"Patients can now look forward to faster, more accessible treatment thanks to this unit, and we are looking forward to watching it take shape over the next year," she said.

Clinical leader of the renal service Dr Murray Leikis echoed her comments, saying the project was "a long-time coming."

"I just want to thank everybody who has been involved thus far; it is really exciting to see it finally get off the ground."

The unit is expected to be completed by February 2014 and will be fully earthquake-strengthened, enabling it to provide alternative access to treatment for patients on home dialysis, should their water or treatment options be affected.

Laboratory

Laboratory staff from both Hutt Valley and Capital & Coast laboratories have been working together to replace their respective Laboratory Information Systems (LIS) with a single system across the two DHBs. This is a major project that required considerable commitment and resource from both laboratories. Go live dates of November 2013 for CCDHB and March 2014 for HVDHB laboratories have been set and a huge amount of configuration has already been completed. The collegiality between the staff from the two laboratories working on this has been excellent.

Driven by the desire for regional and sub-regional cooperation and by the combined LIS project, the two hospital laboratories have also been working on a review process to combine the laboratories into a single Hospital Laboratory Service. A proposal was released for consultation earlier this year and feedback from the consultation process is currently being worked through to assist a final decision.

IT 3000 auto validation software was installed for auto validation and filing of Biochemistry Cobas test results that are within specified rules and ranges. This is a middleware that sits between the analytical systems and the LIS. The previous process required staff performing result filing to view, validate and file every result individually. The laboratory has now further expanded the functionality of this software and the vast majority of routine Biochemistry and Haematology tests are now automatically validated, authorised and released. Staff can now focus on abnormal results. This has vastly increased the turn-around times of tests, which has led to improved patient care and faster clinical decision making.

COMMUNITY HIGHLIGHTS

Integrated Care Collaborative (ICC)

The aim of the Integrated Care Collaborative (ICC) programme is to provide the best whole of system health care for our patients and population through improved experience, safety and quality of care with easy access and equity for all populations. The effect of the approach is to remove barriers between the hospital and community to create a single health service. The approach is open, consensus based and clinically led.

The programme is aligned with the Government's 'Better, Sooner, More Convenient Health Care' initiative to deliver more personalised primary health care services that are closer to home and improves the health of the population.

With new infrastructure, models of funding and innovative service delivery, we will be able to reduce the growing acute pressure on specialist services and hospitals. This will mean more proactive, informed care, resulting in well-managed long-term conditions, continuing independence for older people and proactively supporting Māori, Pacific and high needs populations.

A SHARED CARE RECORD

The Shared Care Record Business Case was completed and approved in 2012. Funding was secured from the Ministry of Health to support implementation. The Shared Care Record is intended to share a patient's relevant health information from their GP with other health professionals, including hospitals. This is done using a secure electronic system.

The type of information that will be initially available includes any long-term conditions or disabilities the person may have, recent tests or results from X-rays or CT scans and what medicines they are currently taking.

This means that if they suddenly go into hospital at night, for example, the hospital doctors can get a more complete view of that person's general practice records and easily see what medication they are taking and if there are any recent test results, making it much quicker and easier to treat them.

Key benefits will be that hospital clinicians will have primary care information when making decisions about patient care. Expected benefits include:

- reduced medicine error rates
- faster treatment resulting in shorter stays
- less re-ordering of radiology and lab tests.

Implementation is planned for early in the 2013/14 year. Coverage is expected to be at 84% of the population, including 40 of 60 practices and all four PHOs.

AUKATI KAIPAIPA – SMOKING CESSATION PROGRAMME:

Reaching Communities, Making a Difference - Evaluation Report February 2013

Regional Public Health (RPH) responded to a concern raised by Kokiri Marae Health and Social Services (Kokiri) that there had been no evaluation of the Aukati KaiPaipa programme (AKP) for over 10 years. RPH decided to complete independent evaluations with three Māori Health Service Providers in the Greater Wellington Region (Te Rūnanga o Raukawa, Whaiora Whānui Trust and Kokiri), with the aim of assessing the effectiveness of the AKP programme in helping whānau quit smoking.

The first evaluation report focussed on the Kokiri AKP programme based in Seaview, Wellington, which also provides the programme from satellite locations throughout the Wellington region.

Findings showed that clients from high deprivation areas in the Wellington region have access to an intensive programme with more than half of all

follow-ups being kanohi ki te kanohi (face-to-face). The evaluation found that there was a relationship between intensity of delivery and staying smoke-free for at least three months. Quit coaches play a vital role in a client's quit journey, with the holistic and flexible approach a strength of the programme. Clients identified this approach as positive for helping to quit smoking or cutting down on tobacco use.

Feedback from Kokiri Marae highlighted they valued the sensitivity shown by the RPH project team and the respectful process of working together to design and deliver the evaluation. Staff at Kokiri indicated the evaluation report provides their service with a tool to improve service delivery. This includes potential to improve access to smoking cessation services, as well as improve the effectiveness of these services for Māori and non-Māori.

ENDOCRINE/DIABETES

A large amount of work has been happening in the Integrated Care Collaborative (ICC) around the implementation and planning of the Diabetes Care Improvement Plan (DCIP) that is a combined Primary and Secondary Diabetes Clinical Network specialist service focused on complex, Type 1, paediatric, gestational and renal diabetes.

The CCDHB model's key components include:

- practice population management
- specialist service focused on complex, Type 1, paediatric, gestational and renal diabetes
- collaborative case service in priority practices
- combined Primary and Secondary Diabetes Clinical Network
- self Management Groups
- workforce development
- performance measures
- nurse practice partnership.

This work has provided specialist support to primary care, identification of specialist nursing support areas and identifying specific high need practices for focused work. A Diabetes Clinical Network made up of clinicians from across the continuum of care has overseen and provided guidance and support on the development of this plan.

The implementation of a Nurse Practice Partnership has been underway to support the initiative and develop seamless pathways for patient management within the community, while accessing specialist knowledge. This work will continue in the next financial year, ensuring patient management and workforce development is consistent across the continuum of care.

This positive work is tribute to the clinicians working in this area and is leading the way we work with our primary care partners. It offers sustainable and consistent care for our patients as close to home as possible.

The model will be implemented in two phases. The first phase will see all key components introduced apart from the 'Nurse Practice Partnership'. The model for the 'Nurse Practice Partnership' has been agreed, however, there are a number of options to consider before its implementation within CCDHB.

Dr Virginia Hope and Minister of Health Tony Ryall at the CCDHB Diabetes stand at Creekfest.

ICC PROGRAMME FRAMEWORK

In 2012/13, the Integrated Care Collaboration (ICC) developed and established a programme framework for undertaking projects and another for measuring benefit. The target for year one was set to curb growth in the number and cost of acute admissions. We achieved the target of reducing acute local bed days by 1,322 (expected 88,806; actual 87,484). This was 2,476 less than historical trends predicted (89,960) without ICC and related projects.

INTEGRATION SURVEY

The baseline survey of health care providers was conducted between 7 and 29 November 2012, to gauge key stakeholders views on the progress that CCDHB had made towards integrating health services. We received 277 complete responses. Of these, 55% were from secondary care, 43% from primary care and 3% from community care. Many respondents provided examples of good and bad practice and gave their views on areas for improvement. The results included:

- Primary care participants in the survey were confident in their knowledge of other health services for their patients, with 66% responding 'sufficiently well informed' or better.
- A majority of primary and secondary care clinical respondents, 50% and 52% respectively, felt they usually or almost always receive all relevant information for patient care at referral.
- A large number of participants from both primary care (41%) and secondary care (55%) reported spending 10% or more of their time on tasks which could be undertaken by someone with less skill or experience.
- A large number of participants from both primary care (48%) and secondary care (42%) reported established guidelines and pathways were easily available for their service.
- In both primary and secondary care 41% of respondents find clinical pathways easy to follow.
- Both primary and secondary care respondents feel there is overlap between services at present.
- The identified barriers to care were similar across primary and secondary care with top responses being financial constraints/cost, timing, location, and cultural.

This information was used by the ICC team to assist in the planning of the ongoing ICC work programme and to target areas that will deliver the most gain for the health system.

WORKPLACE WELLNESS

In February 2013 Regional Public Health launched a new resource to promote health and wellness in the workplace. This practical resource provides a step-by-step guide, tools and examples of how to implement a health and wellness programme in the workplace. The workplace is then able to implement a well designed, comprehensive and effective programme that supports employees to lead a healthy lifestyle.

Alcohol

LICENCE RENEWAL

Regional Public Health (RPH) and CCDHB objected to the liquor licence renewal for Retro Bar in Kapiti following issues with the licensed premises. A brief of evidence was provided at the Liquor Licensing Authority Hearing. The Liquor Licensing Authority cancelled the liquor licence renewal and suspended the duty manager's certificate for six months.

RPH and CCDHB provided support to three communities who objected to liquor licence applications in the CCDHB region.

These included:

- Nischays Liquor Centre, Fantame Street: community objections to the application were referred to the Alcohol Regulatory Licensing Authority for the hearing.
- The Liquor House, Newlands: community objections were received. The application was referred to Alcohol Regulatory Licensing Authority and the license was granted.

Immunisation Facilitator Helen Hartley from Community Infection Control at CCDHB at the family day at Rintoul flats in Newtown.

- Newtown Liquor Stop, 5 Newtown Avenue: community objections resulted in the subsequent withdrawal of the application.

ALCOHOL POLICY

Data from the Wellington Hospital Emergency Department is being used as public health evidence to support alcohol policy change. This data is useful in the development of local alcohol policies as it provides a direct link between injuries and alcohol use. Wellington is in a unique position as there is up to three years of data to evaluate and gauge the impact of alcohol on injury presentations to the Emergency Department.

Pinikilicious Breastscreening Mammogram Drive

The Pinikilicious campaign was launched in February 2013. It celebrated the importance of health and wellbeing for Pasifika women and girls in the Porirua Pacific Churches collective. It was run in association with the Mafutaga Ekalesia So'ofa'atasi (Women's spiritual group) Porirua (MESP) in Cannons Creek and Waitangirua, Porirua.

The Pinikilicious campaign is a spin off from the Vahine Orama 'Get Checked You're Worth It' Programme, Pacifica women presented to the Capital & Coast District Health Board in November 2012. The Mafutaga group worked with the Regional Screening Services to enlist 25 Pacific women to undergo mammograms on the launch day. There were also health stalls and events taking place throughout the day, which a number of CCDHB Board members attended.

Refugee Health

Due to the increase in quota refugees and the complexity of cases, Regional Public Health reviewed it's health screening and referral of quota refugees to meet the increased demand and deliver the contract in a more effective and efficient way.

RPH facilitated a planning workshop with key stakeholders (Red Cross Refugee Services, Primary Care Nurses, School Health Nurses, Adolescent Health Services, School Dental Services, Plunket and Change Makers) and also visited Auckland Regional Public Health Service to observe their delivery model.

From these activities a service delivery model similar to Auckland Regional Public Health Service was identified, which involved a more streamlined refugee home visit with other relevant agencies involved in the care of the refugee family.

This approach enabled public health nurses to link the family with other agencies and clarify the roles and responsibilities of all agencies involved. Overall there has been a reduction in work duplication among health and social agencies involved in resettling refugee families. RPH trialled this working model in the first six months of 2013 and found it to be more sustainable and provide better outcomes for resettled refugee families.

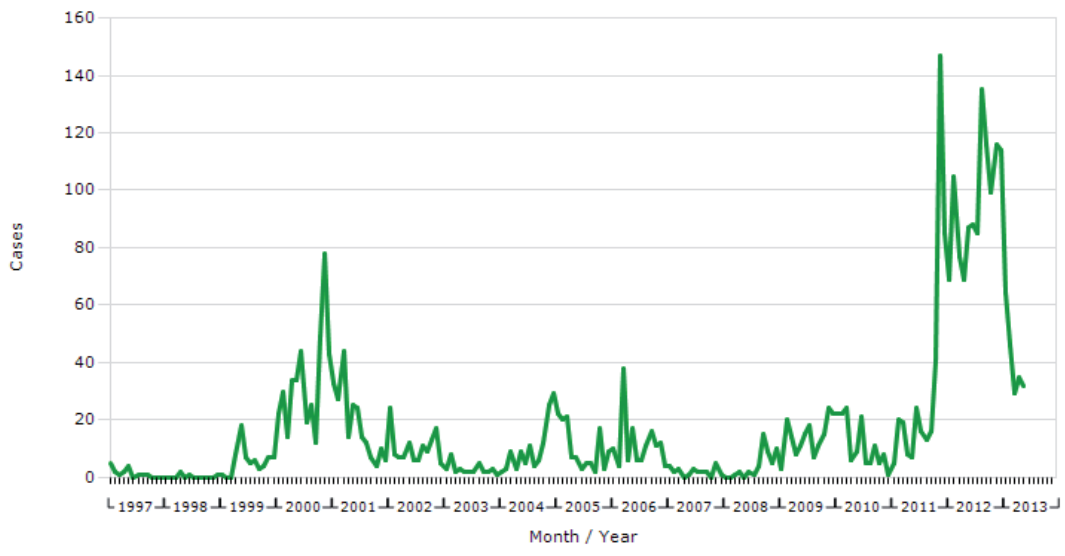
Pertussis outbreak strategies

As at June 2013 Pertussis notifications for the sub-region have significantly decreased to a monthly average of 32 notified cases, however, this remains above pre outbreak case numbers. The sub-region's pertussis outbreak started in October 2011, peaking in November 2011 with 147 notified cases per month. As a result of this high number of notifications RPH introduced a number of strategies including moving from a 'prevention and control' phase to a 'management' phase, with a focus on those at high risk of severe disease and transmission to vulnerable groups.

RPH proactively worked with all health care providers in the sub-region to reduce the spread and severity of the outbreak. CCDHB took the proactive step to offer funded Boosterix vaccination to all pregnant women prior to the national decision to fund the vaccine for all pregnant women.

The graph below shows the spike in Pertussis cases in November 2011.

Pertussis Cases by Month since January 1997 for the Greater Wellington Region



Regional Public Health nurse Annie Highet working with a family in Porirua.

Child Health

A wide range of initiatives were undertaken in 2012/13 to improve child health outcomes within our region as part of the CCDHB Child Health Action Plan. These included:

- an independent review of CCDHB child protection systems;
- exceeding the target for all population groups for the new eight month Immunisation Health Target;
- a shared focus with inter-sectoral partner agencies on improving health outcomes for children across the region;
- continued implementation of the Oral Health Service Change Programme to improve oral health services in our region, especially access for Māori and Pacific children;
- the Free Under-6s policy implemented across CCDHB's region;
- demonstration sites within four practices have been established with the aim of improving the transition for all high needs children with disabilities.

RHEUMATIC FEVER PREVENTION

In Porirua East, there is a high rate of rheumatic fever. The implementation of the government-funded Rheumatic Fever Prevention Programme has led to more than 4,000 throat swabs being performed, with more than 370 of them testing positive for Group A Streptococcus infection, which can cause rheumatic fever.

There are 12 schools in East Porirua taking part in the programme. Community Nurse Chris Campbell said: "If a throat swab result is positive for Group A Strep, a community nurse can take antibiotics to the child's home, or the family can go to the GP. Antibiotics are important in halting the infection and preventing it from developing into rheumatic fever and potentially rheumatic heart disease.

"The increased connection that community nurses are having with children and their parents through the throat swabbing programme means that we are also able to offer more support with other health concerns. It's providing some great opportunities to improve the health of these children."

Judith Wootton, Principal at Porirua East's Windley School, has seen the impact of the disease on several of her students. "It is often quite considerable and it's distressing to know that it can be prevented if people know that sore throats need medical attention.

"The teachers really push the message about the need for throat swabs and are quite explicit with older students about how seriously rheumatic fever can damage your health," Judith says.

The throat-swabbing programme in Porirua is part of the Porirua Kids Project, a joint initiative between primary care providers, Primary Health Organisations, Regional Public Health, and CCDHB. The main aims of the project are to reduce the high rates of rheumatic fever and serious skin infections in children in Porirua East.

2012 Rheumatic fever throat swabs for the school year is as follows:

School Roll	Total	GAS+	GAS+%	GAS negative
2,030	3,123	264	8.45%	2,859

** GAS = Group A Streptococcus*

Dr Fiona Perelini helps launch the the Healthy Heart Check in October 2012

YEAR 8 GIRLS GARDASIL PROGRAMME

In the 2012 school year, the HPV targets for Māori and Pacific students in CCDHB region were achieved across all three doses. This vaccination programme is delivered to all Year 8 girls to protect them from developing cervical cancer later in life. Māori and Pacific women are significantly affected by cervical cancer.

CCDHB HPV data from 1 Jan 2012 - 31 Dec 2012:

CCDHB	Eligible roll total to date	Māori	Pacific
Cohort –	1783	264	163
Dose 1 (70%) vaccinated to date	66%	74%	83%
Dose 2 (65%)	63%	71%	83%
Dose 3 (60%)	60%	67%	72%
Total Consented from Cohort to date	1191	201	140
Consent Return to date	1747	259	157
Decline	537	60	19
Non-return	16	5	6

KICK START YOUR HEALTH TEAM

The Regional Public Health Promoting Schools team held a successful 'Kick Start Your Health Team' workshop at Johnsonville Community Centre. Twenty teachers and 60 students from Decile 1-4 schools attended (10 schools from Capital & Coast District, 7 from the Hutt Valley and 3 from the Wairarapa).

A wide variety of activities were provided to help increase the students' knowledge of the Health Promoting Schools framework, as well as enhancing core leadership skills such as: team work, communication, active listening and role modelling.

From food making to project planning, the workshop had a number of ways to challenge these young leaders.

Comments about the day included:

- "Great to have hands-on activities that can be used in class/at school"
- "OMG – some muesli bars are soooo high in sugar – will read labels more closely now"
- "Some teachers shared some amazing ideas we could use at our school"

Students enjoying delicious corn fritters they had just made.

Student learning the importance of reading food labels.

PORIRUA EAR VAN SERVICE

Regional Public Health has implemented a 'text to remind' service for the Porirua Ear Van, leading to a reduction of Did Not Attends (DNAs) and the resources of the van and staff being well utilised.

The ear van continues to see a large number of children aged 0 – 18 with poor ear health ranging from complex to simple conditions. The ear van service is very well received in the community and gets referrals from B4 School programme, schools, public health nurses and GPs.

Total number of children (new referrals) seen by age:

	0-4yrs	5-9yrs	10+ yrs	Not recorded	Total
Totals	395	343	172	11	921

Total number of children (new referrals) seen by ethnicity:

	Māori	Pacific	Euro	Asian	Other	Total
Totals	268	299	236	72	46	921

GATEWAY SERVICE

The Gateway Assessment process is a collaboration between Child, Youth & Family (CYF) and health and education services. The inter-agency model provides a unique opportunity for each child or young person as the outcome is more likely to provide a brighter future. On average, each referral has at least four significant needs that require attention.

CCDHB delivers 138 assessments each year. Of those assessments 20% of children are below their peers in maths and reading. Schools have reported that

the gateway assessments have made a difference to them being able to understand the "full picture" of the child and apply the support required for the child's education.

Fifty percent of gateway children displayed significant emotional and behavioural concerns affecting their education, relationships with others and their placements with care-givers. Of these children 25% needed primary mental health input to address the trauma and impacts in their lives, and ultimately enable them to have quality relationships and a brighter future.

Twenty percent of children have benefitted from referrals made to Dental, Ear, Nose and Throat and Audiology services with some having surgery after concerns were discovered during the assessment. Improved communications with GPs and primary services has also ensured a wrap-around approach within the community.

CHILD DISABILITY AND BECOMING AN ADULT

Transition to adulthood is a particularly stressful time for children with disabilities and their families. Traditionally children are discharged from child services at 16 years old and adult services are hard to access and understand.

In July 2012, as part of the Child Disability Plan, a sub group from the Integrated Care Collaborative (ICC) set up a Demonstration Site led by Newlands Medical Centre in conjunction with Ngaio and Johnsonville Medical Centres. It offered 23 children the opportunity to participate in the phase one pilot. Together they developed a child and family centred approach that ensures the General Practice acts as a bridge to adult health services.

Work is being undertaken to ensure Primary Care staff learn from the families involved, as well as have input from specialist child health teams. Work on a regional directory to directly address the need for more co-ordinated information about available services and resources is underway and expected to be completed in 2014.

FREE UNDER SIXES

In July 2012 CCDHB implemented a project to provide free general practice care for children under six at their usual General Practice during the day and at three providers after hours and overnight.

The aim of the service was to improve access to primary care services, remove cost as a barrier to accessing general practice, while also reducing presentations to the Wellington Emergency Department. To date the DHB has seen increasing use of the service and while ED presentations have continued at high levels, admission rates for those under six have reduced.

The net economic benefits accrued in the 12 months to date from reduced admissions are estimated to be approximately $1 million.

OPPORTUNISTIC IMMUNISATION – B4 SCHOOL CHECKS

Collaboration across services has enabled the Waitangirua Health Centre to become a “one-stop shop” for parents with young children.

Since 2008 the nationwide B4 School Check programme has run to identify and address any health, behavioural, social, or development concerns which could affect a child’s ability to get the most out of their schooling.

When Compass Health immunisation outreach nurse Sandra Hitchen heard that the B4 School check team was setting up a clinic in Waitangirua, she wondered if they were looking for the same people.

Now when parents bring their kids in for B4 School checks they can also receive their immunisation for four-year olds, which covers measles, mumps, rubella, diphtheria, tetanus, whooping cough, and polio.

“It’s also an opportunity for me to ask parents about immunisations, and answer any questions they might have about vaccination, if they’ve read something online or in the papers.”

Plunket nurse Kylie Woodcock does a B4 School Check at Waitangirua Health Centre.

Sometimes they'll find a child has missed shots they were supposed to have earlier, or the parents may have a younger child with them who also requires vaccination.

Delaying vaccination can be for any number of reasons, she says, but cost is a factor, particularly in high-needs communities such as Waitangirua.

"They might be holding off because they have an unpaid bill at the clinic, but the Plunket service is free."

Plunket nurse Kylie Woodcock says the clinics are held once a fortnight at Waitangirua, "but we run clinics every day from Strathmore to Waikanae."

"It's a final check up for these kids before they start school - we check their behaviour, motor skills, vision, hearing, and more. Teeth are a big issue for us, so we can refer kids on to the right service for further help if necessary."

Opportunistic immunisation "brings the service to where the people are, but the results are all down to the co-operation of the Plunket nurses," Sandra says.

"It's increasing ease of access by getting different services together. We work better together the more we do it."

Plunket Area Manager Tina Syme, Director of Nursing, Primary Health Care and Integrated Care Vicky Noble, with four year old Libby Duncan, who had recently completed her Before School Check, with her mum, Rebecca Duncan and B4 School Check Co-ordinator Chris Rice. (Left to right)

Community Health Services

Community Health Services (CHS) continue to work with community and inpatient areas to support the safe discharge of patients and prevention of admissions to care facilities. Support has been provided to aged residential care facilities to prevent admissions through telephone consultations and home visits.

Work has increased within the acute care space with the community clinical nurse specialist working directly with internal medicine and infectious diseases to support home intravenous antibiotics, particularly in relation to Cellulitis.

The community clinical curse specialist (Wound) has also continued her work ensuring wound care management is supported in primary care, as well as in the community. The Silhouette System of 3D wound imaging has been in development for most of the year with CHS working in partnership with ARANZ Medical to develop this. The system will be implemented fully in early 2014 with the ability to measure wounds to inform clinical management, as well as be used to do research around wound care management.

Bringing wounds to life

A new digital wound imaging system developed by a Kiwi company that worked on the Lord of the Rings movies is set to take the guesswork out of wound management for Capital & Coast staff.

Wound care Community Nurse Specialist Natalie Scott said CCDHB is the first DHB in the country to introduce the Silhouette advanced wound assessment and management System. Developed by ARANZ Medical, the Silhouette system is comprised of portable 3D laser cameras that capture dimensions of length, area, depth, height and volume at the point of care.

That information is then logged on a secure database, which automatically generates a report to assist district nurses in the accurate and reliable measurement of surgical wounds, pressure sores and leg and foot ulcers.

“If healing rates are not optimal as per Silhouette assessment, we will refer patients to specialists in a timely manner to minimise the risk of chronicity,” says Natalie.

Currently nurses rely on manual measuring, using a plastic film placed over the top of a wound.

This method is not always accurate and can be uncomfortable for patients. The use of conventional photography can be deceptive if subsequent photos are not taken from the same angle.

District nurse Sara Best says studies show that wound care accounts for about 50% - 60% of district nursing workloads. For some patients, particularly those with diabetic foot ulcers and venous leg ulcers, the ability to objectively track their healing progress over time is an essential component of their management, Sara says.

“Being able to see the progression with a wound is quite a motivator for patients to adhere with health education advice such as elevation, exercise, or trying to get their blood sugar under control.”

A previous trial of the Silhouette System at a specialist wound care clinic in a Porirua PHO saw an outcome of 68% of patients healed at 12 weeks, against an international benchmark of 55%.

The system will be invaluable for collecting data on existing gaps in knowledge, such as leg ulcers rates for Māori and Pacific Island patients.

Smoking Cessation advisor Tama Tua and a Quit Coach speak with a patient who no longer smokes.

PRIMARY HEALTH READY FOR DISASTERS

Events such as the H1N1 pandemic in 2009 and the Canterbury earthquakes in 2010/11 illustrated the vital role general practices have in disasters. In both those incidents more patients were treated in the community than at hospital.

CCDHB Emergency Management Service, in consultation with General Practices in the region, organised for 28 practices across the district to have mass casualty kits and emergency radios. Compass Health has also been working with PHOs to develop plans and procedures for the co-ordination of the primary health disaster response.

An exercise this year provided the opportunity to test the Primary Health Emergency Operations Centre.

As part of CCDHB's disaster response co-ordination, mass casualty kits were given to 28 General Practices in the region.

STUBBING IT OUT

With the Government's target of Smokefree Aotearoa 2025 just a little over a decade away, CCDHB is redoubling on its efforts to stamp out smoking across the district.

Smoking Cessation advisor Tama Tua, who patrols Wellington Hospital's wards on a daily basis says patients have gone from saying "I don't want to know about it", to the point where they accept they're going to be asked about their habit.

"I'm proud to say over the last three years that we've achieved our target – staff have taken it on board, from the management level to our nurse champions. Patients know about it, and now accept they're going to be asked about their smoking as part of standard practice."

Along with Ora Toa ABC facilitator (Ask, Brief Advice, Cessation support) Judy Hutton, Tama provides Smokefree and Nicotine Replacement Therapy (NRT) competency training to nurses on the wards.

Once they've finished the face-to-face tutorial, nurses complete an e-learning module that enables them to administer Nicotine Replacement Therapy (NRT) patches, lozenges and gum to patients to help their withdrawal symptoms.

Judy also provides Quit Card Provider training to nurses, so they can offer them to patients for them to access subsidised NRT. Judy has assisted the Emergency Department in training their own staff, so that there is a Quit Card Provider available during each shift.

The Minister of Health, Tony Ryall gets his blood pressure checked at Creekfest.

Tama is accompanied twice weekly on his ward rounds by a Quit Coach from either the Pacific Smoking Cessation team or Aukati Kaipaipa.

Both groups are active in providing face-to-face smoking cessation support in their local communities, and health promotion at local events. Ward rounds are an opportunity to provide seamless cessation support from hospital to home with no delay in support.

Judy says hospital admission often provides a smoker with the opportunity to think about quitting, so it's an ideal time for health professionals to offer advice and support to quit smoking.

Having achieved the 95% target for support for smokers to quit in hospitals, CCDHB's focus has now shifted to ensure 90% of smoking patients seen by a health practitioner in primary care are offered brief advice and support to quit smoking.

Creekfest 2013

Capital & Coast staff from different directorates returned to Creekfest to celebrate its 10th anniversary in 2013.

The annual smokefree event, which is also alcohol and soft drink free, was well attended by festival-goers, who enjoyed live music from local bands, and took part in Zumba-style dancing directed from the main stage.

Health providers and organisations set up information stalls to provide education and advice, including Regional Public Health, CCDHB's Community Alcohol and Drug Service, the Child Adolescent Mental Health Service, and our Diabetes nurses who focussed on raising awareness of Type 2 Diabetes prevention.

There had been a 14% rise in the number of Wellington dialysis patients in the past two years, compared with the national increase of 7%, and Type 2 is believed to play a role in this variance.

Unlike Type 1, which has a genetic origin, the risk of developing Type 2 can be reduced by healthy lifestyle choices from exercise to eating well.

Diabetes research nurse Pip Cresswell said their display was designed to raise awareness of the empty calories being consumed in sugary drinks, such as juice or energy drinks, and was really well-received.

"A lot of people were quite shocked to learn they had a high risk of developing Type 2 diabetes, but I think everyone needs a wake-up call like that to really make a change," she says.

"People were amazed at how much sugar was in drinks and this proved to be a very successful way of getting our message across."

Festival-goers also received free tests to measure their Diabetes risk level, she said.

The Diabetes nurses also took their stall to the Newtown Festival.

Both stands were supported by staff from the Results Room gym, who were on hand to provide exercise tips to help members of the public to achieve a healthy and active lifestyle.

HOSPITAL HIGHLIGHTS

Elective Services

Capital & Coast has continued to improve access to Elective Services. The total number of First Specialist Appointments (FSA) planned for 2012/13 was 25,105 but we managed to increase that by delivering 29,715 appointments.

In June 2012, 178 patients were waiting more than five months for an FSA. As of May 2013 we had reduced this so that no patient was waiting longer than five months and so became one of the first DHBs to achieve this.

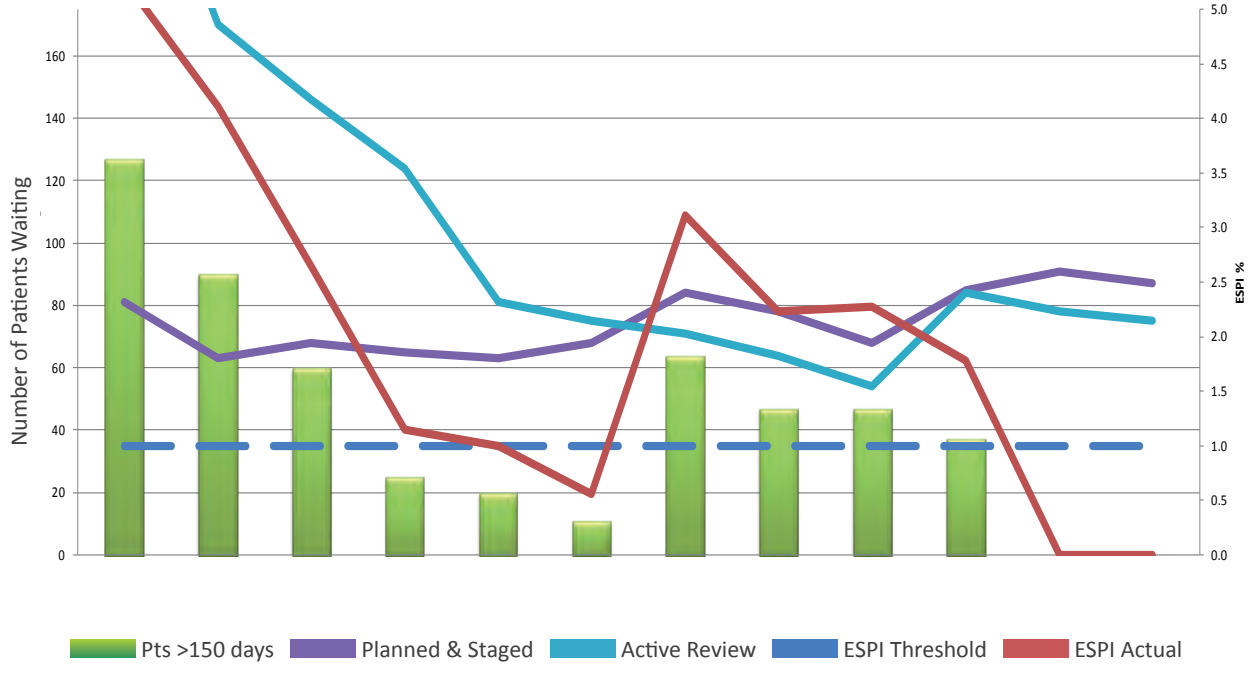
The team also delivered an additional 494 discharges in 2012/13, which again exceeded our elective surgery discharge target.

In addition to providing more elective surgery than ever before, we reduced the time patients have to wait for their surgery. As of June 2013 we had no patients waiting more than 150 days for treatment. We have also continued to reduce the number of patients assigned an Active Review status. Historically this category was often confusing for patients, raising expectations for surgery that could not be met. In July 2012, 251 patients were managed in the Active Review category. As of June 2013 this figure had been significantly reduced so that there were 60 patients in this category.

> *"I would like to express what wonderful attention and service I received yesterday. The reception staff, doctors and nurses I met were all cheerful and helpful. The nurses in post-op were really attentive and helpful. You have a great service."*
>
> PATIENT AT KENEPURU

We envisage further improvements during the coming year and we are committed to further improving access to both assessment and treatment.

ESPI 5 Compliance and Patients Waiting Greater than 150 days using a 1% Threshold



Surgical Services

CARDIOTHORACIC

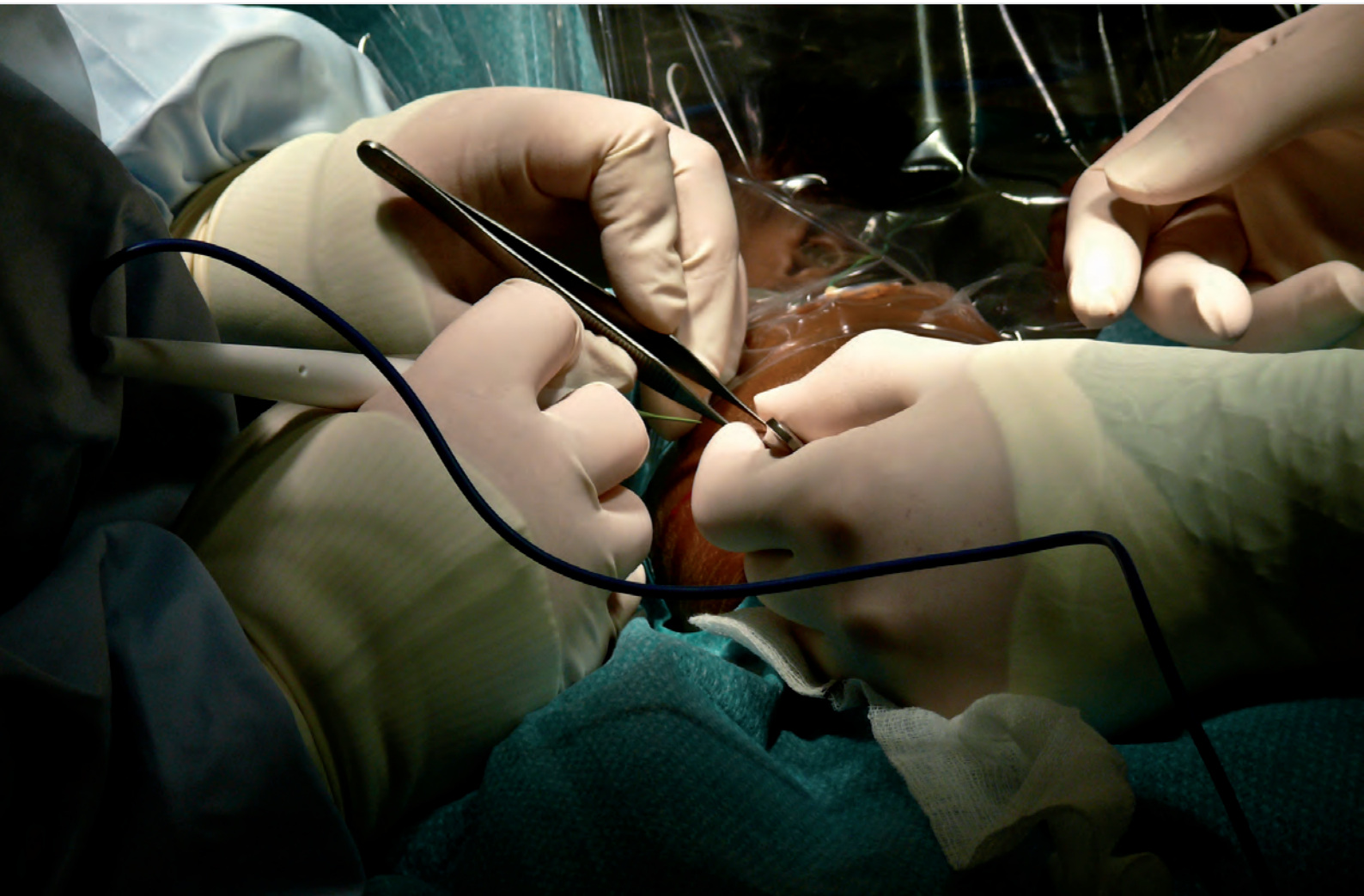
This year has seen the Cardiothoracic waiting list go from 62 at the beginning of July 2012, to 22 at the end of June 2013, an achievement we are proud of but will look to further improve.

Cardiothoracic now has all relevant information for patients and GPs on the internet site Health Point. During the coming year we are working with the Ministry of Health as part of the five centres that offer cardiac surgery to implement a national register of patients. This will enable National Quality Assurance Audits to take place.

VASCULAR DEPARTMENT

A fourth Vascular Surgeon started in November 2012. This has allowed the service to increase the number of elective patients operated on and allowed us to introduce a weekly acute afternoon and evening theatre list. This list was implemented to provide operating time for patients that did not need surgery within 48 hours but did within a week. Prior to this, these patients disrupted already booked elective patients on a regular basis.

The service is currently evaluating Endovenous Laser Treatment for Varicose Veins. This procedure is done as a day case and can be done in a procedure room so does not use premium theatre space. This would enable us to treat a group of patients who suffer significant discomfort but previously did not meet the treatment threshold.



General Surgical

CREATING A SAPU TO REMOVE BARRIERS FOR PATIENTS

During the past 18 months the General Surgical Department looked at ways to improve the surgical services pathway for acute general surgical patients. The senior doctors requested we trial an acute on duty roster instead of on call Senior Medical Officer (SMO) roster Monday to Friday 0800 to 1800. The SMO on duty would have no other public or private commitments during this time.

In June 2012 a business case was approved that proposed a strategy for streamlining the acute assessment of general surgical patients. Following further development of this strategy approval was granted to:

- create a new unit, the Surgical Assessment and Planning Unit (SAPU), with the expectation that it would be up and running in the 2013/14 financial year
- investigate the possibility of moving the General Surgical SMO from on call to on duty for acutes, Monday to Friday 0730 to 1800
- create an acute team with an on duty SMO attached acute Registrar and House Surgeon Monday to Friday 0730 to 1800
- to increase the number of surgeons to support the meeting of the standardised intervention rate for general surgery.

The SAPU will open on 2 September 2013. This ties in with the start of the SMO on duty Monday to Friday 0730 – 1800 six month trial, and coincides with changes to the registrar run descriptions to support this new model.

SAPU will have 10 dedicated short stay beds and two assessment beds. All surgical specialties will use the inpatient beds. The two assessment beds are for the use of general surgery.

The steering and working groups have had representatives from ED, surgical management and specialist clinicians, allied health, and administration staff working on developing patient pathways for general surgical patients designed to remove barriers to flow.

The pathways include:

- 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, 1230 – 1630

Patient flow and patient satisfaction will be improved by having SMOs on site on duty, which will lead to quicker diagnosis and treatment decisions. The designated radiology and clinical pathways will support the improved patient flow. Having an SMO on site will also increase RMO training and support.

After Canterbury DHB implemented this new model, they saw a reduction of 2,579 bed days in their first year. They also had a reduction of Length Of Stay (LOS) from 2.54 to 2.04 days for surgical inpatients.

The General Surgical Team is now confident it can improve the surgical patients' journey, as well as enhancing our patients experience and satisfaction, reduced waiting times and length of stay. The new model will be monitored and reported against a number of factors.

ENHANCED RECOVERY AFTER SURGERY (ERAS)

In April 2012, CCDHB was given the opportunity to begin its own Enhanced Recovery after Surgery (ERAS) initiative for colorectal surgery. Implementation of the colorectal enhanced recovery pathway began in September 2012.

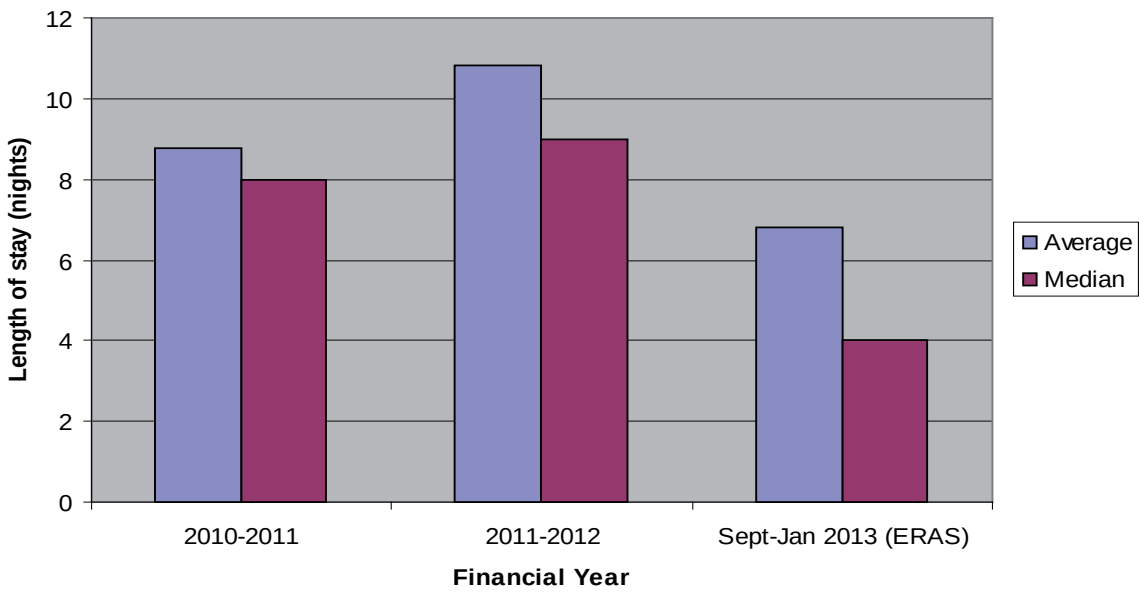
ERAS requires a team approach and is fast becoming an integral part of colorectal surgery and has already been adopted by other surgical specialities. Other surgeons and hospitals within New Zealand and internationally, have been tailoring ERAS protocols to the requirements of their specialties, showing similar results of improved patient outcomes.

Current evidence for enhanced recovery programmes in colorectal and other surgical specialties has been shown to be safe and effective.

It can now be expected that patients will recover faster, with reduced postoperative complications and reduced hospital costs. Benefitting both the patient and the hospital.

Decreasing the time a patient spends in hospital is a key benefit of enhanced recovery. The following graph shows the beginning of a downward trend in length of stay for elective colorectal surgery from the first 37 patients along this pathway, along with increasing day of surgery admissions. However, improvements to the length of stay for some procedures do not yet match the anticipated target of a reduction by two nights, as supported in a meta-analysis of randomised trials of ERAS and conventional care.

Length of stay for DRG G01 - Rectal and Pelvic Resections



A positive trend can be seen in reducing the length of stay for patients having elective rectal or pelvic bowel resections. There has been a dramatic reduction in both the average and median length of stay to 6.9 nights and 4 nights respectively. Our median LOS target was 5-7 nights for this population group.

SAVINGS FROM AVERAGE LENGTH OF STAY

Table One: Average cost per patient of elective admission for Rectal Pelvic Resections that meet ERAS criteria.

	Total number of patients	Average LOS (nights)	Average ward cost per patient
Financial Year 2010/2011	42	8.7	$4506.60
Financial Year 2011/2012	51	10.8	$5594.40
ERAS Sept 2012-Jan 2013	18	6.82	$3532.76

Table Two: Average cost per patient of elective admission for Small and Large Bowel Resections that meet ERAS criteria.

	Total number of patients	Average LOS (nights)	Average ward cost per patient
Financial Year 2010/2011	53	9.2	$4506.60
Financial Year 2011/2012	46	8.9	$4610.20
ERAS Sept 2012-Jan 2013	12	6.2	$3211.60

The next area that we are looking to introduce ERAS protocols to is pancreaticoduodenectomy surgery after the consensus guidelines published by the ERAS Society were updated in 2012 to include this protocol.

"Everyone was lovely and helpful. I liked the double check system and thoroughness."

SURGICAL PRE-ASSESSMENT PATIENT

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. On average SSI prolongs a patient stay by 7.4 days, at a cost of $1000 a day, according to the Health Quality and Safety Commission.

Local reporting of SSI is a key priority for our Infection Prevention & Control service, which has been collecting data, and providing analysis and feedback to clinical staff.

As part of this reporting, Clinical Nurse Specialist James Robertson says the service observed that there was no way to compare SSI rates across DHBs. The Health Quality & Safety Commission is currently engaged in a project to address this gap by standardising the way data is collected across all DHBs.

The goal is to provide DHBs with a robust reporting system for infection rates, to enabling performance comparisons, and greater access to feedback and reporting, to improve patient care and reduce infection rates.

James says CCDHB was pleased to be chosen as one of the eight development sites in the project's pre-launch phase, and views the intent to publish SSI rates as "a welcome step toward allowing comparisons to be made, and ultimately, improved patient outcomes."

Data collection commenced in mid-March with draft reports expected in late 2013, followed by a national rollout of the project, and further expansion of the types of operative procedures included.

OPHTHALMOLOGY

During the past 12 months the service has been focusing on reducing the numbers of patients in Active Review, meeting Ministry health targets, achieving and maintaining ESPI compliance and the 3DHB model.

ORTHOPAEDICS

The Orthopaedic Service Redesign Project, funded by the Ministry of Health Elective Services Productivity and Workforce Programme, commenced in June 2012 and is scheduled to be completed by December 2013. As part of this project the service has developed a new orthopaedic referral pathway, designed to ensure that patients with conditions likely to respond to non-surgical care receive this in the community prior to referral for specialist care. Trial of the new orthopaedic pathway began on 13 June 2013. These pathways have been developed in collaboration with primary care.

A new orthopaedic surgical prioritisation tool has also been developed to enable more consistent prioritisation of patients for the surgical waiting list. The Ministry of Health provided provisional recognition of this tool as a local Orthopaedic Scoring Tool in April 2013. Trialling of the tool began in May 2013.

Opportunities to reduce the number of hospital initiated orthopaedic clinic appointment reschedules have also been investigated, to ensure that patients receive surgery within 120 days of being placed on the waiting list.

A new inpatient hip and knee replacement clinical pathway designed to ensure patient fitness and commitment to treatment has been developed to reduce the variation in inpatient length of stay,

Citric spray helps stroke patients

Citric acid delivered in mist-form promises to make hospital stay easier for stroke patients who find the liquid difficult to swallow. Speech-Language Therapy Team Leader Molly Kallesen says research at the University of Canterbury has promoted the benefits of using nebulised citric acid as an objective means of identifying stroke patients' ability to cough. Patients without a cough reflex are at higher risk of choking on food and drink, and contracting pneumonia, which can significantly increase their length of stay in hospital.

Speech-Language Therapist Naomi Seow demonstrates use of the nebuliser to perform the cough-reflex test on Clinical Nurse Specialist Lai-Kin Wong.

Speech-Language Therapists Naomi Seow and Libby French have since trained 25 nurses from Ward 7 South to perform the cough reflex test. The multi-disciplinary approach means that since March 2013, all stroke patients are now automatically screened upon admission to hospital, to determine whether they require referral to Speech-Language Therapy. Bedside monitoring of patients as they ate or drank was more effective if nurses could be sure of their patient's ability to cough or swallow, Libby says.

Following the introduction of cough reflex testing, Capital & Coast has taken part in further research with the University of Canterbury, looking into use of the test with ICU patients.

and reduce acute readmissions. Development of the tools and templates required to implement the pathway are nearing completion, and trialling is expected to start in September 2013.

The orthopaedic service has considerably reduced patient waiting times for specialist assessment and treatment. All patients are now assessed within five months of referral and receive their surgery within five months of the decision to place them on the surgical booking list. The service is making good progress towards providing patient assessment and treatment within four months.

Anaesthesia

The Department of Anaesthesia and Pain Management is in good heart, fully staffed, and providing a high level of service to the patients presented. We remain committed to providing a high standard of care and introducing new ways of improving that care.

The department was sad to see the resignation of Malcolm Futter, who was Clinical Director for the past five years. Malcolm's leadership abilities had resulted in a significant amount of progress. This culminated in the department being inspected last September, as part of a Central Regional Training Scheme Inspection, and subsequently receiving ANZCA Accreditation of Training in Anaesthesia without restriction until 2019.

As a result of Malcolm's resignation there were a number of associated changes with Derek Snelling appointed to the role of Clinical Director, Sally Ure appointed as Deputy Clinical Director, Kirsten Cunningham and Nicola Moore appointed to the roles of Supervisor of Training and Andrew Usher taking over Clinical Leader for Paediatrics.

Training continues to be a strong point with results in the final exam for FANZCA remaining at 100% success. We are grateful for the commitment to teaching from the whole department with strong leadership from Chris Thorn (Primary Course) and Douglas Mein (Finals Course). The Finals Course run by the department continues to attract international recognition, being significantly over subscribed on each occasion that it is run.

Anaesthesia continues to participate in reviewing the financial implications of what pharmaceuticals and equipment we use, with many improvements in this area impacting favourably.

Additional time has been provided to Adjunct Professor Sandy Garden to develop a greater research base within the department and we have recently signed up to our first multicentre trial. A research fund is also being set up to manage the funds generated by this endeavour.

Pre-assessment of patients continues to provide challenges, but electronic tools available to us now allow a much better understanding of the implications that our patient's co-morbidities will present. Tools include the ability to email concerns to GPs, electronic results sign off, and increasing access to Manage My Health as a resource for understanding patient medications or alerts.

The Anaesthesia Technician Team has also had a successful year, and included a change in leadership with the appointment of Jim Hesketh as Team Leader. This has produced significant gains as the team are now fully staffed and much less reliant on casual and overtime to cover shortages. There have been notable exam success for the trainees and the recent inaugural Allied Health Awards resulted in Sadun Kithalugoda receiving the award for Clinical Excellence and Jim Hesketh being a finalist for the Leadership Award.

PAIN MANAGEMENT SERVICES

In the past year the Wellington Pain Management Service has become accredited by the Australasian Faculty of Pain Medicine as a teaching facility. Pain Management has also recently become a recognised speciality in New Zealand. As we are a training facility this will allow us to provide training for Pain Fellows, who will exit the training scheme with the recognised speciality qualifications. The appointment of Dr Neville Berry, Occupational Health Physician, as the first Fellow for 2014,

has enhanced the service's ability to provide a multi-disciplinary approach to patient management.

Changes in referral processes and reminder systems in the past year saw a marked drop in our Did Not Attend (DNA) numbers from over 20% in most months to below 10%, with the lowest rate at 5.6%. Considerable work has been done to reduce the number of patients not turning up to appointments. This includes a new requirement that referred patients fill a set of pain specific questionnaires before prioritising routine referrals for medical only or comprehensive pain assessments. We also provided extensive information to GPs about the changes and how to access these questionnaires on Health Point.

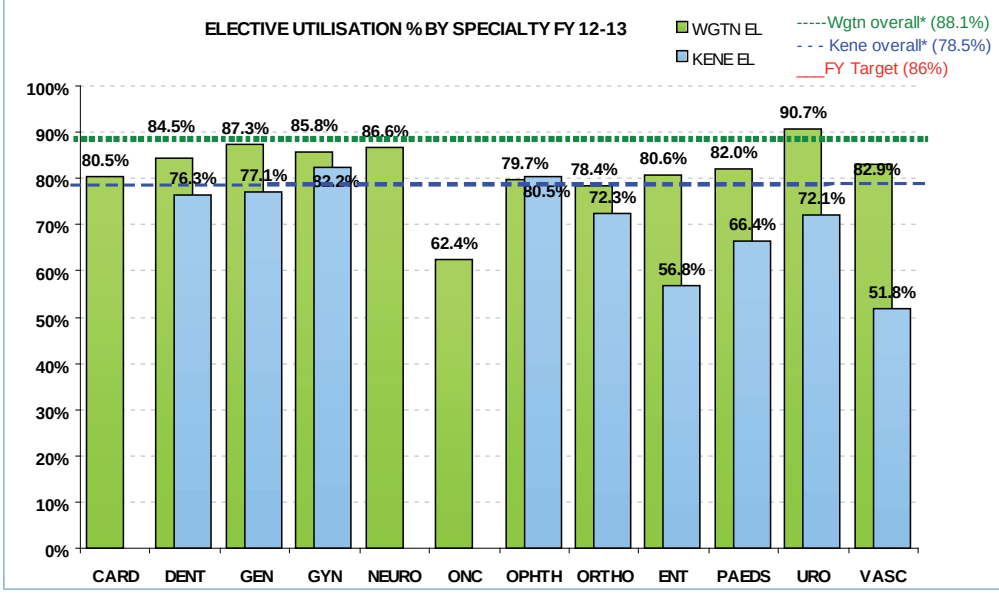
DNAs of the comprehensive assessments had been a particular concern for our service as each one represents three clinical hours lost. Over nine of the last 12 months we have had no DNAs for the comprehensive assessments. As there was no lost time in clinics, this has meant more patients were able to access this service. Written and text reminders also contributed to the increase in attendance rate and patient feedback has been complimentary about the text reminders.

The number of referrals passed the 1000 mark for 12 months. This steady growth is leading to a gradual increase in waiting times, although we are currently managing to book within the recommended timeframe for most new appointments. Of note is the high proportion of referrals to our service specifically requesting multi-disciplinary input. This focus away from the medical and medication model to intervention for improving physical and psychological functioning is promoted and supported by the clinical leadership.

WELLINGTON AND KENEPURU THEATRES

Theatre services continue to focus on supporting the delivery of surgery to both the region and sub-region population. This translated into 7897 elective procedures performed at Wellington and 2982 at Kenepuru in 2012/13. In addition, Wellington theatres supported 5971 acute operations and 1369 caesarean sections. Wellington theatres exceeded the utilisation target by 2.1%, and both Wellington and Kenepuru theatres raised their overall utilisation by 4% compared to the 2011/12 financial year.

Utilisation Summary 2012-2013



**Overall figures based on DSU monthly reports with rounding for days with 100%+ utilisation (overruns)*

Cost savings continue to be a focus for the operating theatres. The Procurement Group meet fortnightly and are supporting recent initiatives, including the use of sequential devices, and reducing the wastage of blood products. Using products covered by contract prices is a strong focus.

The Kenepuru Surgical Unit implemented a number of changes in-line with the direction of Kenepuru Hospital. In September 2012, the number of resourced beds was increased from 20 to 24 and orthogeriatric patients were moved to this ward for rehabilitation. The results of this move have led to a faster transition from inpatient Wellington Hospital beds and a shorter length of stay. This has meant patients are able to transition back into the community and their own homes faster.

There has also been a significant increase in patients under the non-acute rehabilitation contract with the focus from the multi-disciplinary team on this ward.

PERIOPERATIVE SERVICES

The Perioperative Service has continued to focus on improving patient flow to assist in meeting the Ministry of Health's elective surgery targets. These improvements have been right across the patient's surgical journey from pre-assessment to the Post Anaesthetic Care Unit (PACU) and Second Stage Recovery (SSR).

"I would like to let you know how impressed I was with the treatment I received at the hospital. Everyone I had to see before and after the procedure could not have been more capable and kind; made me feel confident and relaxed."

KENEPURU PERIOPERATIVE UNIT

The service has made changes to the way they operate with more efficient use of phone pre-assessment and screening of patient health questionnaires. They have also been involved in the orthopaedic redesign and ERAS projects.

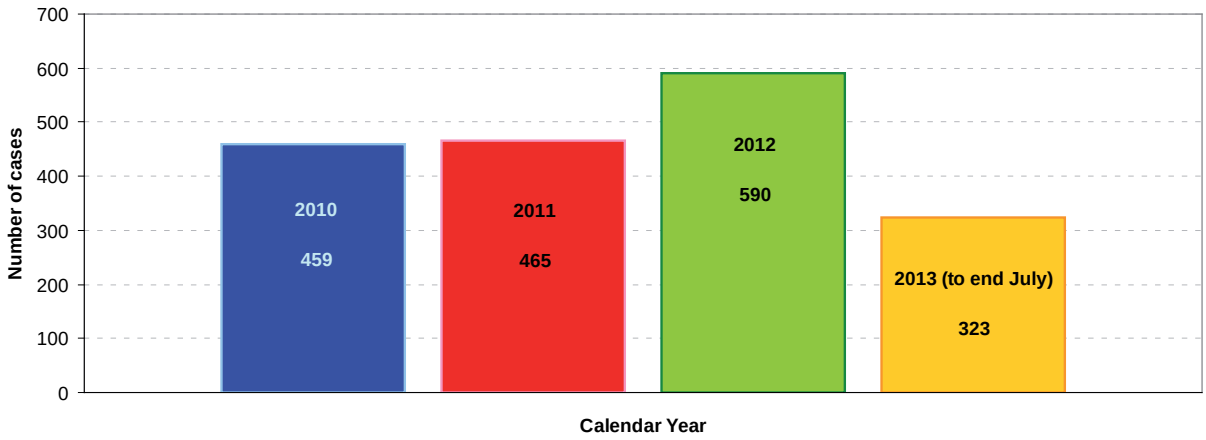
PACU has continued to operate at capacity throughout the year. The introduction of the AIRVO high flow nasal oxygen therapy system has had a positive impact on patient outcomes in terms of reducing length of stay and also decreased admissions to ICU from PACU. A more robust on-call system has been introduced, and PACU nurses continue to provide support to the acute pain management service over the weekends on a rostered basis. Staff movement has been minimal which has resulted in a stable and experienced workforce.

Month	Patients through PACU	PACU LOS (minutes)
July	1305	81
August	1283	78
September	1153	83
October	1319	76
November	1321	71
December	N/A	N/A
January	1127	71
February	1254	70
March	1290	75
April	1305	75
May	1456	74
June	1172	77

Vascular Access Service operates from PACU, and is essentially a nurse-led service with anaesthetic and IV clinical nurse specialist support. A specialty clinical nurse – vascular access has been appointed and additional Healthcare assistant (HCA) support has been built in to assist with Periphally Inserted Central Catheter (PICC) line insertion. The service operates across the week and now has six trained inserters. Overall wait time for a PICC is down as is patients waiting for a PICC prior to discharge. This service leads the way in terms of services of its type in New Zealand.

Second Stage Recovery provides nursing care for day case patients and overnight post-op patients expected to stay in hospital 24 hours or less. The unit has operated at near capacity throughout the year. It is supported by the Surgical Admissions Unit which admits patients on day of surgery, thus eliminating patients taking up a bed the night prior to surgery.

TOTAL PICC insertions per calender year



Surgical Safety Checklist (SSC)

In 2011 the World Health Organisation Surgical Safety Checklist was introduced to all DHBs. As part of the HQSC Patient Safety campaign one of the four specific areas of focus is reducing perioperative harm. The quality safety marker for perioperative harm will initially be compliance with all three phases of the SSC - Sign in phase, Time Out phase and Sign Out phase.

To gain greater clarity regarding the audit sample size requirements we hosted a representative from the HQSC Advisory Group last November who advised our sample size was too small.

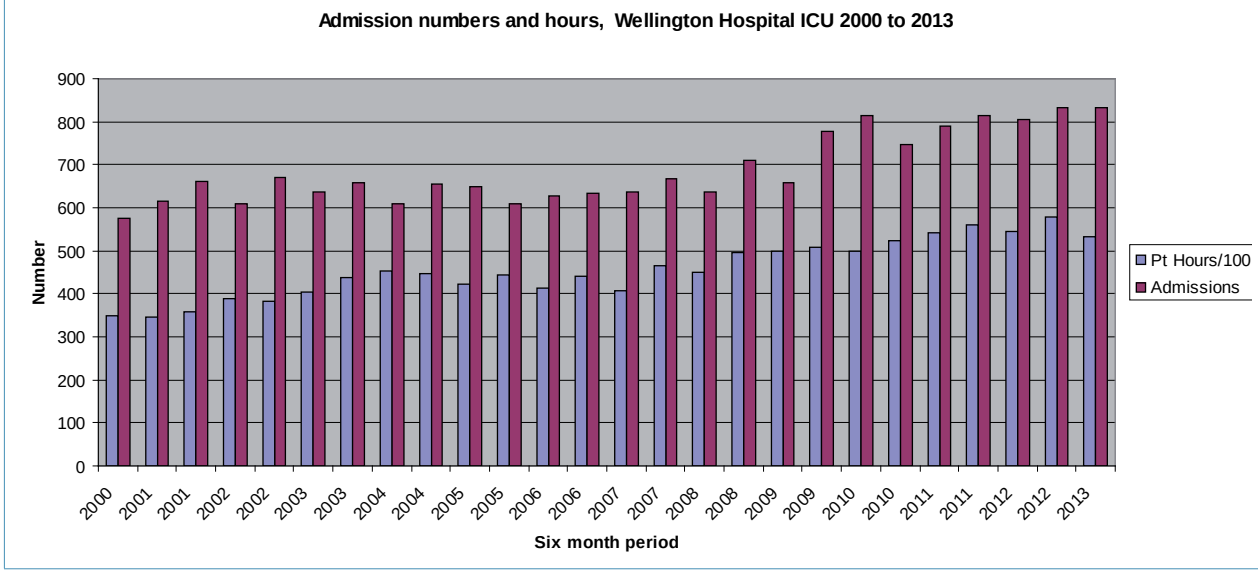
While our compliance was very good we knew that by updating the audit tool we would be able to have more targeted focussed quality improvement activities, and also increase sample size to meet quarterly target audit sample size. With this aim the audit tool was modified and the audit sample size comparison shows CCDHB is now achieving well above sample size requested, and as a DHB we are leading nationally with the percentage of operations where all three parts of the SSC are used.

The last audit completed in May 2013 showed the Surgical Safety Checklist Audit overall compliance had increased to 98%.

Picture by Dr Alex Psirides

INTENSIVE CARE UNIT (ICU)

Admission numbers and hours, Wellington Hospital ICU 2000 to 2013



Intensive Care Services (ICU) has had another busy year with increases in occupancy and continues to actively foster and support ongoing training and development for both medical and nursing staff. Ten registered nurses achieved proficient or expert status on the Professional Development and Recognition Pathway. In addition three registered nurses graduated with Masters qualifications during the year.

Research involvement and capability continues to grow within the unit with the service contributing to 19 clinical trials. These include two international studies that were initiated and led by Wellington ICU.

Wellington ICU successfully hosted the 500 delegate conference for Australasian's Intensive Care Specialists. In addition, the final preparation course for trainee ICU specialists in Australasia was established at Wellington ICU in 2013.

ICU Specialist Dr Paul Young with potential saline alternative Plasma Lyte - a solution designed to more closely resemble natural levels of chloride in the blood.

INTRAVENOUS FLUID THERAPY: MORE THAN JUST SEAWATER?

A Wellington-led clinical trial is set to determine whether it's time to take saline off the shelf.

The $400,000 SPLIT (Saline vs Plasma-Lyte for ICU Fluid Therapy) study, which won funding from the Health Research Council of New Zealand, will be carried out in four Intensive Care Units in Wellington, Auckland and Christchurch.

Led by CCDHB ICU Specialist Dr Paul Young, the 28-week study will investigate the effectiveness of a saline-alternative called Plasma-Lyte.

"We are particularly interested in whether or not the use of saline might put patients at greater risk of kidney failure than an alternative fluid called Plasma Lyte," says Dr Young.

"The levels of sodium and chloride in saline are nothing like those in plasma (blood). Current use of intravenous saline in clinical practice partly reflects the fact that this is what has been done for more than 150 years."

Intravenous use of saline dates back to UK cholera epidemics of the 1830s. Currently, more than a million litres of saline are administered to patients around the world daily. Plasma Lyte is an alternative intravenous fluid with a lower chloride concentration than saline which more closely resembles the composition of human plasma (blood).

This study will help establish which fluid is preferable for the sickest patients in the hospital.

Intravenous fluid use is common in ICU and Dr Young expects around 90% of patients coming through there will take part in the study, which is expected to begin by the end of the year. "This study has the potential to change clinical practice around the world," he says.

"The care of my dad has been fantastic, staff have been wonderful with informing us on his change. It's so great to be with doctors and nurses that have a great passion for what they do. The nurses in ICU are angels."

FAMILY OF ICU PATIENT

National focus to avoid a CLAB

Central venous lines are common for patients in Intensive Care Units (ICU). Nationally there are around 19,000 ICU admissions each year. These vulnerable patients are at risk of central line infection and associate complications, including death. The cost of each Central Line Associated Bacteraemia (CLAB) has been estimated to be between $20,000 and $54,000.

The CLAB National Collaborative was funded by the Health Quality and Safety Commission (HQSC) and co-ordinated by Counties Manukau DHB and Ko Awatea. All 20 District Health Boards participated in this 18 month initiative that began in October 2011. The national key objective was to reduce the rate of CLAB in New Zealand ICUs towards zero. This was to be achieved through standardised insertion and maintenance processes and agreed national data collection and reporting measures.

CCDHB ICU has been actively involved in this collaborative and as at 30 June 2013 it had achieved 270 days without a CLAB. This is a good achievement and reflected in the HQSC National Quality Safety Markers published in July 2013, showing CCDHB compliance with the insertion bundle as 99% to 100% for the last three quarters.

“The ability to network with other DHBs and openly share knowledge and information has been valuable. We have all listened and learnt from one another and as a consequence have made the programme work in and across our DHBs. It’s been an amazing effort” says Dr Shawn Sturland, National Clinical Lead for Target CLAB Zero and Clinical Director for CCDHB ICU.

Emergency Department

Wellington Hospital's Emergency Department (ED) saw 54,468 patients during the 2012/13 year, up from 52,109 the previous year.

The average length of stay for all patients presenting in ED was four hours, consistent to the previous year. The ongoing drive to admit, discharge or transfer 95% of patients within six hours has led to the number of patients with a length of stay greater than six hours reducing from 8,520 in 2010/11 to 7,089 in 2012/13.

The ED team has worked hard to improve triage processes in order to meet patient demand in a timely manner. The Green Zone for minor injuries is going through a redevelopment phase to ensure all minor injuries and illnesses are seen within this area, allowing for more serious conditions to be dealt with in the major part of the department. The Green Zone meets its monthly KPI of seeing, treating and discharging appropriate patients within three hours. The Department looks forward to the introduction of contracted Clinical Nurse Specialists to continue championing this area, with a newly allocated 1.4 FTE.

"I want to say how professional the team who sorted me out and got me more comfortable, quickly. From the team at the desk who took details, the triage nurse who reviewed me and sorted me out, to the nurses and finally the doctor who provided some great care and advice. A great set of people who helped me out when I was not in a good state."

PATIENT IN ED

To continue improving quality measures, the ED nursing team has changed its handover process to reflect the ISoBAR tool used throughout the DHB. Handovers are now done at the patient bedside and the structured process ensures the risk associated with handover is mitigated as much as possible. Continuing along this line, the handover process to the ward is next to be addressed utilising the same structured process.

The recent redesign of the Short Stay Unit (SSU) has created additional and protected bed space for the observation of emergency patients and will go a long way in improving our patients' care.

EMERGENCY MEDICINE TRAINING

Wellington ED has had fantastic success in both the Primary and Fellowship exams with a 100% pass rate in both over the past 18 months. Since January 2013 there has been a huge focus of nursing staff PDRP progression with a goal of achieving 85% of staff on the pathway by December 2013.

PRACTISE MAKES PERFECT

Regular simulation training is keeping Capital & Coast staff in touch with crises they wouldn't regularly encounter, as well as with each other. These sessions run 'live' in ED every Tuesday and involve both medical and nursing staff.

'Trauma in the Emergency Department Advance Multidisciplinary Simulation' (TEAMS) is one example. This simulation was based on a real-world scenario and began with a call from Wellington Free Ambulance (WFA).

An inter-professional response was led by ED staff and involved staff from a variety of departments, including; anaesthesia, surgery, intensive care, radiology, the blood bank and the orderlies.

The convenor, anaesthetist and simulation fellow, Dr Phil Quinn says scenarios like TEAMS are good opportunities for staff to practise the management of life-threatening trauma cases that wouldn't normally be seen in Wellington, such as gunshot wounds or high-speed car crashes, as Wellington's narrow roads generally kept drivers' speed low.

"The whole idea is to get our people practising in a safe environment – we try to push them into situations where they might feel uncomfortable, but we also want them to come back for more."

ED Registrar Dr Jason Feng says the simulations a good opportunity to put staff from different disciplines, including organisations like WFA, together to practise communicating and working as a team.

Other weekly scenarios generally run for about half an hour after which participants are debriefed by senior medical staff, to enable learning through reflective discussion about the team performance, and to identify any systems issues that need to be improved for the future.

Although simulations are regularly conducted, setting up is a big team effort requiring weeks of planning and rehearsals, Technology Specialist Peter Watts says.

Included in this preparation is the programming of CCDHB's $140,000 Laerdal 3G SimMan, (donated by the Wellington Hospital's and Health Foundation), whose abilities include speaking, bleeding and all the usual critically ill patient responses, in order for as accurate a representation as possible.

Internal Medicine

A number of initiatives were undertaken to improve our responsiveness to patient admissions. These included an additional registrar being rostered on at night to prevent a backlog in the Emergency Department, as well as more Senior Medical Officers being recruited to support timely decision making of patient conditions.

The Clinical Leader of Internal Medicine is undertaking a model of care review to support the increase in patient numbers and complexity principles of RMO support. The review will take into account timely patient assessments and decision making, along with the importance of providing a comprehensive, responsive medical service.

Nursing has also undergone a review of inpatient rosters to support patient assessment and treatment. This resulted in a decision to move the High Dependency Bay from MAPU to Ward 5 South, thus ensuring MAPU has adequate assessment space. This move is supported by guidelines developed by the Clinical Leader of Internal Medicine. Work is underway to make changes to nursing rosters and training to support the move, which will take place in September 2013.

Neurology

Work has been focused on meeting Health Targets related to first specialist assessments and follow ups. Prioritisation is made in a timely manner and appointments are undertaken within the required timeframes.

A new Stroke Physician has been appointed and is part of the Regional Stroke Steering Group. Work around stroke has indicated that our thrombolysis rates meet expectations and work is now focused on patients being admitted in the acute phase. The Stroke Physician and Stroke Clinical Nurse Specialist are also working with the Rehabilitation Team to ensure transfers are timely and appropriate. Stroke data is also being captured to enable measurement of our achievements in-line with regional and Ministry targets.

The acute stroke pathway is being reviewed and further refined in association with Radiology Medical and Surgical Services.

Cancer Nurse co-ordinators Rowena Price, Kate Whytock and Ginny Youmans.

Pathfinders improve the experience for patients

Life with cancer can be challenging at best, but three new roles at Capital & Coast are set to smooth the journey for patients and their families / whānau.

Cancer Nurse Co-ordinators Kate Whytock, Ginny Youmans, and Rowena Price are working to improve the experience for cancer patients, and overall access and timeliness to diagnostic and treatment services as part of a national initiative by the Ministry of Health.

"Initially we are establishing a 'snapshot' of each tumour stream pathway, from referral to diagnosis and treatment, with the aim of identifying gaps and improving service provision," says Ginny.

Kate says their roles will "evolve in scope", but the vision is to put pathways and systems in place to assist the patient to navigate their cancer journey, so they're well supported, and receive care in a timely fashion in accordance with the new Faster Cancer Treatment Initiative.

"It's about patients knowing what the next step is, having defined pathways, and everybody being clear about what's coming next, because there are a lot of disciplines involved in cancer care."

The cancer nurse co-ordinators are beginning with three specific tumour streams; lung, sarcoma and colorectal, with a focus on improving systems, tracking referrals, investigations, and appointments in order to act on delays in diagnosis and treatment.

Communication and consistency between the DHBs and primary health care teams is necessary to achieve the best outcomes for patients, says Kate.

"We've worked closely with our colleagues in Hutt and the Wairarapa to ensure consistency when it comes to IT and/or communications solutions, as a lot of their patients come here for surgery, medical oncology, or their first specialist appointment."

Cancer Services

The Multi-Disciplinary Meeting (MDM) framework has now been implemented across 11 Cancer centres. Video conferencing is in place and allows clinicians from other DHBs to engage in the meeting without having to travel. A sub-regional Governance Group has been established and maintains oversight of the development of these.

Cancer Centre Clinical Staff have been actively engaged in regional and national developments in relation to Cancer. This includes membership of regional and national committees and participation in the tumour stream work programme and the National Medical Oncology Models of Care.

The implementation of the first phase of the Faster Cancer Treatment programme has been a major achievement. The organisation has a robust retrospective data collection system in place and is working collaboratively with other regional DHBs on data collection and quality issues. CCDHB has appointed three Cancer Nurse Co-ordinators (2.2FTE) that are tasked with putting in place pathways to assist patient to navigate their cancer journey.

The Radiation Oncology, Haematology and Medical Oncology Department has continued to achieve its wait time target of four weeks from decision to treat to first radiation treatment.

CANCER RESEARCH UNIT

The Wellington Blood and Cancer Research Unit's team consists of research nurses and co-ordinators. Over the past year, they have been working with Oncology and Haematology patients who are eligible and consent to participate in trials, by providing them with a greater choice of treatment options and regimens otherwise unavailable.

Currently, there are more than 30 clinical trials taking place. These are open to patients in medical and radiation, oncology and haematology. There are also a similar number of trials reaching the end of their trial period.

A patient's story

Juanita Sullivan is one of life's special people. With an infectious laugh and a beaming smile you wouldn't think she was currently undergoing treatment for cancer.

A year ago Juanita found a lump in her breast. She went to her doctor and following a biopsy was diagnosed with breast cancer and referred to the Wellington Blood and Cancer Centre where she met her Oncologist Dr Kate Clarke and Surgeon Christine Mouat.

"One of the first things Chris did was sit me down and work out my treatment plan, and top of the list was to shrink the lump. To do this I started a six week course of chemotherapy straight away and once this was complete, I was able to have the mastectomy.

"The chemo was incredibly hard going as you spend a long time sitting in the chair during the treatment and it makes you very sick. Also losing my hair was a bit of a bummer, but getting a wig was a lot of fun as you get to choose whatever style wig you like!

"As my hair is naturally curly I went for long straight hair, a look I have never been able to achieve," commented Juanita. According to Juanita whenever someone gets a wig they are told they should name it. "I decided to call mine 'Kimmy', as the style reminded me of Kim Kardashian's hair."

By naming the wig, friends and family members can then use that name as a way of discussing how the wig is performing while out in public i.e. "How is Kimmy doing". For Juanita this was vitally important as her friends and family were integral to her journey so they needed to feel comfortable when talking about what was happening.

"They're angels – fantastic. They have supported me throughout this whole process and I just think they are amazing."

JUANITA - WHEN ASKED ABOUT THE TEAM IN THE BLOOD AND CANCER CENTRE

Once Juanita had recovered from surgery she began the next stage in her plan, a six week programme of radiation therapy. "This was easy in comparison to the chemotherapy, although it did affect my skin quite badly." Her last session was on 31 December 2012.

"After my final radiotherapy session I remember thinking 2013 is going to be my year. I decided to concentrate on myself and my family, taking my four children up in Auckland so we could spend some quality time together over the Easter break, which was a lot of fun."

Over the next few months, things went well for Juanita until one day, at the end of April, she collapsed at work and was rushed to hospital. She underwent an MRI scan which confirmed the cancer had spread and there was now a tumour in her brain.

"The first thing I remember thinking was 'Oh no I'm going to lose my hair again!" I had just grown it back following the last treatment and had it dyed blonde and thought what a waste of money!"

Juanita underwent surgery straight away and the tumour was successfully removed in May. "The surgeon is confident he got it all, which is great news. Now it's more about treatment, but everyday I feel better."

Juanita is currently undergoing regular sessions of Herceptin and radiation therapy and although nothing is guaranteed, that doesn't stop her staying positive and focusing on the brighter side of life.

Maternity

In 2012/2013 3786 women gave birth to 3850 babies. This was a 0.3% decrease on the previous year. A total of 3435 delivered at Wellington (11/12 3448), 224 at Kenepuru Birthing Unit (11/12 232) and 127 at Paraparaumu Birthing Unit (11/12 116).

There was no significant change in the mode of birth from 2011/2012 to 2012/2013.

Mode of birth	2011/ 2012	%	2012/ 2013	%
Spontaneous vaginal	2174	57.3	2182	57.6
Forceps	237	6.2	203	5.4
Ventouse	179	4.7	196	5.2
Manual rotation	1	00.0	0	0.0
Breech	27	0.7	27	0.7
Total Vaginal	**2618**	**69.0**	**2608**	**68.9**
Emergency CS	744	19.6	745	19.7
Elective CS	434	11.4	433	11.4
Total CS	1178	31.0	1178	31.1
TOTAL	**3796**	**100**	**3786**	**100**

MATERNITY QUALITY SAFETY PROGRAMME (MQSP)

In 2012, the Maternity Quality Safety Programme (MQSP) was rolled out across all DHBs. The programme involves ongoing, systematic review by local multi-disciplinary teams that work together to identify potential improvements to maternity services. The programme is driven by local midwifery and medical leaders working together with consumers, midwife Lead Maternity Carers (LMC) and other community groups.

The MQSP is governed by a Maternity Quality and Safety Programme Governance Group, who had their first meeting in July 2012. During the past year service delivery was strengthened by many quality and safety initiatives, including:

- Senior medical officers who are on call for delivery suite and the acute services are no longer assigned concurrent clinical responsibilities, and their allocated time has increased from four to eight hours. Other roster changes include increased number of antenatal clinics and availability of senior medical staff during post surgical rounds.
- Implementation of shared or interdisciplinary training and education opportunities (including the management of obstetric emergencies).
- In addition to the diabetic antenatal clinic held in Wellington a second diabetic antenatal clinic started at Kenepuru Hospital. The addition of this clinic has seen the “did not attend” rates reduce significantly.
- Safe sleep campaign for babies initiated.
- A fully automated point of care urinalysis machine was sourced for women’s clinics. The use of the machine removes subjectivity, enhances consistency and reduces false positive results. Results are able to be directly uploaded into the Medical Applications Portal (MAP).
- A clinical audit was undertaken looking at whether iron deficiency anaemia prior to an elective or emergency caesarean section affects women’s blood transfusion requirements and recovery outcomes post-operatively.

FIND A MIDWIFE PROJECT

The Find a Midwife project was set up to provide information and support for women trying to find a Lead Maternity Carer (LMC) for their maternity care. This project commenced on April 1, 2013 and involves an 0800 phone line, a website with information and a downloadable list of midwives and availability, and an early pregnancy class. Early indications are that the project has helped raise awareness for women seeking a midwife.

THE ROLE OF COMMUNITY LACTATION CO-ORDINATOR

The role of Community Lactation Co-ordinator was recognised as being a cost effective health strategy for babies, and a high priority in providing free specialist Lactation Consultancy and support in the community to improve breastfeeding rates. Ongoing funding was gained for 2013/14 where there will be more emphasis on improving Māori and Pacific breastfeeding rates.

MIDWIFERY QUALITY AND LEADERSHIP REPORT

The Quality and Leadership Programme is the career pathway for midwives through three levels: competent, confident and leadership. Midwives who wish to progress to the confident and leadership levels have their portfolios assessed by trained midwife portfolio assessors.

By the end of 2012 a total of 36 midwives had progressed to the confident level and 25 midwives had progressed to the leadership level. In the first half of 2012, a further nine midwives had progressed to the confident level, and seven had gained the leadership level.

Gynaecology

CARE PATHWAYS

Patient Care Pathways are ways to look at improving gynaecology care in the community. New pathways that involve better triage to hospital services have been approved and are now available to GPs on Health Point. The aim of the new pathways is a more seamless referral process as well as reduction in unnecessary referrals, which will enable the prioritisation and assessment of urgent cases.

GYNAE-ONCOLOGY SERVICE

In February 2013 Dr Cecile Bergzoll was appointed as the service's Gynaecological Oncologist. She is involved in the diagnosis, surgical care and post-operative management of patients with suspected gynaecological cancer. In addition her special interest includes ovarian cancer.

This is a small but essential service for New Zealand women and their families as gynaecological cancers make up approximately 10% of all cancer cases and 10% of all cancer deaths in New Zealand. Dr Bergzoll will lead the committed multi-disciplinary team in Women's Clinic. This evolving service will provide the national standards for the management of gynaecological cancer which will ensure all women have timely access to services and supportive care.

A young patient is taken with a teddy bear gifted to him by Wellington Phoenix Captain, Andrew Durante.

Children's Health Services

It has been an eventful year for Children's Services at CCDHB as the centenary year of the Children's Hospital concluded on March 13, 2013. A wide range of initiatives were undertaken to improve child health outcomes within our region and we are proud that CCDHB's Ambulatory Sensitive Hospitalisations (ASH) for children 0 - 4 has continued to decline and is now at similar rates to 2007/08. CCDHB is achieving the target for all population groups and is the best performing DHB for children 0 - 4 in the central region.

The Children's Hospital continues to owe a debt of gratitude to the public who, through the Wellington Hospitals & Health Foundation, have donated more than $400,000 to the Children's Hospital Services.

> *"Thank you. I had a very good time having my injection and I want to do it again. Tap the Frog was fun."*
>
> A YOUNG OUTPATIENT AFTER THEIR MONTHLY INJECTION

CHILDREN'S ACUTE ASSESSMENT UNIT

Young patients and their families are spending less time in ED, and enjoying shorter hospital stays, thanks to the Children's Acute Assessment Unit (CAAU).

Ambulatory Paediatrics Charge Nurse Manager Karen Bridge says preliminary estimates indicate 60 – 70% of all paediatric patients referred to CAAU, which is co-located with the Children's Day Ward, are seen between the hours of 1000 - 1830.

Less time spent waiting in the relatively adult environment of ED is better for young patients and their families, Karen says, as is the contact with skilled paediatric nurses who understand the needs of children.

In addition to taking pressure off ED during peak times like the winter months, waiting times are also shortened for patients as they can be quickly triaged, and have a blood test, or an IV-line inserted if necessary. This means treatment can often be started sooner, increasing the likelihood of an earlier discharge from hospital.

Children with chronic illnesses such as diabetes can also be fast-tracked to the unit for appropriate treatment without having to wait around in ED.

Having initially been run in an ad-hoc capacity and

NICU Clinical Leader Dr Vaughan Richardson.

only accepting acute cases when a room or nurses were available, the service has since expanded to five dedicated acute assessment rooms, following a refurbishment in 2012.

The addition of a full-time Paediatric Nurse, now means the CAAU can accept referrals during the daytime through to 11pm without compromising service delivery.

A new initiative to the Child Health service is RUBY, or At-Risk Unborn Baby. This was developed based on similar ideas overseas as a response to help frontline staff deal with vulnerable pregnant women coming into our service, some without postnatal care. In the past staff were not aware of any background issues and were often not in the best position to provide necessary support and care for mother and baby. RUBY is a child-centric approach that focuses service providers on the child as well as the mother, including factors such as the home environment, immediate antenatal support and wider health needs. Previously the process focussed on the needs of the mother, with the potential to lose sight of the care and protection issues associated with the newborn baby.

A new process now identifies patients either by internal service groups, for example the Emergency Department or external referral, for example Police.

The referrals are triaged by the multi-disciplinary team, which involves a wide range of service providers including DHB social workers, midwives and a CYF social worker. They determine any follow-up actions required including any safety planning in preparation for the birth, post-natal care and subsequent handover to a community support provider.

Last year RUBY managed approximately 80 cases and this year, with growing awareness within the DHB and external partners, this number is expected to grow.

NEONATAL INTENSIVE CARE UNIT (NICU)

The Neonatal Intensive Care Unit had another busy year looking after 932 babies. NICU continues to support new graduate practice and in 2012 it employed four new graduate NETP nurses and in January another five NETP nurses joined them.

Ongoing education is very important for staff, who undergo clinical experience and attend relevant study days. NICU 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, reflect on practice, increase confidence and safe practice, and improve collegiality among hospitals.

In October 2012 the National Level 3 Conference was organised by Capital & Coast's NICU staff. It was well attended by Level 2 and Level 3 neonatal units nationally. Excellent guest speakers, including our medical staff and Dr Swee Tan from Hutt Valley DHB, ensured very positive feedback.

During the past year stronger links have been made with regional hospitals, especially Hawke's Bay DHB. Senior clinical and management staff visited Hawke's Bay DHB to discuss alignment of policies, especially in relation to the safe transport of babies, teaching and learning opportunities, and X-ray reporting.

Violence and abuse is everyone's problem

Child Protection and Violence Intervention Programme (VIP) Co-ordinators Bonnie Fordham and Rob Veale say there is "considerable overlap" in their roles at Capital & Coast.

Family violence and child abuse represent a huge health problem, Bonnie says, but for many people it remains a taboo area. As well as consulting with frontline staff, the pair also work collaboratively with external organisations, such as Child Youth and Family (CYF), Police, and Women's Refuge "to try and pull all the information together."

"We're trying to avoid another James Whakaruru, who died in 1998. James was seen by at least 40 health professionals in the four years of his life, but none of them actually reported his injuries to other agencies," Bonnie says.

Multi-disciplinary meetings are an integral part of reviewing cases that come to the pair's attention, whether it's a pregnant mother with 'high social risk factors', for example with no fixed abode or mental illness, who needs antenatal care, or ensuring a child that's been referred to CYF has received a full paediatric assessment at the hospital.

Rob's programme scope also includes vulnerable adults such as partner abuse and elder abuse, and he says that family violence comes with a context.

"We have to look at family violence as part of a patient's history rather than an isolated event when they present. The real challenge for health professionals is unpacking that context around time and work pressures. Our job is to balance practice with policy for practitioners, to make it work."

From Rob and Bonnie's perspective that means continuous improvement. "We're reviewing our policy and training materials, but we also need to audit, to find out how we are going and then to work with staff to look at ways we can keep people safe."

Bob Veale and Bonnie Fordham.

“We didn’t want to cut back our age range so we worked to layer our services so that we could see more children, as well as providing a more equitable service,” says Child Development Service Team Leader, Sue Doris.

Waiting times reduced for children

Taking a whole of service approach has resulted in dramatic reduction in waiting times without compromising standards of care, says Child Development Service Team Leader Sue Doris.
The service provides specialist multi-disciplinary assessment and intervention for children aged 0 – 16 years who have, or are at risk of, a development disability or delay and/or autism spectrum disorders. It receives an average of 30 referrals per week.

In previous years an average of 38 children a month had been waiting more than six months for an appointment. Following comprehensive process mapping, from point of referral to discharge, the service has overhauled its referral forms. To date the service has reduced the number of children waiting more than six months for their first appointment by 81%, and reduced the number waiting more than three months by 19%.

During this process they also identified some variation in service provision and are now working collaboratively, so that all children receive equitable and appropriate services.”

The development of clinical pathways has also allowed the service to ensure their work is sub-regionally aligned with the Hutt Valley and Wairarapa DHBs, and provided staff, families, and referral agencies with “a clearer picture of what we provide as service.”

“We’ve also worked really hard to improve our liaisons with primary care providers, because they are a really important part of what we do,” says Sue. “Our challenge now is to maintain these improvements, and we will continue to review and assess what we do to ensure that.”

Visitors to the Children's Hospital

NZ Warriors Steve Rapira and Sione Lousi met staff and patients at the Children's Hospital before their historic match against the Canterbury Bulldogs at Westpac Stadium in May.

Superhero Iron Man with a young patient.

Argentinian Sevens players visiting a patient during the Wellington Sevens.

All Blacks Sevens player Lote Raikabula visiting a patient during the Wellington Sevens.

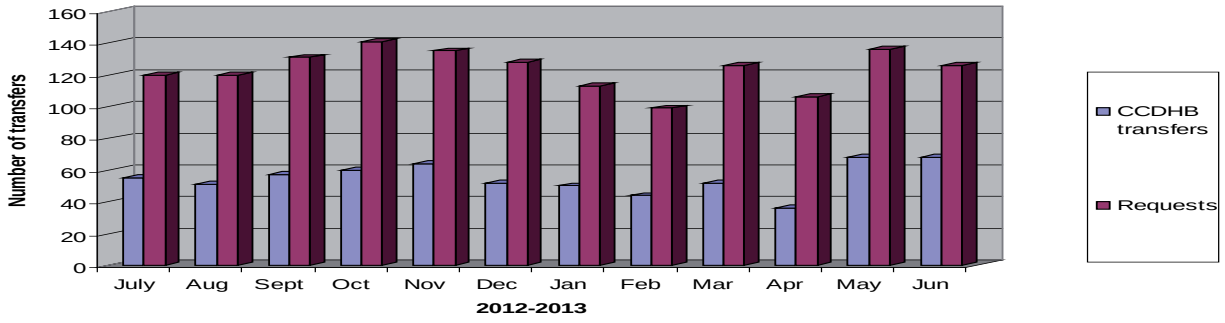
Transit

FLIGHT RETRIEVAL

Flight requests continue to be stable throughout the year with a total of 657 missions completed by the flight team from 1481 requests for transport. Work has started this year with all central flight services in an attempt to standardise transport records, patient transfer request forms and improve communications.

The flight team has taken part in the production of a television series in conjunction with Life Flight Trust, recording the patient journey during a transfer or retrieval. The first episode aired on 15 July and has had consistently high ratings.

Transfers And Requests



WELLINGTON FREE PATIENT TRANSPORT SERVICES

This service is provided by Wellington Free to transport patients between hospital, home or to another hospital. We are fortunate to have the liaison person situated in the Transit Lounge for the past four years. This role has increased communication and timely transfers of patients from Wellington Hospital when used in conjunction with the Transit Lounge. Transport to treatment for renal dialysis patients now includes the Wellington dialysis service whereas in previous years this only included the Kenepuru site. Wellington Free has also taken over the Ambulance service in the Wairarapa, which has improved co-ordination between the two hospitals.

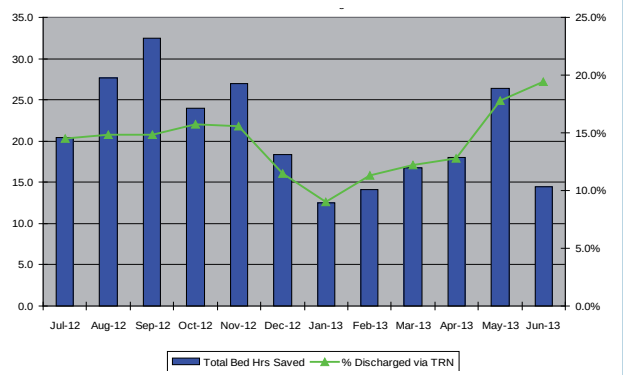
"You arranged all my travel arrangements and I am just so grateful for all you did and this wonderful service that has been provided for relatives of loved ones who find themselves in this tragic situation. Whoever instigated this help and service for relatives had amazing insight into the needs of both patient and family and I, along with many others, are extremely grateful. For me, personally, to be treated in such a loving way was truly a blessing."

PATIENT TRAVEL

THE TRANSIT LOUNGE

The Transit Lounge is in its fourth year of operation and continues to strive to increase its utilisation. Work towards the end of 2012 has seen an improvement in functionality through increasing its usable space. This year has seen a slight increase in use, with more than 30 patients passing through on some days. The end result is that some month's transit can save 20 inpatient bed days.

Transit Lounge



The Transit Service has undergone changes in the last few years to adapt to hospital demand with an increase in hours to cover the after hours period. This now includes four nights per week, Tuesday to Friday, and two to four days with extended day staff cover till 21.30 hours. This is ongoing in its development to continue to meet hospital demand, improve flow and patient safety during the after hours.

Nursing

A key question this year we have asked ourselves as a nursing group is 'could Mid-Staffordshire happen at CCDHB?' The Francis Report highlighted many nursing care issues in the English county of Mid-Staffordshire and while we do not like to think it could happen at CCDHB, it is important to stop and think about whether this level of appalling nursing could happen here. By considering this question, we were able to reflect on the great work that has been happening, but also think of the work that needs to be done in nursing to continue to provide high quality, safe care to our patients.

The focus on the national nursing sensitive indicators of falls, nutrition and pressure injury has meant better outcomes for our patients. The nursing workforce within CCDHB has embraced this work with key improvements in the way we manage patients at risk of falling and prevention of pressure injuries. For example, new assessment tools have been developed to make the assessment of falls risk and pressure injury risk more comprehensive but also easier to be completed.

Another focus for nurses during the past year has been on workforce development. Encouraging nurses to progress on the professional development and recognition programme has seen 165 nurses progress over the year. Looking at the new graduate orientation model saw one ward trial a shared care model of orientation to better prepare new graduates for the reality of a full patient load. Models of sustaining the number of new graduates employed each year are being explored through the Directory of Nursing and Midwifery Office.

Leadership succession planning has been highlighted with opportunities for emerging nursing leaders to step into acting leadership roles.

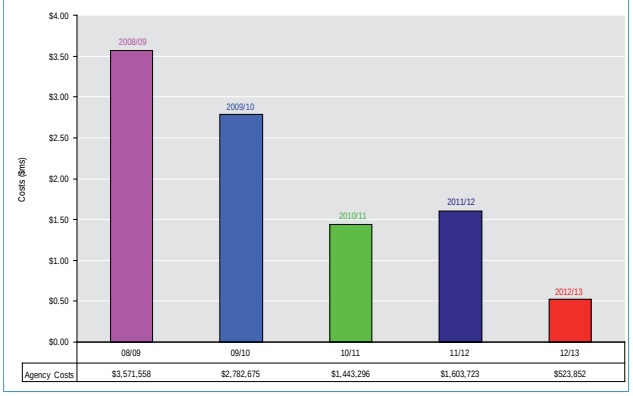
Opportunistic improvements in how we deliver care to our patients have been taken up with enthusiasm. Examples include looking at the model of acute pain management in post-operative patients. Trialling a model where the nursing and surgical team manage the patient's pain with back up from the acute pain management team have seen an increase in the skill and knowledge of nurses. The development of an online bed management tool called Occupancy at a Glance and joint morning "bed meeting" that are attended by all Charge Nurse Managers, has seen greater transparency and more collegiality among wards when managing patient flow.

Over the next year the nursing team plan to continue to build on the great work so far. The focus will be on continuing to provide excellent and safe in patient care.

24 HOUR OPERATIONS SERVICE

The Bureau has had a good year with the Registered Nurse Staffing Officer position being filled and ensuring a streamlined recruitment process. This year has seen the Permanent Pool for Registered Nurses being established with 12.8 FTEs working on a rostered and rotating basis across the DHB. A preferred provider agreement was reached with two outside agencies to provide registered nurse services with considerable savings to the organisation. (see graph)

Outside Nursing Agency Expenditure



A new uniform agreement with the LNI group has been put in place and savings of approximately $30,000 are projected per annum once this is up and running for more than a year.

The service has been heavily involved in activities associated with reducing patient waiting times in the ED. The 'Occupancy at a Glance' dashboard is now used 24/7 to show bed capacity and movement across the DHB sites. The service has participated in a number of improvement initiatives and has led the establishment of the combined daily bed meeting. This ensures an organisational view of hospital capacity and helps identify potential barriers.

Clincal staff worked with ICT to develop Occupancy at a Glance, an online bed management tool.

Clinical Genetics

Genetic Health Service New Zealand has recently completed its first full financial year since its launch. Review of annual volume data indicates unexpectedly high use of the newly established remote (telephone) consult purchase unit. The National Clinical Director has been appointed, with the staffing structure and reporting processes now well bedded in.

The HealthPathways project, which is an online information and referral guideline for GPs in the South Island, is now up and running and has a comprehensive genetics section.

GENETIC SERVICES LABORATORY

There has been considerable focus this year on staff development, including the establishment of a registered technician career pathway and up-skilling cytogenetic staff in the field of molecular genetics in view of converging sciences.

Service improvements include the introduction of prenatal microarray testing nationally, available through the Fetal Medicine Network, and the successful establishment of an in-source partnership with a large laboratory based in Britain.

The service enhanced its profile through rebranding and developing a website to provide further support: www.wellingtongenetics.co.nz

Sterile Services

The focus this year was on completion of the sterile services improvement project.

Most areas of the production unit have now been overhauled and improvements made to the:

- decontamination room with an installation of new semi automated pre cleaning units
- packing room with the purchasing and reorganisation of packing stations to suit the production flow of the area
- dispatch room has been reorganised to free up space for storage of sterile instruments and purchase of dedicated storage baskets to accommodate all steripeel items
- loans room has been relocated to a larger and more efficient work space to accommodate the ever increasing loans service provided for the operating theatres
- ward supplies room has been relocated to provide a specific sterile storage environment for ward and clinic supplies.

Standard operating procedures have been developed to meet best practice ISO compliance.

Training and audits on the procedures have been carried out to meet competency requirements of the standards.

In the coming financial year we hope to refurbish the existing disinfection room to convert it into an endoscopic decontamination room for automated processing of flexible scopes. The next stage is the compartmentalisation of each area within the unit using automated doors which will balance air-conditioning pressures and flow rates, to meet standards of compliance for sterile production units.

Influenza immunisation

In the run up to the influenza season, we have seen more people than ever get vaccinated against influenza, both internally and in our community. Thirty four percent of our region's population has taken the initiative to get protected, which is a significant increase on last year's total of 24%. CCDHB staff also took advantage of the influenza immunisation campaign. We had 600 more people vaccinated than in the previous year, which is our best ever outcome and a credit to the work done by Occupational Health and the Immunisation Champions.

Chief Operating Officer Chris Lowry getting her flu jab.

INFECTION PREVENTION AND CONTROL

Patients in good hands

Since 2008 Hand Hygiene New Zealand has been running a national quality improvement programme to improve hand hygiene practice within all hospitals. This programme is part of the Health Quality and Safety Commission's objective to reduce preventable infections related to healthcare, which are a major cause of morbidity, mortality and increased expenditure in all hospitals.

"A substantial proportion of these infections can be avoided simply, and cheaply, by improving hand hygiene practice among our healthcare workers", says Clinical Nurse Specialist James Robertson of the Infection Prevention & Control service.

"We submit three audits to Hand Hygiene New Zealand annually, and the results are fed back to clinical areas so improvements can be made. Results are made public as part of the HQSC's Quality and Safety Markers," says James.

Chief Medical Officer Dr Geoff Robinson and CEO Mary Bonner using the sterigel in the entrance to Wellington Hospital.

"The Health Quality and Safety Commission set a target of 70%, so we were delighted to report in June that Capital & Coast had exceeded that goal with 75% compliance, which rates among the highest in the country."

Pharmacy

A medicine reconciliation programme for admitted patients was rolled out to DHB inpatient areas from November 2012. By March 2013 this was rolled out to all areas where this programme can make a significant contribution to patient safety. CCDHB is one of the top performers at a national level with this service provision. Internal data shows that medicine errors are being identified with this service and patient harm prevented.

An Infectious Diseases Pharmacist was appointed in late 2012 to facilitate an antimicrobial stewardship programme for CCDHB, in conjunction with the Infectious Disease Service. Aside from quality benefits, such as reduced resistance to antimicrobial agents, the programme has also produced significant cost savings. This has largely been the result of an 'IV to oral' campaign and clinician education in relation to reduced dosing of a specific antimicrobial agent.

In October 2012 the Preferred Medicines List website was launched within Capital & Coast and Hutt Valley DHBs. The website contains a collection of therapeutic guidelines devised in conjunction with clinicians and with Clinical Leader and Clinical Governance Group endorsement. The website usage has been tracked since implementation indicating that this resource is well utilised by staff. New content continues to be added to the site and the Preferred Medicines List ongoing review process has been implemented, ensuring content remains current and relevant to practice.

The Clinical Governance Group included, clockwise from rear, L-R: Dr Nigel Raymond, Dr Tim Blackmore, Dr James Taylor, Dr Mark Jones, Dr Brendan Arnold, Brijul Morar, Dr Michelle Balm.

Switched on and engaged

The launch of the antibiotic stewardship programme has been a huge success in terms of significant cost saving and service delivery. The IV-to-Oral SWITCH campaign is more of a helpful reminder than change of practice.

Stickers with criteria to promote a safe switch are placed on patient notes by ward pharmacists on day two of an IV antibiotic course, says Infectious Diseases pharmacist Brijul Morar.

ID Registrar Dr James Taylor says there was a lot of evidence to support an earlier switch, including a decreased risk for complications, such as hospital-acquired infections. "Those patients then don't have to worry about the discomfort associated with line changes. Their mobility is increased, which has positive implications for their recovery."

That had beneficial flow-on effects for getting patients home and reducing their length of stay by up to 2.4 days. An earlier switch also saved nurses' time as well as cutting back expenditure on consumables, "which can add up over a period of time", says James.

The campaign also helps to cut back on waste says Brijul. "You have to take a lot of factors into consideration, but looking solely at the cost of drugs, we've probably saved around $200,000 since the Antimicrobial Stewardship Programme went live in mid-November."

Radiology

Radiology introduced a “Duty Radiologist” to aid referral and support clinicians in requesting the most appropriate imaging. A report for clinicians and the wider organisation regarding expected waiting times for Radiology imaging was also developed. This can aid clinicians in informing their patients of expected waiting times when referred for Radiology imaging.

This year Radiology underwent a full peer review by International Accreditation New Zealand (IANZ). All areas were audited by experts in the respective modalities. The report following the week long assessment was excellent and the Department received high praise for their culture of and commitment to quality.

“At every appointment the therapists were very efficient with no waiting time. They were all friendly, respectful and caring and I appreciated their willingness to take time to explain the machines and procedures. I also appreciated the cheerful and caring greeting by name of the lovely receptionist, it makes a big difference to a very difficult time.”

RADIOLOGY DEPARTMENT PATIENT

RADIATION THERAPY - EMERGENCY DEPARTMENT

The Radiology Emergency Rooms were upgraded with state-of-the-art digital radiography equipment during a three month refurbishment. Staff have relished the opportunity to work with this new technology in an acute and emergency setting. This offers our patients and clinicians superior image quality at a significantly lower radiation dose. Faster image prossessing time coupled with a redesign of the work environment has helped to optimise space, enhance workflow and reduce examination times.

COO Chris Lowry opens the newly refurbished ED Radiology rooms.

Outstanding contribution by a new graduate

Laura Higham won this year's Outstanding Contribution by a new graduate at the inaugural Allied Health Technical & Scientific awards, which recognises clinicians who have demonstrated exemplary contribution to patient care and/or team workings within their first two years of practice.

Laura works between Radiology and the Perinatal Ultrasound Unit. Both work environments require a high level of autonomy with the reporting and referring doctors.

"There's a high level of trust and responsibility involved in my job, and I really enjoy that aspect of it," she says.

"Sonography can have a big impact - based on an ultrasound finding, patients could have surgery, begin treatment, be delivered, or sent home with no further investigation.

"A lot of the work I do is in fetal medicine, so I see everything from the best news to the worst. Every patient is different and has a different history, so you always have to be sensitive to that. Some fetal conditions are able to be treated in-utero, so those cases are particularly rewarding."

Laura was placed second out of 250 sonographers, sonologists, and radiologists from across New Zealand, Australia, and Asia at a recent foetal medicine conference in Australia, a remarkable achievement for a sonographer who had been qualified less than 12 months at the time.

She has also acted as the Quality Assurance officer for the General and Perinatal ultrasound units. The quality systems she set up were praised during the IANZ audit and also won acclaim from both the radiology quality assurance officer and the Philips engineers responsible for maintenance of the nine machines.

Laura is also the first sonographer to be placed on the ultrasound unit's accelerated sonographer progression development plan to recognise advanced practice by team members.

Laura Higham – Sonographer, Allied Health Technical & Scientific.

Kenepuru and Kapiti

ACCIDENT & MEDICAL (A&M)

Kenepuru A&M was part of the implementation of free under sixes after hours programme, which was introduced in 1 July 2012, in-line with Ministry of Health objectives. This has been successfully implemented with no significant impact on presentation rates and also removed the fee barrier for many families. To prevent people waiting until the evening, work has been done to raise awareness that General Practice is free for under sixes during the day, so they don't have to wait until after hours for free treatment.

A&M was also involved in looking at a new model for the delivery of urgent overnight care in the Porirua area. The model explored was an Urgent Community Care model similar to that delivered in Kapiti by Wellington Free Ambulance. It was found to be innovative and is now being looked at across the sub-region. The A&M will continue to operate 24/7 until this model of care has been investigated fully.

OLDER ADULT, REHABILITATION AND ALLIED HEALTH SERVICES – ALLIED HEALTH

Allied Health services of Dietetics, Occupational Therapy, Physiotherapy, Social Work and Speech-Language Therapy have been involved in a number of important initiatives across the year.

Orthopaedic pathways have identified the value of Allied Health (physiotherapy and occupational therapy) assessment prior to attendance at first specialist appointments and built this into the pathways as a requirement. This means that assessment by a physiotherapist or hand therapist needs to be made before a referral can be made to an orthopaedic surgeon for a number of conditions.

Allied Health assistant workforce development has seen staff enrolled in NZQA training to increase the specificity of their knowledge.

The introduction of the referral management module has been a huge area of work, moving from the previous Allied Health database. This will allow better visibility of input into patient events and more consistent reporting.

Dietetics has been leading work across the organisation on the identification and support of patients who may be malnourished. Malnourishment has been identified in an international study as a risk for hospitalised patients, particularly those who are elderly, so this area of work will be vital in identifying at risk patients.

Community Teams have been implementing training around motivational interviewing to support goal setting with patients for optimal outcomes.

OLDER ADULT, REHABILITATION AND ALLIED HEALTH SERVICES – INPATIENT SERVICES

The inpatient older adult services have been working with Internal Medicine to further support the transfer of frail elderly out to Kenepuru Hospital. Geriatric presence has been provided in Wellington for three days a week and plans are to move this to five days a week in early 2014.

While our rehabilitation physician resigned in early 2013, successful recruitment has enabled the continuity of specialist rehabilitation services, including concussion clinic, outpatient and inpatient services. The rehabilitation physician is also part of the Regional Stroke Steering Group and is promoting early transfer and rehabilitation for stroke patients.

Te Whare o Matairangi (TWoM) Team Leader Derek Challenor talks to Board members and CEO Mary Bonner about the new facility.

Mental Health, Addictions and Intellectual Disability

The Mental Health, Addictions and Intellectual Disability (MHAID) Directorate has received certification for the service for another three years, with a number of registrars also completing training. There have been new facilities for CATT, Te Haika and Te Whare Tipu services, as well as the successful implementation of the family violence intervention programme as defined by the Ministry of Health.

The development of more e-learning courses ensures staff can complete some core foundational requirements remotely - which equates to more efficiency and time to focus on patient care. This enables ease of reporting on infection prevention and control, seclusion, patient watch/observation, privacy and health information.

The Directorate has developed Safe Holding, a two-day training course for staff working in hospital settings with elderly people who experience dementia. The aim of Safe Holding is to minimise risks to clients and staff due to behavioural and psychological symptoms. The course teaches de-escalation skills, meeting un-met needs for people with dementia, enhanced communication skills and pharmacological knowledge.

The programme has been delivered to all nursing and support worker staff at Te Whare Ra Uta (CCDHB's psycho-geriatric assessment unit) as well as to staff at Nelson Marlborough DHB. Evaluation has shown reduction in the use of antipsychotic medications and increased awareness amongst staff of appropriate and helpful responses to challenging situations.

STEPPING STONES PROGRAMME

The Stepping Stones programme was developed by two of the Intellectual Disability Psychologists. This is an innovative 42-week programme that provides a unique way to comprehensively address the emotional regulation needs of offenders with an intellectual disability. The name *Stepping Stones* reflects the philosophy that no matter who you are or where you want to get in life, there are steps to be taken and challenges to be overcome. The programme has been internationally recognised and published in the Journal of Learning Disability and Offending Behaviour.

INTELLECTUAL DISABILITY (ID)

The Intellectual Disability service is currently in the early stages of piloting a restorative justice programme with people in the inpatient service.

We have offered two places to Nurse Entry To Practice graduates to work within the ID service. We hope to repeat this initiative for mid year enrolments for 2014 as well.

THE NATIONAL INTELLECTUAL DISABILITY CARE AGENCY (NIDCA)

A new national service delivered by CCDHB's Mental Health Addictions & Intellectual Disability Directorate was started on 1 January 2013, with locations in Whangarei, Auckland, Cambridge, Wellington, Christchurch, and Dunedin. This service replaces the five Regional Intellectual Disability Care Agencies, which was devolved to a national service at the same time. The national service provides specialist needs assessment and service co-ordination to a mix of high and complex clients with an intellectual disability.

COLLABORATIVE WORKING

Working in partnership with the Mason Clinic in Auckland, the inpatient forensic service at Ratonga Rua has been able to accommodate five patients from Auckland. This has helped shorten the waiting list of the Mason Clinic for clients needing to be transferred from prison to an inpatient service.

Professional Leader for consumers appointed

In February 2013 John Tovey was appointed as Professional Leader – Consumer Consultancy within the Mental Health, Addictions, and Intellectual Disability Directorate (MHAID). In this role he provides strategic advice at senior levels within the directorate and works to raise the profile of the consumer workforce, including the development of processes that strengthen their professionalism and effectiveness.

John has spent many years using his personal experience of bipolar affective disorder to help people in the community deal with similar difficulties; sometimes by working one-on-one or facilitating groups, other times representing consumer opinion at DHB, regional or national levels; often done while managing a small NGO.

Clinical Director of MHAID Alison Masters said that the need for a professional leadership role for consumers had been internationally recognised for several decades. “It’s working within the framework of consumer development to give these employees a place among thinking at the senior level. It’s quite an obvious step really, but it has to be done carefully and sensibly and we are very pleased with the result.”

MHAID Clinical Director Dr Alison Masters and Consumer Consultancy Professional Leader John Tovey.

TE WHARE O MATAIRANGI (TWoM)

After a year in the new unit on the Wellington Hospital site, Te Whare o Matairangi is receiving ongoing compliments from consumers and staff alike. Our seclusion rates have continued to decline and the unit has had a 12 month occupancy of 85% and 12 month readmission rate at 8%.

New TWoM area.

TE ARA PAI (STEPPING STONES TO WELLNESS)

The first services in the Te Ara Pai (Stepping Stones to Wellness) project have begun with the launching of Navigation, Home Based Support and Housing Facilitation services. After significant consultation, the service began and people transitioned successfully. We have already had reports of clients enjoying the new access to community supports.

THE FAMILY CENTRE (TE WHARE TIPU)

The Family Centre was opened by Board member, Margaret Faulkner on 1 July 2013. Te Whare Tipu is an enlarged and refurbished Hania Street Clinic, which brings together services that work with infants, children, young people and their families. It also works with adult women who have mental health issues that have developed in the context of having a baby.

The Wellington Child & Adolescent Mental Health, Specialist Maternal Mental Health and Early Intervention Services (first episode psychosis) are now all based there. The services provided there will have a strong shared focus on family and growing young people. This initiative is also part of the directorate's plan to reduce use of leased premises in the Wellington CBD that includes the Early Intervention Service moving to Te Whare Tipu from Pipitea House.

Opening of the Hania St Clinic.

Māori Health

Aligned with the requirement for DHBs to develop an Annual Māori Health Plan, there has been a significant amount of work undertaken, both regionally and nationally, to provide reporting against the indicators.

Currently CCDHB is:

- the highest performing Central Region DHB for ASH rates 0-4 years and breast feeding
- meeting/exceeding six of the 10 targets
- progressively improving in the remaining four target areas.

To assist accelerated improvement, CCDHB is currently working to identify champions for each target.

TŪ KAHA

CCDHB helped lead the implementation of the 3rd biennial Tū Kaha Central DHB Region Māori Health Development conference in Whanganui. A total of 285 attended the conference, including 69 Rangatahi stream registrations.

The conference provided a unique opportunity for the Māori health network in the Central DHB region and its key stakeholders to come together to share learning and innovation ideas, discuss potential regional priorities and strengthen relationships, as well as discuss Māori health development in the Central Region.

KIA ORA HAUORA - MĀORI HEALTH WORKFORCE PROGRAMME (KOH)

Kia Ora Hauora is a national Māori health workforce development programme aimed at building Māori workforce capacity and capability. CCDHB is leading and hosting the Central Region's Co-ordination Centre of this programme, with the intention of enrolling and retaining 315 Māori on health-related career pathways. To date, the Central Region has a total 1119 registered Māori enrolments, of which 777 registrations are Māori attending secondary Schools.

Key regional initiatives undertaken in 2012/13 have been:

- Rangatahi stream at Tū Kaha Conference
- engagement with Secondary Schools
- supporting stronger intersectoral relationships between health, secondary schools and tertiary institutions

- Involvement with Career Expos
- Identification of existing mentor programmes and developing a process for linking registered users to career advice, mentors and scholarships.

This year a business case was developed for the National Co-ordination Centre and four Regional Hubs. The Ministry of Health has agreed to extend the programme for another three years concentrating on Māori who are currently studying at secondary (aged 13 - 18) or at tertiary levels, in work and in the community.

TIKANGA E-LEARNING

The Tikanga e-learning assessment was developed in January 2010. It is an effective online learning tool that is available to staff within the organisation. Out of the 94 e-learning tools available at CCDHB, Tikanga is currently rated as the 4th most accessed.

Since its development, 3292 CCDHB staff have gained a pass rate of 80% or higher. During 2012/13, 812 accessed Tikanga e-learning with 692 achieving a pass rate.

TIKANGA MĀORI EDUCATION

The Tikanga Māori sessions have had consistently high attendance rates during the past 12 months. Total attendance numbers for 2013 were 685 compared with 628 in 2011. In comparison to 2011, staff numbers have remained consistently higher after promotion strategies were implemented in January 2012. This trend has continued.

The high demand has led to the training being offered externally to other health professionals across the DHB region as well as University of Otago's 4th year medical student Hauora programme and Victoria University post-graduate nursing programme.

TU POUNAMU NETP NURSE INITIATIVE

The Tu Pounamu NETP Nurse Initiative is an innovative Māori workforce development pilot programme spanning the NETP's first intake (January 2013 – January 2014). The initiative is in partnership with the Director of Nursing & Midwifery Office, Child Health and Ora Toa Health Services.

Key aims of the pilot are:

- improving health outcomes for vulnerable population groups, such as Tamariki and Rangatahi
- evolving an integrated service model of care with Whānau Care Services (WCS)
- providing programme content specifically related to areas of highest need for Māori whānau, i.e. child health
- creating opportunities to develop collegial relationships right across the whole DHB, i.e. child health hospital and community services and Ora Toa Health Services
- improving mainstream responsiveness ensuring positive health outcomes for Māori.

The initiative better aligns WCS to an integrated service model so responses are strengthened, improving health outcomes for Māori and achieving 'better sooner more convenient' contact with our high risk whānau. The 12 month pilot has been hugely successful identifying partnerships with our community, primary and secondary colleagues with smarter more streamlined ways of working.

The initiative has involved MHDG supporting a WCS placement of a New Entry To Practice Nurse (NETP) and assisting that nurse in their first year from a new graduate to a competent skilled professional nurse within a cultural specialty framework. The partnership between WCS, Child Health and Ora Toa Health Services has enabled enhanced engagement of our hard to reach whānau, better implementation of whānau ora, improved service integration and service delivery improvements.

WHĀNAU CARE SERVICE (WCS) - SERVICE INTEGRATION AND ALIGNMENT

In November 2011 a Service Plan moving WCS towards an integrated service delivery model was signed off and implementation commenced July 2012. Key outcomes of realigning WCS are:

Strengthen service delivery by:

- extended hours (8am - 6pm Monday to Friday)
- formalised on call roster
- establishment a multi-disciplinary patient centred team approach that is strengths based reflecting workforce skills and skill set
- standardising referral management and data collection process
- supporting Māori outpatient attendance through targeted approach appointment reminding and DNA follow up
- implementing a Whānau Care Service workforce development plan

Greater and early uptake by Māori of primary health services by:

- working with cardiac, child health and Allied Health services as well as primary care to streamline engagement, knowledge translation (health literacy) and strengthen mainstream responsiveness
- Reduction in re-admissions from inappropriate discharge planning and follow up
- strengthening current service delivery within cardiovascular, child health, and medical services to improve community and primary integration and outpatient appointment attendance.

MĀORI OUTPATIENT APPOINTMENT ATTENDANCE SUPPORT

WCS participation in the 'Did Not Attend Outpatient Appointment' initiative has enabled the service to better understand how to smartly apply resources to get different results. Two key activities have been undertaken this year. Firstly, a six week pilot phoning all Māori with outpatient appointments in targeted priority outpatient clinics. Secondly, identify high risk clinics with Māori DNA.

Key service improvement initiatives have been implemented as a result, these include:

- WCS staff providing outpatient reminder calls to all Māori with outpatient appointments three days prior to that appointment in Cardiac and targeted Child Health clinics
- sharing lessons learned from patients and whānau to inform service improvement or streamlining, for example, breaking down attendance barriers, unclear information regarding appointment, accurately recording appointment change results
- establishing process and protocols to follow up on Māori who DNA clinics as close to the event as possible
- WCS clinical staff target repeat DNA patients for speciality support
- liaison with primary services to support high risk patients to attend outpatient clinics
- support of services exploring initiatives to reduce Māori DNAs
- monthly tracking of Māori DNA across all outpatient clinics
- partner with the Ministry of Health and Workbase to review the health literacy environment for DNAs within CCDHB.

Valuable information arising from these initiatives has led to continued refinement of WCS capability to support services to better and sooner respond to Māori DNA, thus improving Māori outpatient appointment attendance.

Pacific Health

During the past year Pacific Health Services spent a lot of time focussing on reducing Do Not Attend (DNA) rates for Pacific people. A six month pilot project identified the four highest Pacific DNA rates in the renal, diabetes, ear nose and throat and paediatric clinical directorates. The Pacific Health Unit, Patient Administration Services, Pacific Navigation Service and the Pacific Radio Programme have collaborated to ensure Pacific communities receive adequate information, follow up and contact to ensure they attend their appointments. The reduction of DNA in these directorates has been successful and sustainable.

Kapiti students get an inside look at a career in health

The Pacific Directorate hosted the first Health Science Academy workshop in May 2013 when more than 50 students from Kapiti and Paraparaumu Colleges got an inside look at a career in health. The purpose of HSAs is to build future workforce with a strong focus on building interest amongst Māori and Pacific students to consider and achieve in science subjects that would lead to a career in health.

Kapiti and Paraparaumu are the first colleges to establish HSAs in the Wellington region, and a third academy, based in Porirua, is currently being worked towards with youth employment NGO Partners Porirua.

Director of Pacific Health Taima Fagaloa says HSAs are all about supporting young people. These academies align with CCDHB's commitment to increase its Māori and Pacific Island workforce.

"We want a specific focus on growing that workforce, which is supported by Health Minister Tony Ryall through the Aka Mo'ui Pathways to Pacific Health and Wellbeing Strategy, and He Korowai Oranga: Māori Health Strategy," says Taima.

"Both strategies reinforce the Minister's commitment to growing the Māori and Pacific workforce, which acknowledges the increase in these populations, as well as the significant health disparities experienced by Māori and Pacific people.

Quality Improvement and Innovation Awards 2012

The Quality and Risk Unit was proud to host the Quality Improvement and Innovation Awards last November. These awards provided a great opportunity to encourage, support and celebrate innovative project work across the region. It was also a chance to highlight the collaborative approach services are taking to reduce pressure on hospital services and improve our population's health.

With more than 60 applications from hospital staff and General Practices, the Supreme Award winner was CCDHB's Patient Administration Services, led by Darlene Natoli.

Persistence and hard work saw the team establish and maintain a centralised booking office that also provides an organisational process in order to address non-attendance of appointments and long waiting lists.

Not only have they significantly improved the quality of the service they provide, PAS has also been able to successfully work with stakeholders across primary and secondary care to develop efficient systems for vulnerable and hard to reach patients.

One example of this was Pacific Island patients, who were noted as having poor attendance at ENT and Diabetes clinics. The outcome of the team's four month focus on this group was a 20% reduction in non-attendance.

Patients' needs are now being met in a more timely manner and their anxieties are being addressed, resulting in a reduction of waiting times and earlier intervention - all contributing to improved patient outcomes and avoiding greater cost of care delivery.

Supreme winner of the 2012 Quality awards was the Patient Administration Service (PAS). Team Leader Darlene Natoli, right, accepted the award and is pictured with PAS Operations Manager Chris Bennet, left, and Executive Director of Clinical & Corporate Support Kelvin Watson.

Quality Improvement and Patient Safety

The Quality team continue to enhance processes throughout CCDHB in order to provide better, faster and safer care to patients. A number of policies have been reviewed, edited and published in-line with our renewal programme. The renewal programme is the method we use to ensure that policies are up-to-date and relevant to the organisation. Additional focus has been given this year to align our policies with colleagues at Hutt Valley and Wairarapa DHBs. This is to ensure that patients see and receive a consistent level of service if they transfer between locations and so that similar standards are in place for staff who work at different locations.

Our data capture process, analysis and reporting of adverse events continues to improve in-line with expectations of our patients and their families. We are investigating new IT tools to ensure we are capturing the process and the insights that we need to drive further improvement. To this end we have implemented an internationally recognised process called the Global Trigger Tool. This will enable us to gain clinical insight to possible causes of harm and, along with adverse event reporting and adverse drug event tools, will help us further improve our service performance.

Adult inpatient surgical wards continue to show a considerable reduction in pressure area occurrence, following on from the 2011 National Pressure Area Audit in November 2011, and the instigation of the Pressure Area Improvement Plan for Surgical Wards in 2012.

The Surgery, Women's and Children's Directorate continues to benchmark clinical practice through Australian Council on Health Care Standards Clinical Indictor Programme. Clinical indicators were submitted for cardiothoracic, ENT, ICU, obstetrics, gynaecology, paediatric surgery, paediatric immunisations, and urology. The services all benchmarked favourably with peer group services and outcomes.

CONSUMER EXPERIENCE

Engaging our consumers in their care plans has continued to be a focus this year and we strive to respond to every complaint and compliment received. All complaints are investigated and appropriate actions are taken to fix any underlying problems. Compliments are passed on to staff as everyone benefits from hearing the good news stories.

It is planned that an on-line Consumer Survey will be launched early in 2014 to enable us to quickly receive feedback about the quality of care we provide. This formal mechanism for recording and reporting patient experiences will provide an opportunity for consumer engagement, collect information that will drive improvement in quality of care and provide consumer experience indicator information for staff, the Board, HQSC, and the Ministry of Health.

Patient Safety

Making patient safety the top of the agenda and continuously building and strengthening our safety culture has been a major focus in the last year.

We have aligned our DHB's patient safety work programme - and our two key strategies 'Zero Patient Harm' and 'Patient and Whānau Centred Care' - with the Health Quality and Safety Commission's patient safety campaign, 'Open for Better Care', and we are working closely with other Central Region DHBs.

We continue to share safety improvements from adverse events with our staff and other health providers across New Zealand, using patient safety newsletters, learning reports and Grand Rounds as ways to circulate learning.

We continue to offer our communication skills development programme to enable staff and services to develop their skills in an area that is

Staff Recognition Awards

In 2012, CCDHB held the inaugural Staff Recognition Awards honouring staff members who had worked here for 25 years or more.

There were over 280 people recognised from all areas of the DHB at sites across the region. The awards have become a great way to acknowledge people who have worked for the DHB for extended periods of time and remained committed to serving the community.

Due to the high number of people needing to be recognised, award ceremonies took place in both Kenepuru and Wellington Hospitals.

Employees who have worked for the DHB for between 20 – 25 years will be recognised in September 2013.

well recognised to impact hugely on patient safety and experience. We offer expert analysis, advice and leadership for patient safety issues and risks, as well as interactional competence and open communication situations.

Some recent initiatives include introducing RMO patient safety forums where junior doctors have a safe and open forum to learn about patient safety and to discuss solutions patient safety issues that they experience.

We have worked with Hutt Valley and Wairarapa DHBs to develop one policy for incident management across the three DHBs. The patient safety officer has a vital role in challenging the organisation to ensure patient safety and areas of concern are tackled and dealt with.

Learning, Development & Research

With the implementation of a new strategy, the Learning Development and Research (LD&R) Group underwent a restructure to greater align itself with the needs of the organisation and delivery of the strategy.

This included the learning portfolio project, which saw these portfolios having the potential to identify mandatory and recommended training, with key performance data to ensure workforce development targets are achieved. The learning portfolios will also identify the cost benefits for the organisation and enable a mandatory training policy to be developed.

LD&R Group's core services, such as CPR and IV therapies training, continue to receive positive feedback along with the new programmes being established. New programmes include:

- **LEADERSHIP CAPABILITY** - a key focus over the past year was to overhaul the existing front line leadership programmes and start a new project relating to management essentials. The foundation programme has been provided to the cancer care network, with the introduction of a competence assessment tool for the new cancer care co-ordinator roles that has achieved regional and national recognition.
- **EDUCATION QUALITY** - a pilot programme was successfully completed with the Academy of Medical Educators forum that provided a structured approach to capability development. Plans are in place to launch the programme for all CCDHB educators.
- **GENERIC ORIENTATION** - attendance and record keeping has been successful in its implementation with an RMO specific orientation programme in place to meet their needs. A plan has been approved towards developing a multimedia approach for new staff, that enhances orientation and reduces non-clinical time.
- **SIMULATION AND SKILLS EDUCATION** - the simulation centre has been refurbished with a number of improvements made, including introduction of new mannequins, development of new courses and the introduction of in-situ training that support simulation training in the workplace.

The growing demand for eLearning across the DHB and the region has led to the LD&R Group reviewing its current eLearning platform. Plans are in place to provide an integrated approach to eLearning delivery to be developed. In addition, the learning management systems aim to support greater regional collaboration, alignment and cost effectiveness by sharing resources effectively and removing duplication.

Regional collaboration continues with an learning and development managers' network being established to identify examples of best practice.

A focus for the region is effective sharing of eLearning resources. The group continues to receive positive feedback and overwhelming support for collaboration.

Research Office

Since opening in June 2010 the Research Office has registered and supported 458 clinical trials and research projects. Statistical clinics in collaboration with University of Victoria continue to be a huge success providing statistical support and training to CCDHB staff. The first CCDHB research report is being published this year and will provide an overview of our research related activity and accomplishments.

The past year was another success for the Clinical Trials Unit, which continues to develop and grow. The unit now has a number of clinical trials conducted in collaboration with the Rheumatology Department at Hutt Valley DHB; the University of Otago; Medical Institute of Research, the Malaghan Institute, and other universities on several research projects and HRC grants.

Legal Services: Privacy Awareness Week

In May the Office of the Privacy Commissioner ran its annual Privacy Awareness Week which aims to raise awareness of the importance of keeping data secure and using it responsibly. CCDHB's legal team decided to run an internal campaign during this week to raise awareness of the importance of using patient information responsibly, especially when searching records.

The campaign included a series of posters using famous slogans and images to engage the target audience, a privacy awareness quiz, regular updates on the intranet and stories within the staff monthly newsletter. The staff canteen was also used for the first time with posters and information displayed, cafeteria food was given 'special' privacy awareness names and members of the legal team were on hand to discuss any concerns staff may have.

The aim was to get staff thinking about what is a breach by giving them real examples of when breaches had occurred and the consequences. It was also important that people were given the opportunity to ask questions. All questions were gathered and responded to in the staff newsletter.

The quiz was well received with over 600 staff members taking part. The campaign also received really positive feedback, with the majority of staff feeling more informed about what to do if a possible breach has occurred and what is considered a breach.

Drop, cover, and hold

Many staff took part in the first "NZ Shake Out" – a national earthquake drill in which Civil Defence wanted a million people across the country to 'drop, cover, and hold' at 09:26am 26 September. They exceeded their target, and the Wellington Region performed particularly well.

Within CCDHB, staff participation in the pre-event activities and in the drill itself was very encouraging and higher than expected.

Hospi takes shelter under his desk.

Emergency Management Service

Preparing staff to cope in unexpected situations remains the focus for emergency services. As it had been a number of years since emergency services in Wellington have had to deal with a mass casualty incident, an exercise was planned in order to test staff and services, so that we remain ready should this type of scenario occur.

Exercise 'Fairlie' provided an opportunity for a number of staff across a variety of clinical areas to work with Wellington Free Ambulance and Police to test their emergency procedures.

The scenario was based on a mass shooting at a tertiary education facility. While it was a very good (and very reassuring) test of the incident management and casualty treatment procedures, it also highlighted a number of special issues that need to be considered when dealing with casualties who are foreign nationals and victims of a criminal act.

Technical Services

The ripples of the 2011 Canterbury earthquakes continued to be felt with a significant time investment in the assessment of the seismic integrity of Capital & Coast's buildings and all 72 DHB owned buildings have now had an initial evaluation completed. A small number of buildings will require additional seismic improvement works to lift them to the desirable level. Currently the biggest project in this area is the Clinical Services Building Stage II seismic project. Seismic projects will continue through the 2013/14 year.

The Board has endorsed one of the most challenging but empowered energy management programmes in the Healthcare sector, with a 10% energy reduction target for the 2013/14 year and a 40% energy reduction target by 2021.

Using the new international standard ISO 50001 as the framework, which is considered as the world's best practice, The Energy Efficiency and Conservation Authority (EECA) has endorsed this work by supporting the DHB with access to low interest crown loans and grant schemes.

There has also been a surge in interest in sustainability practices from staff, culminating in the formation of a Sustainability Group and a number of people from areas across the DHB helping lead our move towards more sustainable practices around energy and waste.

Capital Works has undertaken a large number of projects to support clinical service delivery and organisational priorities. Some significant achievements are:

- Work started on the new Renal Dialysis unit at Kenepuru Hospital, which is due to be completed in February 2014.
- Modification of the Rangatuhi Building at Kenepuru to become the Te Arhue Youth ID facility, including significant seismic upgrading of the structural slab and a new Sally Port.
- Relocation of the Te Haika call centre to the Staff Residence Building at Kenepuru.
- Construction of 14 new beds in the Wellington Regional Hospital to assist with meeting our acute patient flow. This began in January and was completed in July 2013.

There has also been significant investment in our Facilities Management plumbing and carpentry teams and in a number of other technical areas, which has enabled CCDHB to take on more core work with a reduction in cost to the DHB. The Facilities Management is continuing to develop fit for purpose asset management and plant maintenance strategies.

On a national level our Clinical Engineering Manager is participating in the National Clinical Engineering Advisory Group, working with HBL and Medsafe to ensure that the best approach is taken with respect to clinical devices and to align DHB strategies for managing this equipment to asset management policy and plans and resourcing.

Information and Communication Technology

ICT has had a significant year of achievements in supporting regional and sub-regional initiatives, as well as internal work. It has also been a year of change with the start of the convergence of the 3DHB's Information and Communication Technology teams.

The formation of the Information, Privacy and Security Group has provided structure and support to the management of key security matters as security continues to be a key focus for the DHB.

A number of ICT projects have been completed to support the Minister's initiative of Better, Sooner, More Convenient healthcare delivery. This includes the Referral Management Module for Outpatients and Allied Health, which offers a number of benefits including more accurate data capture and reporting, as well as an ability to view and better manage a patient's full care plan and referrals in real time.

Other key projects include Electronic Results Sign Off, Occupancy at a Glance and the provision of wireless access for patients and their visitors, and staff. This has been a great success.

CCDHB has had significant input in supporting the CRISP activities, especially regional work which involves a standardised:

- Patient Management system
- PACS system (Radiology Imaging)
- Clinical Workstation (standard application desktop view across the regional DHBs)
- development of a Regional Service Delivery model which is led by CCDHB
- development of a Regional Infrastructure platform

Transport

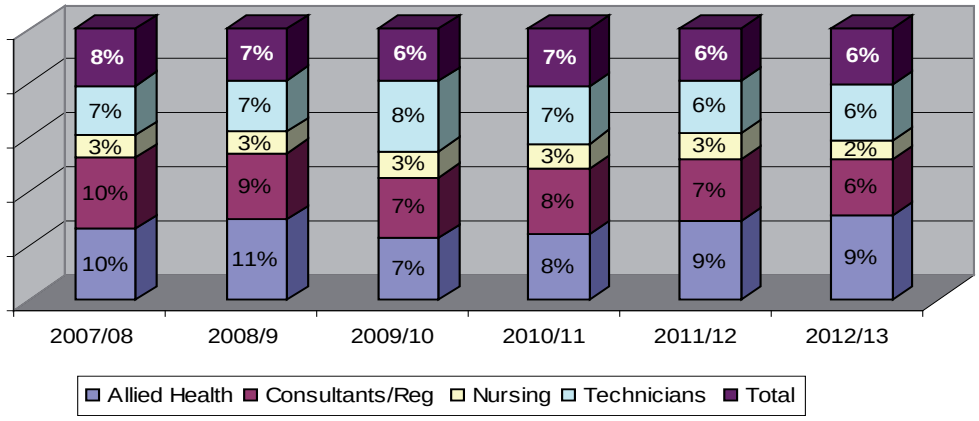
In 2012/13, the Transport Service introduced an initiative to review its vehicle resource through the Bishop Fleet Optimisation report. This report was a snapshot of individual fleet vehicle use over a limited period and resulted in the reduction of nine leased vehicles from the fleet, with other vehicles being re-allocated to new services where a new vehicle resource was needed. As a result of this initiative, Transport is now in a much better position to assist services manage their vehicle resource better through the effective monitoring of mileage and associated running costs.

Patient Administration Service

NON-ATTENDANCE RATES

Our non-attendance rate for the last financial year was 6% overall. We have maintained this rate for the last two financial years due to a number of strategies that were put in place.

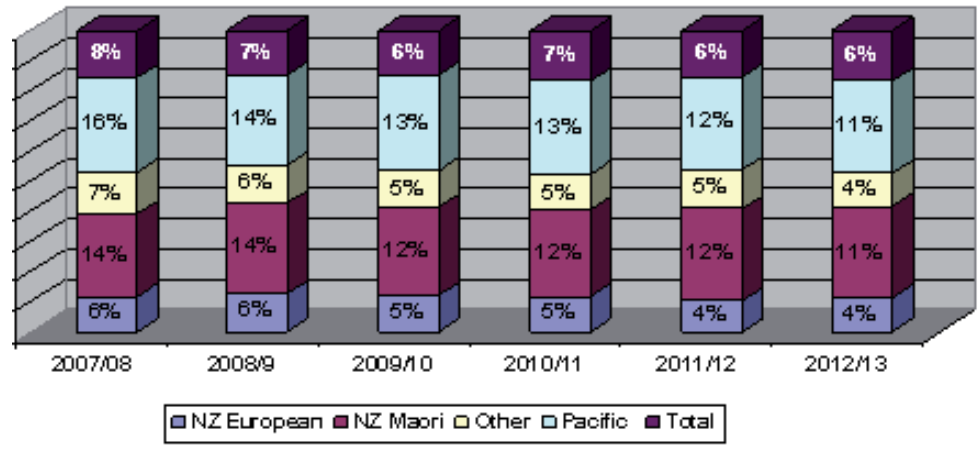
DNA Rates by resource



An organisational project was set up last year to make further improvements to attendance rates specifically in Māori and Pacific Island patients as the rates for this group have been historically higher than NZ European and other rates. The DNA project group identified a number of innovations and improvements and these will be implemented in the coming year. There is also a Health Literacy project underway focussing on Māori Health.

Māori and Pacific Island non-attendance rates were both 11% averaged across the financial year compared with 12% in the previous year.

DNA Rates by ethnicity



QUALITY AND INNOVATION

The Outpatient Booking Centre team won the Quality and Innovation Supreme award for the work that they have done to improve booking within the Ministry targets and the steps that have been put in place to improve attendance rates.

E-REFERRALS FROM GENERAL PRACTITIONERS

Phase 2 of this project is fully implemented and referrals are being received electronically from most Primary care practices. The system generates an automatic acknowledgement to the General Practitioner when the referral arrives. The next Phase of the project will allow the referrals to migrate to the Clinical Document Viewer.

REGIONAL / SUB-REGIONAL COLLABORATION

Working with Hutt Valley Health or other DHB's on the following projects from an administration perspective:

- Call Centre
- Outpatient Booking
- U Book
- DSU reporting for follow-up work
- Faster Cancer targets
- Colonoscopy regional process for shared waiting lists
- ENT sub-regional booking to achieve equity
- 3 DHB Radiology project to work towards a regional service
- CRISP WEBPAS and Clinical Portal groups

A number of planning workshops have been set up for CRISP. The purpose is to validate and agree the business requirements for each WEBPAS module across the six DHB's. The system is currently in the design phase and requires a shared approach by both administration and ICT staff. We are currently working with the vendors to negotiate improvements to the systems prior to the regional system being implemented.

MEDICAL RECORDS STRATEGY

A medical records strategy has been put in place to assist the organisation to move from paper records. With implementation of the electronic systems it is essential that we continually review processes and ensure that business opportunities are maximised to reduce duplication of electronic and paper information. We need to encourage use of the electronic systems so that they become the main source of patient information, particularly if the intention is to share electronic information with primary care and other district health boards as part of the CRISP project.

Procurement & Supply Services

Procurement & Supply Services has grown to efficiently deliver centralised non-pharmaceutical procurement across the DHB for clinical, ICT and corporate procurement. It has a greater presence in negotiations and overall governance and through initiating clinical product changes, financial and process savings have been gained.

A revamped Forward Procurement Programme has been developed and will align with healthAlliance as well as Waikato and Canterbury DHBs. This will improve access to financial outcomes through greater leverage in volumes. Procurement is also engaged at a national level with Health Benefits Limited.

Imprest Services within Supply Chain has continued to revamp its internal replenishment processes. This has resulted in less stock being held on-site, and a greater range of items being ordered through the Oracle imprest based replenishment process.

Improved procurement planning, processes and templates continue to be a priority. This ensures items over $100k, and at times, significant items under $100k have a procurement plan completed which includes risk assessments, mitigation plans, detailed market and category analysis.

Through participation in national and regional initiatives CCDHB achieved annual savings in 2012/13 of $5.1m. These are on a par with the $5.3m saved in 2011/12. A large majority of these savings came through CCDHB internal initiatives, supported to a lesser extent by savings from HBL and 'All of Government' initiatives. It is anticipated this figure will grow during 2013/14 as financial benefits from national and regional initiatives come into place.

Clinical Product Advisors continue to work closely with all clinical services standardising medical consumables and finding less expensive but clinically acceptable alternative products.

Since December 2012 CCDHB has provided procurement services into Hutt Valley DHB (HVDHB) and to a lesser extent Wairarapa DHB. This has allowed for a greater alignment of procurement planning and by June 2013 additional savings of $290k to HVDHB.

STATEMENT OF SERVICE PERFORMANCE

The Statement of Service Performance describes the DHB's non-financial performance and provides an indication of how well activity over the past year contributed to improving the health and well-being of the local population.

The Statement of Service Performance also measures operational performance, ensuring the DHB is delivering sustainable and quality services effectively and efficiently. The Statement of Service Performance reports against targets outlined in the DHB's Statement of Forecast Service Performance in the Annual Plan and Statement of Intent. One of the functions of the Statement of Service Performance, as stated in the Crown Entities Act (s142) is to show how what Capital & Coast DHB did in 2012/13 is measured. These performance measures, targets and milestones are subject to annual audit by auditors appointed by the Office of the Auditor General.

The performance measures include national measures, which are consistent across all 20 DHBs, along with local measures and associated targets. The measures presented are intended to provide a picture of access to services, timeliness of service provision and the quality of care being provided, in order to enable evaluation of performance over time. In determining the set of performance measures, we have focused on our identified health gain priorities, the transformation we are seeking to achieve and the expectations of the Minister of Health. The national 'Health Targets' are the measures that reflect the Minister of Health's expectations for 2012/13, and these are mixed through the Statement of Service Performance.

While the DHB is a provider of hospital and specialist services, we are also the funder of services for our community and work in partnership with other health and disability service providers, external agencies and organisations to collectively improve the health of our community. As the funder, we are often reliant on a third party to deliver the outputs needed to achieve the desired outcomes or objective, and our role is in influencing and enabling change through partnership, leadership and supportive contracting. A number of the associated performance measures in the 2012/13 Statement of Forecast Service Performance were chosen to provide an indication of the success of that collective and collaborative approach.

In the performance tables, each measure has a "key" which indicates the type of measure: coverage (C), Timeliness (T), Quality (Q) or Volume (V). 2011/12 comparative information is provided with measures where available.

PERFORMANCE INTERPRETATION

The tables on the following pages have the achievements against targets for each of these output classes. These have been categorised according to the table below:

Achievement	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.

This Statement of Service Performance has been grouped into four output classes. These groupings enable us to provide an overview of the services for which the DHB is responsible or accountable. The four output classes applied across all 20 DHBs are outlined below.

PREVENTION SERVICES (PUBLIC HEALTH SERVICES)

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

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and equality in health status is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protection services such as immunisation and screening services.

EARLY DETECTION AND MANAGEMENT (PRIMARY AND COMMUNITY HEALTH SERVICES)

Primary and community health care services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

INTENSIVE ASSESSMENT AND TREATMENT (HOSPITAL SERVICES)

The hospital services output class comprises services that are delivered by a range of secondary, tertiary and quarternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable collocation of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

REHABILITATION AND SUPPORT (SUPPORT SERVICES)

Support services comprise services that are delivered following a 'needs assessment' process and co-ordination input by Needs Assessment Service Co-ordination Services for a range of services including palliative care services, home-based support services and residential care services.

FINANCIAL PERFORMANCE (000's)

Revenue	2011/12	2012/13 Budget	2012/13 Actual
Prevention	8,516	8,642	7,768
Early Detection and Management	175,275	185,675	183,476
Intensive Assessment and Treatment	632,997	629,611	667,115
Rehabilitation and Support	102,534	99,705	100,861
Total	**919,322**	**923,632**	**959,220**

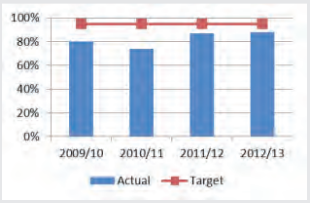
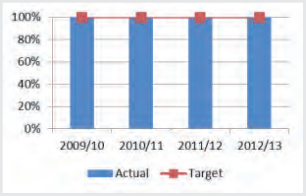
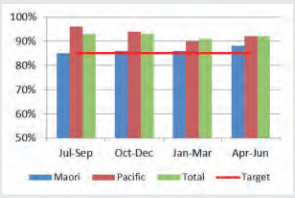
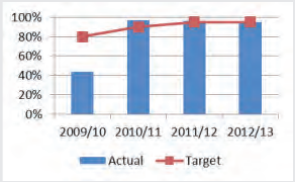
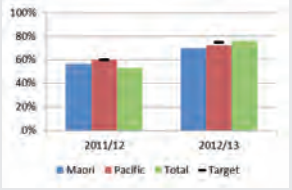
Expenditure	2011/12	2012/13 Budget	2012/13 Actual
Prevention	8,516	8,062	7,871
Early Detection and Management	175,277	182,618	183,481
Intensive Assessment and Treatment	652,366	644,684	678,407
Rehabilitation and Support	103,107	98,282	100,235
Total	**939,267**	**933,646**	**969,994**

Performance Highlights

In 2012/13 CCDHB maintained high performance in areas of achievement and progressed work to improve the health of the CCDHB population. CCDHB has made good advances in reducing disparity and increasing access for vulnerable populations, such as the increase in cardiovascular risk assessments, mental health access, immunisation, and adolescent utilisation of dentists.

- 92% of eight month olds had received their scheduled immunisations in 2012/13. Immunisation rates are 88% for Māori, 92% for Pacific and 89% for children living in deprived areas, exceeding the national target of 85%.
- CCDHB also continues to perform well for immunisation at two years, with 93% of children fully immunised for Total, 91% Māori, and 94% coverage for Pacific.
- CCDHB provided advice to help quit to 96% of people who smoke and were admitted to hospital in 2012/13.
- CCDHB PHOs have achieved the 75% national target for cardiovascular risk assessments with 76%, and the DHB is placed third nationally. This represents an increase of 23% from 2011/12, and 16,074 risk assessments completed by primary care in 2012/13. This is a significant volume for primary care and reflects the hard work of Compass Health, Cosine PHO, Ora Toa PHO, and WellHealth Trust.
- People in CCDHB are less likely to be admitted to hospital for an avoidable condition compared with national rates. Avoidable hospitalisation rates have improved for some population groups, particularly children and Māori, in 2012/13.
- 71% of adolescents received free dental care from a DHB funded community dentist. This is an increase of 9% (1117) from 2011/12.
- 8,360 elective surgeries were delivered to the DHB population in 2012/13; above what was planned and 494 more than in the previous year.
- Wellington Cancer Centre continues to provide a high quality service with 100% of patients ready for treatment receiving radiotherapy or chemotherapy within four weeks.
- More people accessed specialist mental health services. Three percent of the population are estimated to require specialist mental health services and CCDHB has achieved 3.19% in 2012/13.
- The percentage of residential care providers meeting three year certification standards has increased from 84% in 2011/12 to 90% in 2012/13.

Minister's Health Targets

Health Target	Description and 2012/13 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. 2012/13 Result: 86% **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. CCDHB's target was 8272 discharges in 2012/13. 2012/13 Result: 8360 (101%) **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. 2012/13 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. 2012/13 Result: 92% **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. 2012/13 Result Hospital: 96% Primary Care: 66% **Output Class: Prevention Services**	**Hospital**  **Primary Care** 
Better diabetes and cardiovascular services 	75 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. 2012/13 Result: 76% **Output Class: Early Detection and Management**	

Prevention Services

HEALTH PROMOTION AND EDUCATION SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: The percentage of smokers hospitalised and given advice to quit	C	96%	95%	96%	Achieved
Health Target: The percentage of smokers enrolled in PHOs receiving advice to help quit	C	54%	90%	66%	Not Achieved
Minimum number of house insulation installations for low income residents with long-term respiratory or circulatory conditions	V	351	200	296	Achieved
The percentage of infants exclusively or fully breastfed at 6 weeks	C,Q	70%	74%	72%	Not Achieved
Māori		63%		64%	
Pacific		57%		58%	
The percentage of infants exclusively or fully breastfed at 3 months	C,Q	62%	57%	64%	Partially Achieved
Māori		54%		53%	
Pacific		44%		48%	
The percentage of infants exclusively or fully breastfed at 6 months	C,Q	35%	27%	34%	Partially Achieved
Māori		28%		22%	
Pacific		19%		19%	

Commentary

The DHB continues to provide advice to quit to over 95% of smokers who are hospitalised. In 2012/13 the percentage of smokers enrolled in PHOs receiving advice to quit did not reach the 90% target, however rates did increase by 12%, or 3262 patients.

Breastfeeding rate targets have been partially achieved. While the DHB did not achieve targets for all population and age groups some gains have been made, particularly for total and Pacific populations at six weeks and three months. Breastfeeding has been shown to improve the health of the child, therefore improved breastfeeding rates are positive and will help improve health outcomes for the children who are breastfed.

POPULATION BASED SCREENING PROGRAMMES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The percentage of eligible women having cervical screening in the last 36 months [1]	C	80%	75%	81%	Achieved
The percentage of eligible women (50-69) having breast screening in the last 24 months	C	68%	68%	69%	Achieved

Commentary

Targets for cervical screening and breast screening for eligible populations have been achieved in 2012/13. Work continues to improve knowledge about screening programmes and to raise awareness in high need communities.

WELL CHILD, WELL SCHOOL SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Number of visits to schools by health nurses	V	2,859	3,363	2,369	Not Achieved
Percentage of eligible children receiving a Before School Check	C	80%	80%	77%	Not Achieved
High needs		80%	80%	82%	Achieved

Commentary

There has been improved practice around data capture and a new system has been implemented to ensure data quality. Within the total 3724 visits occurring across Hutt Valley and Capital and Coast, there were 491 home visits and 960 visits relating to the Rheumatic Fever Programme in Porirua. Home visits are based on school referrals and require a large time investment from the nurses. This measure has been changed for 2013/14 to better reflect what is accurately captured in data systems.

[1] *Data from the National Screening Unit for the three years to 31 March 2013. The National Screening Unit has revised the methodology and eligible age group for this measure based on international best practice, therefore the age group is 25-69 rather than the previous 20-69.*

IMMUNISATION SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: The percentage of 8 month olds fully vaccinated	C	New measure in 2012/13	85%	92%	Achieved
The percentage of two year olds fully vaccinated	C	94%	95%	93%	Not achieved
The percentage of enrolled people over 65 years vaccinated against flu	C	66%	67%	69%	Achieved
High Needs		65%	66%	66%	Achieved

Commentary

Capital & Coast DHB has exceeded the Ministry of Health target of 85% of children fully immunised by 8 months by June 2013. Performance for the year to 30 June 2013 is 92% total, 88% Māori and 92% Pacific. CCDHB also continues to perform well for immunisation at two years, with 93% of children fully immunised for Total, 91% Māori, and 94% coverage for Pacific.

Early Detection And Management

PRIMARY HEALTH CARE SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The number of CCDHB domiciled population enrolled in a local PHO	V,C	271,257	272,488	273,388	Achieved
The percentage of children enrolled with a PHO by 8 weeks of age	C,T	New measure in 2012/13	85%	65% [2]	Not achieved
The ratio (high need: non high need) of standardised GP and nurse utilisation	V	1.09	≥ 1.06	1.07	Achieved

Commentary

The number of CCDHB domiciled population enrolled in a local PHO has increased by 2,131 in 2012/13. Māori enrolment has increased by 4.5% from baseline (January 2012), improving enrolment rates for Māori 0-4 and 15-24. As Māori children have historically had low rates of enrolment this is a positive result.

The percentage of children enrolled with a PHO by eight weeks of age is a measure still under development by the Ministry of Health, and data is only presently available to quarter 3. The DHB expects rates will improve as work is advanced in this area.

[2] *Data period 19 November 2012 to 19 February 2013*

PRIMARY AND COMMUNITY CARE PROGRAMMES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The percentage of diabetics receiving an annual check	C	83%	69%	68%	Not Achieved
Health Target: The percentage of eligible people assessed for CVD risk	C	53%	75%	76%	Achieved
The percentage of the PHO enrolled population enrolled in CarePlus	C	5%	5%	6%	Achieved
The percentage of diabetics checked with HbA1c less than or equal to 64 mmol/mol	Q	72%	72%	73%	Partially Achieved
Māori		58%		65%	
Pacific		52%		55%	
The percentage of practices with a diabetes care improvement plan	Q	New measure in 2012/13	90%	Implementation delayed to 2013/14	
The standardised discharge ratio of ambulatory sensitive hospitalisations age 0-74 [3] Total	CQT	88	<95	87	Achieved
Māori		91		85	Achieved
Pacific		96		99	Not Achieved
The standardised discharge ratio of ambulatory sensitive hospitalisations age 0-4 Total	CQT	91	<95	77	Achieved
Māori		100		87	Achieved
Pacific		114		101	Not Achieved
The standardised discharge ratio of ambulatory sensitive hospitalisations age 45-64 Total	CQT	86	<95	88	Achieved
Māori		81		80	Achieved
Pacific		92		97	Not Achieved

Commentary

Diabetes annual reviews and management – Target for diabetes annual reviews has not been achieved for the total population, however it was for Māori and Other populations. There has been an improvement in the percentage of diabetes who have satisfactory control in 2012/13, however target was not achieved. Positively, the rates for Māori and Pacific have improved, reducing disparity. It is to be acknowledged that improving diabetes management is complex and empowering patients to self-manage is part of what is needed to improve rates.

Reduced Ambulatory Sensitive (Avoidable) Hospitalisations – Avoidable hospitalisation rates have improved for Māori at all ages and for children. Rates for Pacific 45-64 have slightly increased, resulting in an increase to the 0-74 rate; however, rates for Pacific children have decreased from 114 to 101.

Health Target: Cardiovascular risk assessments – Capital & Coast DHB's PHOs have made gains of 23%, meeting the national target for the percentage of eligible populations having received a cardiovascular risk assessment in the last five years. This equates to 16074 risk assessments completed in 2012/13. This has been a focus of their work in 2012/13, and they are well placed for the increase in the target to 90% for 2013/14.

[3] *Data year to March 2013 for ambulatory sensitive hospitalisations.*

ORAL HEALTH SERVICES [4]

Measure	Key	2011 Performance	2012 Target	2012 Performance	Achievement
The percentage of children under 5 years enrolled in DHB funded dental services	C	40%	68%	41%	Not Achieved
The percentage of children 0-12 years not examined according to their planned recall period	T	18%	18%	18%	Achieved
The percentage of adolescents accessing DHB funded dental services	C	62%	61%	71%	Achieved

Commentary

The percentage of children under 5 years enrolled in DHB funded dental services did not reach target of 68% in 2012. There are number of planned actions under development for 2013/14 to improve enrolment of eligible children into the Bee Healthy Regional Dental Service, for example:

- Enrolment from birth. Once in place parents will be invited to "opt-out" of the service if they choose rather than the current "opt-in" process of enrolment.
- Increase options for the public to enrol such as website, when visiting the doctor and when engaging with other child services.
- Targeted enrolment initiatives.

In 2012/13, 71% of adolescents received free dental care from a DHB funded community dentist. This is an increase of 9% (1117) from 2011/12. A proposed "opt-out" Adolescent Oral Health transfer system has been developed and is due to be implemented mid-September 2013, which will improve the transition from the Regional Dental Service to a community dentist.

COMMUNITY REFERRED TESTING AND PHARMACY SERVICES

Measure	Key	2011/12 Actual	Expected volume [5]	2012/13 Actual	Achievement
The number of community pharmaceutical items dispensed	V	3,300,858 [6]	3,570,000	3,356,717 [7]	Achieved
The number of community laboratory tests performed [8]	V	2,209,554 [9]	2,280,000	2,284,189 [10]	Achieved

Commentary

On 1 July 2012 the new national Community Pharmacy Services Agreement (CPSA) was introduced. One of the key changes to this national agreement was the shift towards a capped funding model for pharmacy services based on patient need, rather than reimbursement based on dispensing volumes. The result of this can be seen in 2012/13 results, with volumes being lower than expected.

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[4] *Oral Health Services are measured on a calendar year basis to align with the school year*

[5] *Rather than a true target CCDHB would like to achieve, it was anticipated that actual volumes will fall within a range around this level of expected volumes.*

[6] *Results for the year to April 2012.*

[7] *Results for the year to April 2013.*

[8] *This measure is for CCDHB and HVDHB combined as services are contracted with a single provider.*

[9] *Results for the year to May 2012.*

[10] *Results for the year to July 2013.*

Intensive Assessment And Treatment

MEDICAL & SURGICAL SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	87%	95%	86%	Not Achieved
The rate per 1000 of central line acquired bacteraemia infections in ICU	Q	0	<2	0	Achieved
The rate of acute readmissions	Q	10.98%	11.21%	10.40%	Achieved
The number of surgical first specialist assessments (FSAs)	V	15,476	15,223	15,641	Achieved
Health Target: The number of surgical elective discharges	V	7,866	8,272	8,360	Achieved
The percentage of elective and arranged surgery occurring on the day of admission	T	68%	75%	76%	Achieved
The average length of stay for inpatients (days)	T	4.15	4.02	3.90	Achieved
The percentage of elective and arranged surgery performed as day cases [11]	T	57.6%	58%	56%	Not Achieved
The percentage of "DNA" (did not attend) patients for outpatient appointment Māori	Q	12%	<13%	12%	Achieved
Pacific		12%	<13%	12%	Achieved
The percentage of people with accepted referrals for elective coronary angiography who receive their procedure within 3 months (90 days)	T	New measure in 2012/13	Establish baseline	97%	N/A
The percentage of people with accepted referrals for CT or MRI scans who receive their scan within six weeks (42 days) CT MRI	T	New measure in 2012/13	Establish baseline	81% 57%	N/A

[11] *The Ministry of Health revised the methodology for this measure and therefore revised DHB targets and previous year results.*

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within two weeks (14 days)	T	New measure in 2012/13	Establish baseline	44%	N/A
The percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks (42 days)	T	New measure in 2012/13	Establish baseline	45%	N/A
The percentage of people waiting for a surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date	T	New measure in 2012/13	Establish baseline	96%	N/A
The rate of inpatient falls per 1000 bed days	Q	1.29	<1.4	1.37	Achieved
The rate of inpatient medication errors per 1000	Q	0.85	<0.9	0.86	Achieved
The rate of compliments per 1000	Q	4.2	>4	4.4	Achieved
The percentage of publicly funded NMDS events loaded into the NMDS [12] more than 21 days post month of discharge	T	4.36%	Greater than 2% and ≤5% late	3.6%	Achieved

Commentary

Capital & Coast DHB continues to provide high quality, timely care to patients. Targets have been achieved for new measures from the Ministry of Health for diagnostic services and more patients are receiving first specialist appointments and elective surgery. Achievement of quality measures such as acute readmissions, reduced average length of stay, and increased surgery on the day of admission means patients are receiving high quality care when they need it and returning home when appropriate. The increased rate of compliments per 1000 bed days lets the DHB know that patients are satisfied with the treatment they have received.

[12] *National Minimum Data Set – New Zealand public hospital inpatient data collection*

CANCER SERVICES

Measure	key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Health Target: The percentage of people who start radiation therapy or chemotherapy within four weeks of decision to treat	T	100%	100%	100%	Achieved
The percentage of people referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days	T	New measure in 2012/13	Establish baseline	64%	N/A
The percentage of people with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat	T	New measure in 2012/13	Establish baseline	89%	N/A
The percentage of people referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days	T	New measure in 2012/13	Establish baseline	91%	N/A

Commentary

The Wellington Cancer Centre continues to provide a high quality service to cancer patients. Baselines have been established for new measures along the patient journey to cancer treatment, and the DHB looks to improve upon these in 2013/14.

MATERNITY SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The percentage of births in primary maternity facilities	V	9.6%	>9.3%	9.9%	Achieved
The percentage of births by caesarean section	Q	31.1%	<30%	30.9%	Not Achieved
The percentage of infants exclusively breastfeeding on discharge [13]	C,Q	79.3%	83.5%	79.6%	Not Achieved
The median postnatal length of stay for primiparous [14] women discharged home after normal delivery	Q,T	1 day 20.5 hours	1 day 20 hours	1 day 22.1 hours	Achieved

Commentary

The percentage of infants exclusively breastfeeding on discharge has changed wording from what was in the Statement of Forecast Service Performance 2012/15 to align with the measure in the CCDHB Women's Health Annual Report. While target was not achieved, rates have improved 0.3% from 2011/12.

The postnatal length of stay for primiparous women has increased, allowing first time mothers to establish breastfeeding and gain confidence in caring for their new infant before returning home.

[13] The wording of this measure has been updated to align with what is reported in the Women's Health Annual Clinical Report

[14] Woman who has not previously given birth from 20 weeks gestation

MENTAL HEALTH SERVICES

Measure	key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The percentage of people 0-19 years accessing secondary mental health services	C	3.29%	3.27%	3.66%	Achieved
Māori		4.89%		5.45%	
The percentage of people 20-64 years accessing secondary mental health services	C	3.14%	3.23%	3.37%	Achieved
Māori		6.94%		7.10%	
The percentage of people 65+ years accessing secondary mental health services	C	1.16%	1.15%	1.24%	Achieved
Māori		2.11%		2.00%	
The percentage of people accessing secondary mental health services – Total	C	3%	3.01%	3.19%	Achieved
The percentage of long term clients who have up-to-date relapse prevention plans	Q	84%	95%	91%	Not Achieved
Māori		88%		93%	
The percentage of patients referred to non-urgent mental health services who are seen within three weeks	T	New measure in 2012/13	60%	73%	Achieved
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	New measure in 2012/13	75%	87%	Achieved
The percentage of patients referred to non-urgent addictions services who are seen within three weeks	T	New measure in 2012/13	60%	53%	Not Achieved
The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	New measure in 2012/13	75%	90%	Achieved

Commentary

During 2012/13 there has been a steady increase in access through non-government organisation (NGO) mental health providers, which has contributed to the improvements achieved.

While target for the percentage of long term clients who have up-to-date relapse prevention plans was not achieved, there has been good improvement of 4% for total and 5% for Māori since 2011/2012.

The DHB is pleased with initial performance for the new measures on wait times for mental health and addictions services, and looks to improve these in 2013/14 now data is available.

Rehabilitation And Support

NEEDS ASSESSMENT SERVICES CO-ORDINATION

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 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 assessment and a completed care plan	C,Q	New measure in 2012/13	95%	99.8% [15]	Achieved

Commentary

CCDHB ensures patients who receive long term home support services have a comprehensive clinical assessment and a completed care plan.

HOME BASED SUPPORT

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
Number of people receiving home and community support services during the year	V	3,275	>3,299	3,004	Not Achieved

Commentary

Although the number of clients over the year has been less than the target, the numbers of clients with complex needs remains stable and the hours of support provided to these clients has also remained the same. We are comfortable that this confirms that our approach to better target our services and resources to meet the needs of clients with higher and more complex needs is working, and in line with our expectations around prioritising services and improving the allocation of resources.

RESIDENTIAL CARE SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The number of respite days	V	6,048	>5,104	5,646	Achieved
The number of rest home level bed days	V	132,528	<135,000	137,014	Not Achieved
The percentage of residential care providers meeting three year certification standards [16]	Q	84%	>80%	90%	Achieved
The percentage of people arriving from residential care into ED with an admission discharge checklist	Q	New measure in 2012/13	Establish baseline	76%	N/A

[15] *Result for January-March 2013 due to data delays*

[16] *Excludes one provider who is has a limited certification due to new ownership*

Commentary

The percentage of residential care providers meeting three year certification standards has increased in 2012/13 to 90%. This is a positive result of the DHB working with providers to improve standards in facilities. Further quality improvement work has been undertaken with the continuation of the "Yellow Envelope" admission discharge checklist for people arriving from residential care into ED. By June 2013, 76% of people arriving from residential care into ED had an admission discharge checklist, allowing those treating them to have information on their health prior to arrival in the hospital, and for those treating them in residential care when they are discharged from hospital to have information on the treatment they received.

DISABILITY SUPPORT SERVICES

Measure	Key	2011/12 Performance	2012/13 Target	2012/13 Performance	Achievement
The number of CCDHB employees who identify as having a disability	V	1.3%	>2.5%	2.7%	Achieved
The percentage of new CCDHB staff attending disability awareness training sessions	C	New measure in 2012/13	75%	86%	Achieved
The number of disability newsletters published	V	New measure in 2012/13	6	6	Achieved
Reduced number of complaints from people identifying as having a disability	Q	New measure in 2012/13	Establish baseline	34% [17]	N/A
The percentage of outpatient appointments for people with an impairment recorded that were not attended	Q	New measure in 2012/13	Establish baseline	Implementation in 2013/2014	
The percentage of people identifying as having a disability who reported they were "satisfied" with hospital services	Q	New measure in 2012/13	Establish baseline	56%	N/A
Māori Disability Forum meetings	V	New measure in 2012/13	3	4	Achieved

Commentary

Significant work continues to be undertaken in the disability support area. Improved data collection has been established to allow measurement of health information specific to those with an impairment or disability, which will help the DHB to improve service quality and responsiveness.

Impacts and Outcomes

Long-term outcomes are progressed not just through our work alone, but through the combined effects of all working across the health system and wider health and social services. Evidence about the state of our population's health and the environment in which they live helps us monitor progress towards our intended outcomes. As such, we identified performance indicators related to each outcome in our Statement of Intent 2012-2015, and report against these below. Given the long-term nature of these outcomes, the aim is to make a measurable change over time rather than achieve a specific target. The information provided is the latest available at the time of publication; where possible this pertains to the 2012/13 year with a trend view.

Due to increasing collaboration across Wairarapa, Hutt Valley and Capital & Coast DHBs in 2012/13, the high level impact measures have been aligned across the three DHBs. The strategic visions of the three DHBs were similar for 2012/13, and have been combined into a single set of joint operating priorities in 2013/14. As the 2012/13 strategic visions were similar, many of the outcomes and impacts align. The original wording as in the 2012/13 Statement of Intent has been used for the outcome measures.

POPULATION HEALTH OUTCOME: REDUCED DISPARITY

What difference have we made for our population?

Reducing disparities in our district is a focus for CCDHB. In 2012/13 an Equity Report was developed for the three DHBs. This report uses measures where results are available quarterly, and the headline indicators are preschool oral health enrolment, cardiovascular risk assessments, and the rate of outpatient "did not attend" (DNA) appointments. It is anticipated that through improved monitoring of disparities, the DHBs will be able to more effectively plan activities and reduce the disparities which exist.

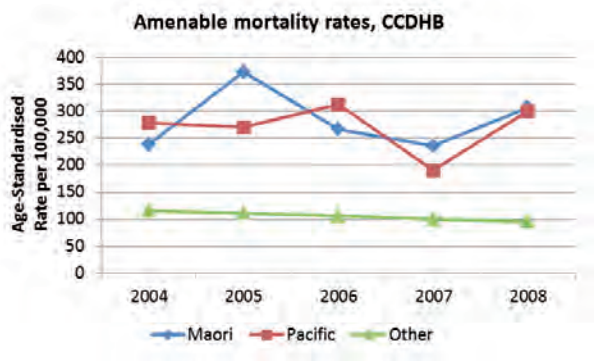
The current level of amenable mortality can be thought of as potential for population health gain through improvements in the health system. It is defined as premature deaths from those conditions for which variation in mortality rates reflects variation in the coverage and quality of health care. Similarly, ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that may be prevented or treated by appropriate interventions in a primary or community setting. It is a shorter term measure than amenable mortality. Since 2008/09, performance has remained relatively consistent. Performance for Pacific has worsened in 2012/13, and work will be undertaken with an aim to reduce these rates. CCDHB continues to perform better than national for Māori and Other ethnicities. Acute admission rates are influenced by a broader set of strategies including prevention and treatment in primary care as well as alternative models of care.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

A reduction in amenable mortality rates for Māori & Pacific

- Amenable mortality is measured by identifying a set of conditions (causes of death) that can be prevented or treated by health care services. Premature deaths have been defined as deaths under 75 years of age.
- Māori and Pacific in CCDHB experience amenable mortality rates that are approximately three times the rate for non-Māori non-Pacific (2008 year).
- 2012/13 results are not presently available due to delays in mortality data, therefore the most recent data currently held by the DHB has been provided.

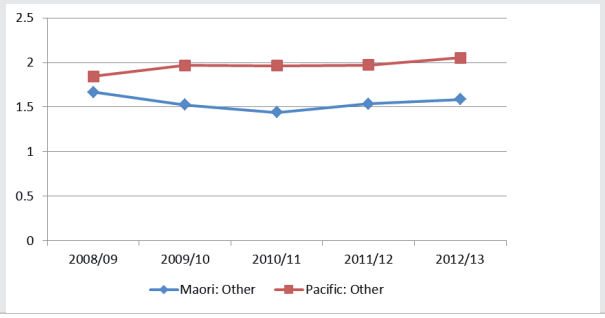
This measure links to the Early Detection & Management and Intensive Assessment & Treatment output classes.



A reduction in acute admissions for Māori & Pacific

- Māori are one-and-a-half times more likely to be admitted acutely to hospital than non-Māori non-Pacific.
- Pacific are twice as likely to be admitted acutely to hospital than non-Māori non-Pacific.

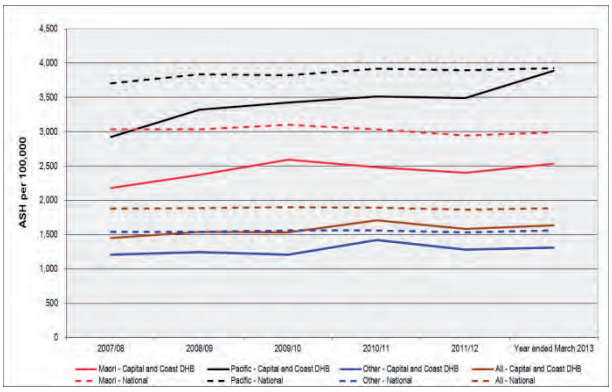
This measure links to the Prevention Services and Early Detection & Management output classes.



A reduction in the ambulatory sensitive hospitalisation (ASH) rates (0-74)

- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of ambulatory sensitive hospitalisations in Capital & Coast is lower than the national rate, which is positive. However, it still represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.

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



Source: Ministry of Health, 2013

POPULATION HEALTH OUTCOME: RISK FACTORS ARE MINIMISED

What difference have we made for our population?

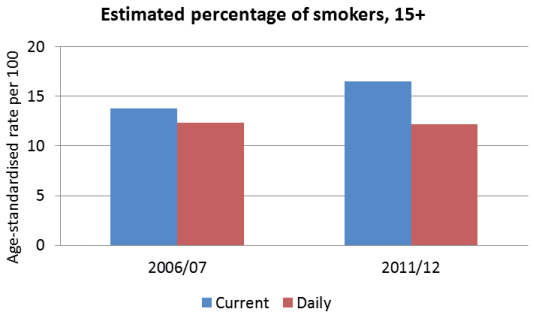
We are pleased to see a continued increase in the proportion of year 10 students who report never smoking in the annual Action on Smoking and Health Survey. While we were disappointed to see a rise in the estimated percentage of current smokers 15+, it is positive that there has been a decline in those who smoke daily. There has been an increase in the percentage of the CCDHB population consuming 2+ fruit and 3+ vegetable servings daily, showing an improvement in healthy eating. However, there has been an increase in the estimated prevalence of obesity in the CCDHB population. CCDHB and its partners such as Regional Public Health and local PHOs continue to advocate for healthy lifestyles, which will see long term gains for our population.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

A reduction in smoking rates for the CCDHB population

- The proportion of the DHB's population who are current smokers is estimated at around 16%. Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care.
- While the estimated prevalence of current smokers has increased in the CCDHB population, the rate of daily smokers has decreased. It is anticipated over time, with reduced uptake of smoking as teenagers, that overall smoking rates will decrease.

This measure links to the Prevention Services output class.

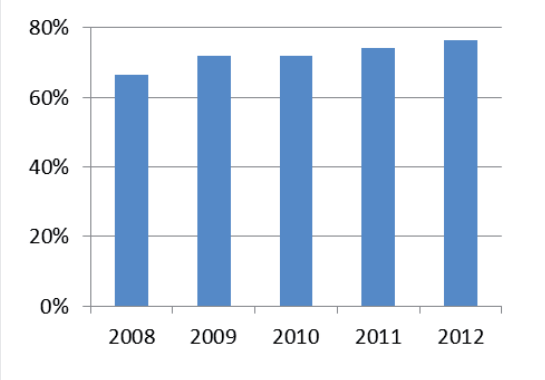


Source: NZ Health Survey

An increase in the proportion of young people who report never smoking

- Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.
- A reduction in the uptake of smoking is a good proxy measure of successful engagement and a change in the social and environmental factors that influence risk behaviour.
- There is an increasing trend of Yr 10 students who report never smoking. Since 2008 this has increased by 9.7%.

This measure links to the Prevention Services output class.

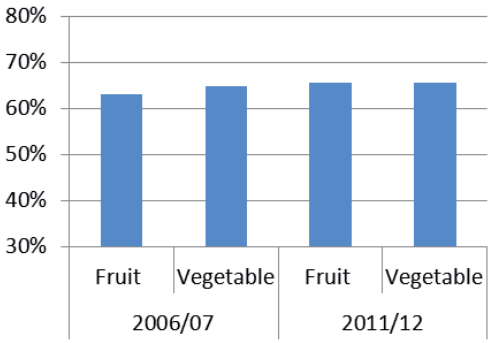


Source: ASH Yr 10 Survey

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 obesity, CVD, diabetes and some common cancers and contributes to maintaining and healthy body weight.
- Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.
- There has been an improvement for CCDHB residents since the 2006/07 survey.

This measure links to the Prevention Services output class.

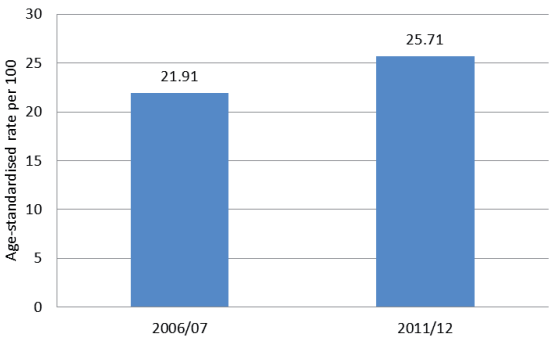


Source: NZ Health Survey

A reduction in obesity prevalence amongst the CCDHB population 15+

- Obesity prevalence estimates are obtained from the New Zealand Health Survey.
- Obesity rates are increasing across New Zealand. With effective preventative measures, including people being more active and eating more healthily, obesity rates can be reduced. Reducing obesity rates will reduce the incidence of related preventable diseases, including diabetes and cardiovascular disease.
- There has been a slight increase in the estimated rate of obesity in the CCDHB population. Work is ongoing to provide information on healthy eating and the benefits of an active lifestyle, to enable our population to live longer, healthier lives.

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



Source: NZ Health Survey

POPULATION HEALTH OUTCOME: IMPROVED CHILD HEALTH

What difference have we made for our population?

Many lifelong habits are established in childhood, and health promotion for children and their parents influences long term outcomes. By keeping children healthy, the DHB aims to ensure not only a healthy start but also a healthy life. Oral health results for children are recognised as an indicator of lifelong health. CCDHB has some of the best performance nationally for the rate of children caries free at five years and the average number of decayed, missing or filled teeth at Year 8. However, disparities are evident at these ages. Improved preschool enrolment in and early engagement with the dental service will help all families to have good oral health.

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that may be prevented or treated by appropriate interventions in a primary or community setting. ASH rates for CCDHB children 0-4 have declined in the year to March 2013, and work will continue to be undertaken to reduce these rates

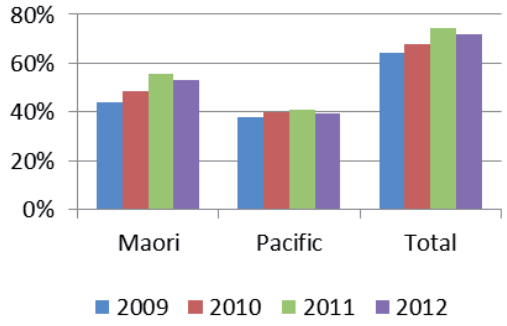
Rheumatic fever mostly affects children and adolescents and is a consequence of a throat infection caused by streptococcus bacteria. It can result in chronic heart disease with reduced life expectancy. Rheumatic fever is the leading cause of childhood heart disease in New Zealand, contributing to poor child health outcomes. Māori and Pacific children are disproportionately represented in terms of disease incidence and rheumatic fever outcomes in New Zealand. A school-based throat swabbing programme began in Porirua East in April 2012 and it is anticipated this will lead to a reduction in rheumatic fever notifications from 2012.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

Increased proportion of children caries free at five years

- Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, prevention and education initiatives are essential to good oral health.
- Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services. It also serves as an indicator of risk factors, such as poor diet, and therefore can provide other benefits in terms of improved nutrition and healthier body weights.
- While there has been a slight decline in 2012, the overall trend remains positive and the rate of children caries free at five years is above the national (59%).

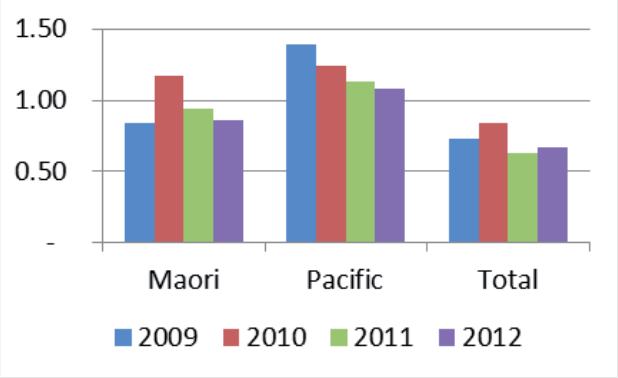
This measure links to the Early Detection & Management output class.



Decrease in the mean number of decayed, missing or filled teeth (DMFT) at Year 8

- Māori and Pacific children are more likely to have decayed, missing or filled teeth, and improved oral health is a good proxy measure of equity of access to services and the effectiveness of mainstream services in targeting those most in need.
- CCDHB has a declining trend in the mean number of decayed, missing or filled teeth, which is good. The 2012 mean DMFT for all ethnicities is below the national mean of 1.16.

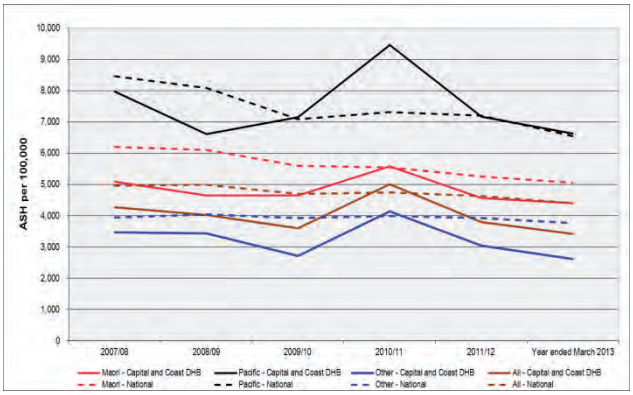
This measure links to the Early Detection & Management output class.



A reduction in ambulatory sensitive hospitalisations of children (0-4)

- Ambulatory sensitive hospital admissions are usually unplanned admissions that are potentially preventable by appropriate health services delivered in community settings, including through primary health care. They provide an indication of access to, and the effectiveness of, primary health care, as well as management of the interface between the primary and secondary health sectors.
- 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.

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

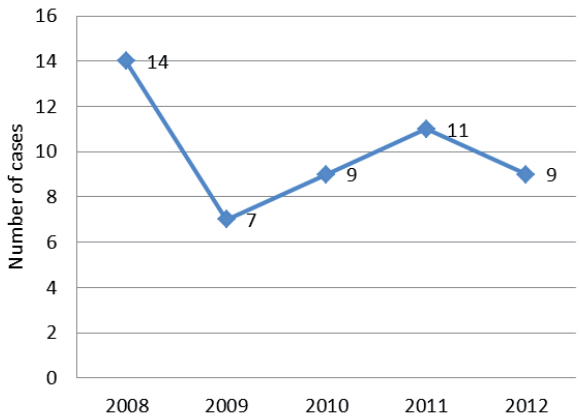


Source: Ministry of Health, 2013

Reduced incidence of rheumatic fever in vulnerable children

- Rheumatic fever is a serious illness which affects the young and can damage their health for life. New Zealand has very high rates of this preventable disease compared to other developed countries. The rates are particularly high amongst Māori and Pacific people. Eastern Porirua has one of the highest rates in New Zealand.
- A rheumatic fever project began in Eastern Porirua in April 2012, and results will be seen in the longer term. A subregional rheumatic fever plan is being developed in 2013/14 to further work on reducing the incidence of rheumatic fever in Capital & Coast, Hutt Valley, and Wairarapa DHBs.

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



Source: ESR surveillance reports

POPULATION HEALTH OUTCOME: LONG TERM CONDITIONS ARE MANAGED

What difference have we made for our population?

There is an increasing burden of long term conditions, seen in the continued increase in diagnosis of cardiovascular disease and diabetes. By better managing the health of people with long term conditions, the DHB can help them lead longer, healthier lives and prevent unneeded hospital admissions. Improved screening for and detection of cardiovascular disease and diabetes helps management occur earlier, reducing the likelihood of complications. Since 2010/11 there has been a reduction in the rate of hospital admissions for cardiovascular disease, and a limit to the growth that was occurring in diabetes hospitalisation rates.

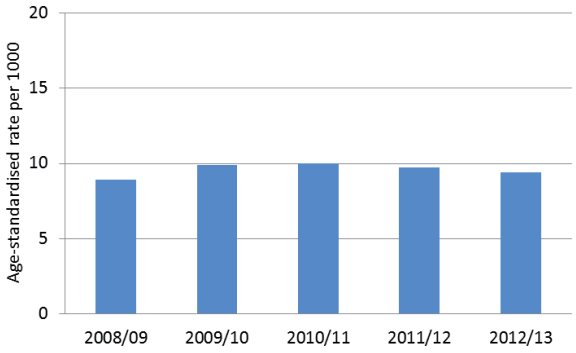
Another measure of the management of long term conditions is the percentage of diabetics with satisfactory blood glucose control. In CCDHB, rates for Other and Total populations remain high, while there have been increases in the rates for Māori and Pacific in 2012/13.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

A reduction in the cardiovascular disease (CVD) hospitalisation rate

- Cardiovascular disease (CVD) includes heart attacks and strokes - which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk.

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

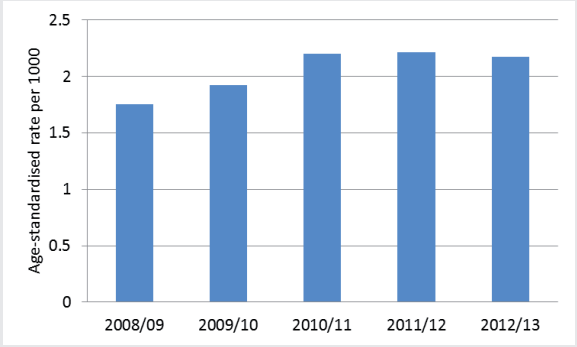


Source: National Minimum Dataset

A reduction in diabetes hospitalisation rate

- Diabetes is defined by the body's inability to control blood glucose. Diabetes is a chronic condition, which can cause kidney failure, eye disease, foot ulceration and a higher risk of heart disease if not well managed.
- Supporting people to manage their diabetes well reduces acute admissions to hospital.
- The number of diabetics has been increasing at a rate of approximately 8% a year for patients enrolled in CCDHB PHOs (MOH Virtual Diabetes Register). While the aim is to reduce diabetes hospitalisations, given the rate of increase in the number of diabetics, the maintenance of the hospitalisation rate over 2011/12 and 2012/13 is positive.

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

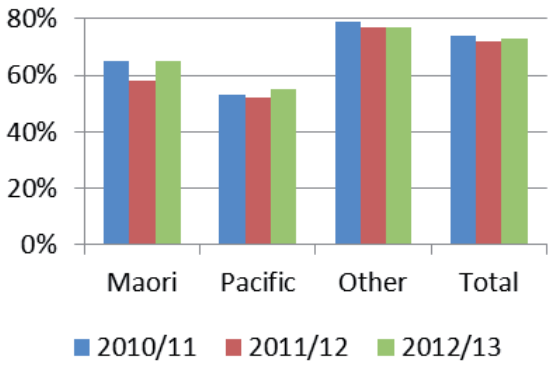


Source: National Minimum Dataset

Increased proportion of diabetics checked with satisfactory or better blood glucose control (HbA1c less than or equal to 64 mmol/mol)

- Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as lower limb amputation, kidney failure and blindness, and will improve people's quality of life.
- The target for 2012/13 aspired to achieve equity in outcomes, with the target for Māori, Pacific and Total populations at 72%. While equity was not achieved, improvements of 7% and 3% have been seen for Māori and Pacific respectively compared to 2011/12.

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



POPULATION HEALTH OUTCOME: PEOPLE LIVE WELL IN THEIR OWN HOMES

What difference have we made for our population?

When people are supported to remain in their own homes, they live healthier, more independent lives. The DHB provides home-based support services to those who require them, so that people are able to remain in their own home. In 2012/13 there has been a decrease in the proportion of older people 65+ receiving home based support services. This is due to a change to the model to ensure services are being provided to those who require them. The number of clients with complex needs has remained stable and the hours of support provided to these clients has also been maintained. We are comfortable that this confirmed that our approach to better target our services and resources to meet the needs of clients with higher and more complex needs is working, and in line with our expectations around prioritising services and improving allocation of resources.

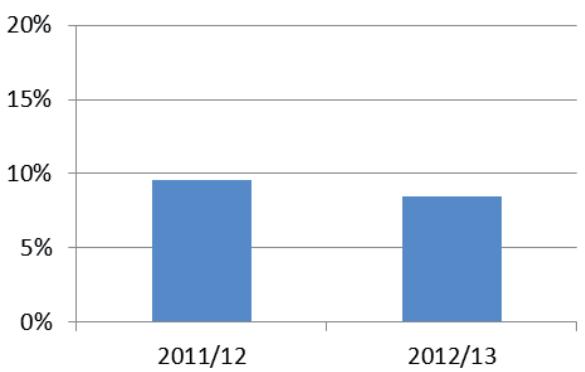
While there had been an increasing trend of unplanned acute admissions for people 65+ in 2011/12 and 2012/13 the growth has been constrained. This is reflective of people receiving appropriate support, and improved management of long term conditions.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

An increase in the proportion of older people 65+ years supported to live at home

- When people receive the adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities.
- The model for home based support services changed from 1 November 2011 to better target services to those who require them.

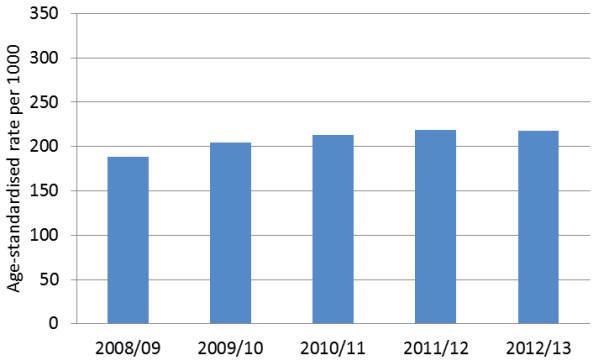
This measure links to the Rehabilitation & Support output class.



A reduction in the unplanned acute admission rate for people aged 65+ years

- By supporting older people to remain at home and maintaining functional level for longer in addition to supporting good management of long term conditions, the DHB seeks to reduce the unplanned acute admission rate for people aged over 65 years.
- While the rate has an increasing trend, growth has been constrained in 2011/12 and 2012/13. This is a positive result of the efforts being made to keep people healthier longer.

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



POPULATION HEALTH OUTCOME: PEOPLE ACCESS INTEGRATED, SUSTAINABLE, QUALITY SERVICES

What difference have we made for our population?

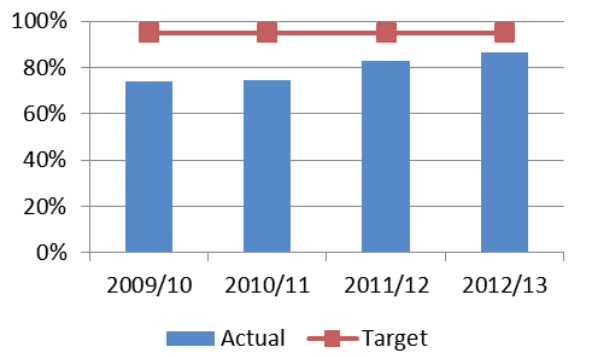
Patient-focused, clinically driven pathways of care provide flexibility for early intervention and planned readmission where clinically appropriate, and support improvements in care across the whole continuum. In 2012/13, CCDHB maintained performance in the Shorter Stays in Emergency Departments Health Target, and the DHB continues to work to improve patient flow. Quality patient care and integration with primary care continue to be prioritised, as seen in the quarter on quarter reductions in the rate of acute hospital readmissions within 28 days. Patients who require elective services are receiving them at an increased rate, with the standardised intervention rate for CCDHB patients increasing annually since 2009. These measures indicate that patients accessing CCDHB services are receiving integrated, sustainable, quality services.

MEASURES - THE DHB MEASURES PROGRESS THROUGH:

Shorter stays in Emergency Department (ED)

- Timely access to treatment improves health outcomes and is indicative of increased capacity and improvements in the flow of patients through DHB services. It also demonstrates a commitment to addressing the needs of Capital & Coast DHB patients and valuing their time.
- Timely acute care in ED is also a proxy measure for how well the whole system is working together to support people to stay well and to provide timely and appropriate complex care through management of acute demand in the community, improved capacity in ED and supported discharge into services in the community.

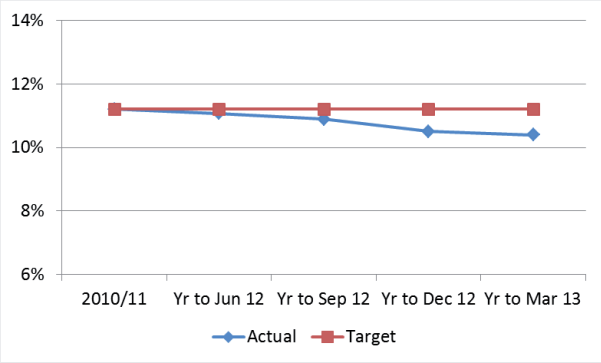
This measure links to the Intensive Assessment & Treatment output class.



A reduction in the acute hospital readmission rate

- Hospital unplanned acute readmission rates are a well-established measure of quality of care, efficiency, and appropriateness of discharge for hospital patients, particularly as a countermeasure to average length of stay.
- Over 2012/13 there has been a quarter on quarter decrease in the acute readmission rate.

This measure links to the Intensive Assessment & Treatment output class.

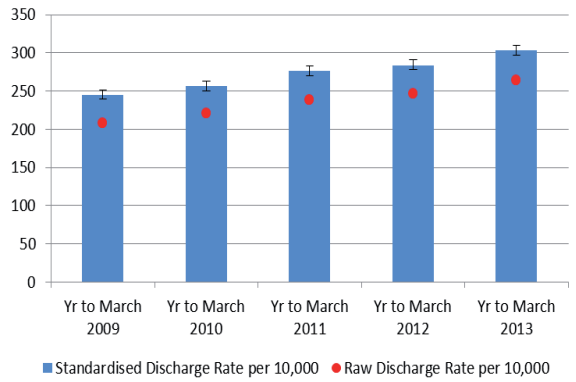


Source: Ministry of Health

An increase in standardised intervention rates (SIR) for elective services

- One of the areas of focus for elective services is the level of service being provided to the Capital & Coast population (as measured by Standardised Intervention Rates), and the level of service being provided for identified key conditions, including cardiac procedures, major joint replacement and cataract procedures.
- There is an increasing trend in the standardised intervention rate for CCDHB residents since 2009.

This measure links to the Intensive Assessment & Treatment output class.



AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of the Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2013

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

We have audited:

- the financial statements of the Health Board on pages 122 to 168, that comprise the statement of financial position as at 30 June 2013, 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 94 to 108 and the report about outcomes on pages 109 to 117.

UNMODIFIED OPINION ON THE FINANCIAL STATEMENTS

In our opinion the financial statements of the Health Board on pages 122 to 168:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Health Board's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

QUALIFIED OPINION ON THE PERFORMANCE INFORMATION

Reason for our qualified opinion

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.

Qualified opinion

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board on pages 94 to 117:

- 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 2013, 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 2013. 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;
- the material performance measures, including the national health targets; 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 opinion, we did not obtain all the information and explanations we required about the performance information. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

RESPONSIBILITIES OF THE BOARD

The Board is responsible for preparing financial statements and 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.

S B Lucy
Audit New Zealand

On behalf of the Auditor-General
Wellington, New Zealand

FINANCIAL STATEMENTS

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2013

in thousands of New Zealand Dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Revenue	1	938,919	923,633	919,322
Reversal of impairment previously recognised	6	20,301	-	-
Total income		**959,220**	**923,633**	**919,322**
Clinical supplies		110,718	102,987	104,089
Employee benefit costs	2	391,450	373,800	369,785
Infrastructure and non-clinical expenses		50,115	42,293	48,032
Other operating expenses	3	11,230	10,534	4,306
Outsourced services		21,222	17,706	23,386
Payments to non-health board providers		316,099	317,014	318,636
Capital charge	4	9,408	9,206	9,629
Finance costs	5	17,890	18,117	19,763
Depreciation and amortisation expense	6,7	41,862	41,990	41,642
Total expenses		**969,994**	**933,647**	**939,268**
Surplus/(deficit) for the year		**(10,774)**	**(10,014)**	**(19,944)**
Other comprehensive income				
Revaluation reserve movement		1,585	-	-
Other comprehensive income for the year		**1,585**	**-**	**-**
Total comprehensive income for the year		**(9,189)**	**(10,014)**	**(19,944)**

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 2013

in thousands of New Zealand Dollars

	Crown equity	Other reserves		Total equity
		Revaluation reserve (land)	Retained earnings	
Balance at 1 July 2011	424,716	22,021	(292,511)	154,226
Contribution from the Crown	423	-	-	423
Repayment of equity	(3,484)	-	-	(3,484)
Total comprehensive income of the year	-	-	(19,944)	(19,944)
Balance at 30 June 2012	**421,655**	**22,021**	**(312,455)**	**131,221**
Balance at 1 July 2012	421,655	22,021	(312,455)	131,221
Repayment of equity	(3,484)	-	-	(3,484)
Total comprehensive income for the year	-	1,585	(10,774)	(9,189)
Balance at 30 June 2013	**418,171**	**23,606**	**(323,229)**	**118,548**

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 2013

in thousands of New Zealand Dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Assets				
Current assets				
Cash and cash equivalents	11	74	1,580	252
Trade and other receivables	10	42,765	31,935	39,789
Inventories	8	8,019	6,417	6,775
Trust and special funds	12	6,960	7,938	7,634
Total current assets		**57,818**	**47,870**	**54,450**
Non-current assets				
Property, plant and equipment	6	532,053	529,765	534,291
Intangible assets	7	5,918	15,866	12,391
Investments in joint ventures	9	1,934	-	700
Total non-current assets		**539,905**	**545,631**	**547,382**
Total assets		**597,723**	**593,501**	**601,832**
Equity				
Crown equity		418,171	436,020	421,655
Revaluation reserve		23,606	22,021	22,021
Retained earnings/(losses)		(323,229)	(330,223)	(312,455)
Total equity		**118,548**	**127,818**	**131,221**
Liabilities				
Current liabilities				
Trade and other payables	16	64,077	60,184	69,210
Borrowings	13	37,442	110	153,278
Employee entitlements	14	59,524	57,503	54,451
Provisions	15	300	2,230	323
Patient and restricted funds	17	166	-	161
Total current liabilities		**161,509**	**120,027**	**277,423**
Non-current liabilities				
Borrowings	13	311,454	339,540	186,261
Employee entitlements	14	5,960	6,116	6,658
Provisions	15	252	-	269
Total non-current liabilities		**317,666**	**345,656**	**193,188**
Total liabilities		**479,175**	**465,683**	**470,611**
Total equity and liabilities		**597,723**	**593,501**	**601,832**

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 2013

in thousands of New Zealand Dollars

	Note	2013 Actual	2013 Budget	2012 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		896,771	893,947	874,469
Other receipts		38,405	29,685	36,814
Cash paid to suppliers		(512,669)	(491,952)	(501,824)
Cash paid to employees		(386,265)	(373,800)	(366,226)
Cash generated from operations		**36,242**	**57,880**	**43,233**
Goods and Services Tax and other taxes (NET) (a)		(2,256)	(1,000)	4,146
Capital charge paid		(4,861)	(9,206)	(10,605)
Net cash flows from operating activities	11	**29,125**	**47,674**	**36,774**
Cash flows from investing activities				
Proceeds from sale of property, plant and equipment		-	800	-
Interest received		1,458	1,765	1,729
Acquisition of property, plant and equipment	6	(14,202)	(25,816)	(23,297)
Acquisition of intangible assets	7	(3,984)	(6,868)	(6,124)
Investment in joint venture		(1,234)	-	(700)
Appropriation from trust and special funds (b)	12	676	-	89
Net cash flows from investing activities		**(17,286)**	**(30,119)**	**(28,303)**
Cash flows from financing activities				
Proceeds from equity injection		-	10,000	423
Borrowings raised		28,525	-	-
Repayment of borrowings		(28,000)	-	-
Repayment of equity	18	(3,484)	(3,484)	(3,484)
Repayment of finance leases		(278)	-	(276)
Interest paid		(17,890)	(17,963)	(19,763)
Net cash flows from financing activities		**(21,127)**	**(11,447)**	**(23,100)**
Net increase/(decrease) in cash and cash equivalents		(9,288)	6,109	(14,629)
Cash and cash equivalents at beginning of year		252	3,409	14,881
Cash and cash equivalents at end of year	11	**(9,036)**	**9,518**	**252**

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 2013

in thousands of New Zealand Dollars

	Note	2013 Actual	2012 Actual
Legal proceedings against the DHB		372	425
Other contractual matters		1,076	885
		1,448	**1,310**

The DHB has been notified of 5 potential claims but assesses that it is not likely to be liable under these claims as at 30 June 2013 (2012: 6).

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 (2012: $nil).

STATEMENT OF COMMITMENTS

As at 30 June 2013

in thousands of New Zealand Dollars

	Note	2013 Actual	2012 Actual
Capital commitments		**4,470**	**1,642**
Non-cancellable commitments – operating lease commitments			
Not more than one year		2,530	2,766
One to two years		1,306	1,148
Two to five years		1,641	426
Over five years		-	-
		5,477	**4,340**

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

STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Capital & Coast District Health Board (DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, 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 will be eligible to apply the reduced disclosure regime (Tier 2 reporting entity) of the public sector Public Benefit Entity Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. Therefore, the DHB will transition to the new standards in preparing its 30 June 2015 financial statements. The DHB has not assessed the implications of the new Accounting Standards Framework at this time. 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.

Basis of preparation

The financial statements for the year ended 30 June 2013 were approved by the Board on 29 October 2013.

The financial statements have been prepared for the period 1 July 2012 to 30 June 2013. Comparative figures and balances relate to the period 1 July 2011 to 30 June 2012.

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.

Joint ventures

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

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

The results of the joint venture company have not been included in the financial statements as they are not considered significant.

Foreign currency

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

Additions to property, plant and equipment are recorded at cost

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

Disposal of property, plant and equipment

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

Leased assets

Finance leases

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

Operating lease

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

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

Subsequent costs

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

Depreciation

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

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

Class of asset	*Estimated life*
■ freehold buildings	1 to 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 are short term obligations and are calculated on an actual basis at the amount the DHB expects to pay. The DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

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

Restructuring

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

Trade and other payables

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

Derivative financial instruments

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

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

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

Hedging: cash flow hedges

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

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

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

Income tax

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

Goods and services tax

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

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

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

Borrowing costs

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

Capital charge

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

Revenues

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 2013, indirect costs accounted for 1.47% of the DHB's total costs (2012: 1.48%).

Accounting estimates and judgements

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

Key sources of estimated uncertainty

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

Property, plant and equipment

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

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

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

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

Retirement, long service leave, sick leave and continuing education

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

Critical accounting judgements in applying the DHB's accounting policies

Leases classification

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

Finance and operating leases

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

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

in thousands of New Zealand Dollars

1. REVENUE

	Note	2013 Actual	2012 Actual
Ministry of Health contract funding		710,656	690,688
Other government		17,527	16,129
Inter district flows (other DHBs)		187,196	182,784
Non government & crown agency sourced		22,082	27,992
Interest income		1,458	1,729
		938,919	919,322

2. EMPLOYEE BENEFIT COSTS

	Note	2013 Actual	2012 Actual
Direct staff costs (excluding increases in employee benefit provisions)		365,558	345,094
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)		12,533	13,776
Contributions to defined contribution plans		9,091	7,493
Increase/(decrease) in employee benefit provisions		4,268	3,422
		391,450	369,785

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

in thousands of New Zealand Dollars

3. OTHER OPERATING EXPENSES

	Note	2013 Actual	2012 Actual
Impairment of trade receivables (bad debts)		-	1,404
Increase /(decrease) in provision of trade receivables (doubtful debts)	10	369	(768)
(Gain)/loss on disposal of property, plant and equipment		391	52
Impairment losses		6,562	-
Audit fees for financial statements audit		180	194
Board member fees	20	391	371
Rental and other operating expenses		3,337	3,053
		11,230	4,306

4. CAPITAL CHARGE

	Note	2013 Actual	2012 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 2013 was 8 per cent (2012: 8 per cent)		9,408	9,629

5. FINANCE COSTS

	Note	2013 Actual	2012 Actual
Interest on bank overdraft		-	2
Interest on CBA loan		442	1,275
Interest on term borrowings		17,413	18,433
Interest on finance leases		35	53
		17,890	19,763

in thousands of New Zealand Dollars

6. PROPERTY, PLANT AND EQUIPMENT

	Freehold land	Freehold buildings	Lease Improve-ments	Plant & Equipment	Furniture & Fittings	Work in progress	Total
Cost							
Balance at 1 July 2011	24,114	446,151	2,694	66,433	34,407	14,449	588,248
Additions	-	4,797	-	9,208	4,061	28,440	46,506
Disposals	-	-	-	(479)	(90)	-	(569)
Revaluations	-	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	(23,400)	(23,400)
Restatement plant & equipment, furniture & fittings	-	-	(2,324)	(5,726)	(3,691)	-	(11,741)
Transfer between categories	6	828	-	(47)	16	(828)	(25)
Balance at 30 June 2012	24,120	451,776	370	69,389	34,703	18,661	599,019
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
Depreciation and impairment losses							
Balance at 1 July 2011	-	(1,980)	(2,335)	(20,099)	(15,971)	(28)	(40,413)
Depreciation charge for the year	-	(21,976)	(128)	(9,185)	(5,119)	-	(36,408)
Impairment losses	-	-	-	-	-	-	-
Disposals	-	-	-	277	71	-	348
Revaluations	-	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	3	2,325	5,726	3,691	-	11,745
Transfer between categories	-	(28)	-	(1,016)	1,016	28	-
Balance at 30 June 2012	-	(23,982)	(138)	(24,297)	(16,312)	-	(64,729)

in thousands of New Zealand Dollars

6. PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	Freehold land	Freehold buildings	Lease Improve-ments	Plant & Equipment	Furniture & Fittings	Work in progress	Total
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)
Carrying amounts							
At 1 July 2011	24,114	444,171	359	46,334	18,436	14,421	547,835
At 30 June 2012	24,120	427,795	232	45,092	18,391	18,661	534,291
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

in thousands of New Zealand Dollars

6. PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

Revaluation

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

The revaluation of land and buildings was carried out as at 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 2013 was $16m (2012: $nil).

Restrictions

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

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

Leased assets

The net carrying amount of property, plant and equipment held under finance leases is $0.228m (2012:$0.5m).

Property, plant and equipment under construction

The total amount of property, plant and equipment in the course of construction is $8.5m (2012: $18.7m) which includes $3.84m (2012: $14.3m) 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 2011	18,901	-	1,986	20,887
Additions	5,596	-	873	6,469
Disposals	-	-	(26)	(26)
Transfer between categories	(70)	-	(324)	(394)
Balance at 30 June 2012	24,452	-	2,509	26,961
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
Amortisation and impairment losses				
Balance at 1 July 2011	(8,498)	-	(1,269)	(9,767)
Amortisation charge for the year	(5,017)	-	(216)	(5,234)
Impairment losses	-	-	-	-
Disposals	-	-	24	24
PP&E restatement	82	-	324	406
Transfer between categories	-	-	-	-
Balance at 30 June 2012	(13,433)	-	(1,137)	(14,570)
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)
Carrying amounts				
At 1 July 2011	10,404	-	717	11,121
At 30 June 2012	11,018	-	1,373	12,391
At 1 July 2012	11,018	-	1,373	12,391
At 30 June 2013	2,174	2,637	1,107	5,918

in thousands of New Zealand Dollars

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 and owned by the 20 DHBs across the country. 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 2013, the DHB has accrued $2.64m as its share of the project. This funding represents an intangible asset and gives the DHB the right to access shared services.

8. INVENTORIES

	2013 Actual	2012 Actual
Pharmaceuticals	1,548	1,435
Surgical & medical supplies	5,876	5,111
Other supplies	595	229
	8,019	6,775

The amount of inventories recognised as an expense during the year ended 30 June 2013 was $52.2m (2012: $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 (2012: $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

	2013 Actual	2012 Actual
Uncalled ordinary share capital	-	-
Advance on redeemable preference shares	1,934	700
	1,934	700

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

As at 30 June 2013, a further investment in CRTAS includes an advance, for the acquisition of Class B Redeemable Preference Shares. The advance will convert to Redeemable Preference Shares after all terms of the issue, compliance with the applicable law and any requirements of the Ministry of Health are complied with.

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%)

	2013 Actual	2012 Actual
Non-current assets	786	238
Current assets	3,053	1,149
Non-current liabilities	-	-
Current liabilities	1,457	1,212
Net assets/(liabilities)	2,382	175
Income	3,296	1,934
Expense	3,294	1,882
	2	52

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. (2012: $nil)

The DHB's share in commitments

The DHB share of Capital Commitments for CRTAS is $1,018 (2012: $nil).

10. TRADE AND OTHER RECEIVABLES

	2013 Actual	2012 Actual
Trade receivables from non-related parties	4,506	4,030
Ministry of Health receivables	21,032	19,731
	25,538	23,761
Accrued income	12,693	12,072
Prepayments	4,534	3,956
	42,765	39,789

Trade receivables are shown net of a provision for doubtful debts amounting to $0.5m (2012: $0.9m)

The carrying value of receivables approximates their fair value.

As at 30 June 2013, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	2013			2012		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	23,143	-	23,143	22,153	-	22,153
Past due 1-30 days	1,791	-	1,791	914	-	914
Past due 31-60 days	96	-	96	150	-	150
Past due 61-90 days	85	-	85	302	-	302
Past due > 91 days	912	489	423	1,124	882	242
Total	26,027	489	25,538	24,643	882	23,761

in thousands of New Zealand Dollars

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:

	2013 Actual	2012 Actual
Balance at 1 July 2012	882	1,650
Additional provisions made during the year	369	372
Provisions reversed during the year	-	-
Receivables written-off during period	(762)	(1,140)
Balance at 30 June 2013	489	882

11. CASH AND CASH EQUIVALENTS

Cash and cash equivalents

	2013 Actual	2012 Actual
Petty cash	13	13
Bank accounts	61	102
Call deposits	-	137
Cash and Cash equivalents (excluding Secured HBL loan)	74	252

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

	2013 Actual	2012 Actual
Cash and Cash equivalents	74	252
Secured HBL loan (Note 13)	(9,110)	-
	(9,036)	252

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 $50.8m.

in thousands of New Zealand Dollars

11. CASH AND CASH EQUIVALENTS (CONTINUED)

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

	2013 Actual	2012 Actual
Surplus/(deficit) for the year	(10,774)	(19,944)
Add back non-cash items:		
Depreciation & amortisation	41,869	41,641
Revaluation gain	(20,301)	-
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	6,923	52
Interest income on financial assets	(1,458)	(1,729)
Add back items classified as financing activity:		
Interest expense on financial liabilities	17,890	19,763
Movements in working capital:		
(Increase)/decrease in trade and other receivables	(2,976)	(9,443)
(Increase)/decrease in inventories	(1,244)	(436)
Increase/(decrease) in trade and other payables	(5,140)	4,080
Increase/(decrease) in employee benefits	4,376	3,559
Increase/(decrease) in provisions	(40)	(769)
Net movement in working capital	(5,024)	6,434
Net cash inflow/(outflow) from operating activities	29,125	36,774

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	2013 Actual	2012 Actual
Balance at 1 July 2012	7,490	7,577
Monies received	1,616	1,538
Interest received	298	303
Payments made	(2,592)	(1,928)
Balance at 30 June 2013	6,812	7,490
Patient funds		
Balance at 1 July 2012	144	151
Monies received	198	231
Interest received	2	2
Payments made	(196)	(240)
Balance at 30 June 2013	148	144
Total trust and special funds	6,960	7,634

in thousands of New Zealand Dollars

13. INTEREST BEARING LOANS AND BORROWINGS

	2013 Actual	2012 Actual
Current		
Secured Ministry of Health loans	28,000	125,000
Secured HBL loans	9,110	-
Secured bank loans	-	28,000
Unsecured EECA loans	79	-
Finance leases	253	278
	37,442	153,278
Non-current		
Secured Ministry of Health loans	311,000	186,000
Unsecured EECA loans	446	-
Finance leases	8	261
	311,454	186,261

Secured loans

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

Interest rate summary	2013 Actual	2012 Actual
Ministry of Health	2.74% - 7.13%	3.16% - 7.13%
Health Benefits Ltd (HBL)	4.25% - 4.67%	-
Bank loan	-	4.54%
Finance leases	6.50%	6.50%
Energy Efficiency and Conservation Authority (EECA)	0%	-

Loan repayable as follows:	2013 Actual	2012 Actual
Within one year	37,189	153,000
One to two years	71,105	-
Two to five years	130,315	124,000
Later than five years	110,026	62,000
	348,635	339,000

in thousands of New Zealand Dollars

13. INTEREST BEARING LOANS AND BORROWINGS (CONTINUED)

Analysis of finance leases	2013 Actual	2012 Actual
Minimum lease payments payable		
Within one year	270	313
One to two years	9	270
Two to five years	-	9
Later than five years	-	-
Total minimum lease payments	279	592
Future finance charges	(18)	(53)
Present value of minimum lease payments	261	539
Present value of minimum lease payments payable		
Within one year	254	294
One to two years	7	238
Two to five years	-	7
Later than five years	-	-
Total present value of minimum lease payments	261	539

Term loan facility limits	2013 Actual	2012 Actual
Ministry of Health loan	339,000	311,000
Bank loan	-	28,000
Energy Efficiency and Conservation Authority (EECA)	525	-
	339,525	339,000

Security and terms

The loan facility is provided by the Ministry of Health. 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.
- 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.

in thousands of New Zealand Dollars

14. EMPLOYEE ENTITLEMENTS

	2013 Actual	2012 Actual
Current liabilities		
Liability for long service leave	1,840	1,730
Liability for sabbatical leave	280	290
Liability for retirement gratuities	1,030	786
Liability for annual leave	36,048	33,001
Liability for sick leave	1,653	1,673
Liability for continuing medical education leave and expenses	8,600	8,348
Salary and wages accrual	10,073	8,623
	59,524	54,451
Non-current liabilities		
Liability for long service leave	3,737	3,724
Liability for sabbatical leave	360	421
Liability for retirement gratuities	1,863	2,513
	5,960	6,658

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%, (2012: 3.5%) and a discount rate ranging from 2.53% to 6.00% (2012: 2.28% to 6.00%) from 1-10+ years.

in thousands of New Zealand Dollars

15. PROVISIONS

	2013 Actual	2012 Actual
Current provisions		
ACC Partnership Programme	300	323
Provision for demolition	-	-
	300	323
Non current provisions		
ACC Partnership Programme	252	269

ACC Partnership Programme	2013 Actual	2012 Actual
Undiscounted amount of claims at balance date	441	489
Discount	14	21
Central estimate of present value of future payments	497	533
Risk margin	55	59
	552	592

The movement in provisions is represented by:

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

	ACC Partnership Programme
2013	
Balance at 1 July 2012	592
Additional provisions during the year for the risks borne in current period	271
Additional 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)

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

Average inflation has been assumed as 2.40% for the year ending 30 June 2013. A discount rate of 2.70% has been used for the year ended 30 June 2013.

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.

in thousands of New Zealand Dollars

16. TRADE AND OTHER PAYABLES

	Note	2013 Actual	2012 Actual
Trade payables to other related parties	20	5,153	6,731
Trade payables to non-related parties		4,177	5,371
GST and other taxes payables		11,302	13,558
Income in advance		1,027	914
Capital charge due to the Crown		4,547	-
Other non trade payables and accrued expenses		37,871	42,636
		64,077	69,210

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

17. PATIENT AND RESTRICTED FUNDS

Patient funds	2013 Actual	2012 Actual
Balance at 1 July 2012	144	151
Monies received	198	231
Interest received	2	2
Payments made	(196)	(240)
Balance at 30 June 2013	148	144

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 2013 are not recognised in the statement of comprehensive income, but are recorded in the statement of financial position as at 30 June 2013, both as an asset and a liability.

Holiday homes funds	2013 Actual	2012 Actual
Balance at 1 July 2012	67	63
Monies received	17	15
Interest received	2	1
Payments made	(15)	(10)
Balance at 30 June 2013	71	67
Hutt Valley DHB Portion ¼ of holiday homes total	18	17
Total patient and restricted funds	166	161

The holiday homes were purchased for the benefit of staff from funds bequeathed for the purpose in 1993. The holiday homes are two units at Taupo, which are let to staff of Capital and Coast District Health Board, and Hutt Valley District Health Board, at a rate which will cover operating costs. The holiday homes transactions are recognised in the statement of comprehensive income, and in the statement of financial position.

in thousands of New Zealand Dollars

18. OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2013 Actual	2012 Actual
Less than one year	2,530	2,766
Between one and five years	2,947	1,574
More than five years	-	-
	5,477	4,340

During the year ended 30 June 2013, $2.7m was recognised as an expense in the statement of comprehensive income in respect of operating leases (2012: $2.5m)

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:

	2013 Actual	2012 Actual
Less than one year	125	145
Between one and five years	697	626
More than five years	1,409	1,406
	2,231	2,177

During the year ended 30 June 2013, $2.3m was recognised as rental income in the statement of comprehensive income (2012: $2.6m)

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.
- 31 short term commercial leases, all subject to 6 month termination notice.
- 2 residential leases all subject to the Residential Tenancies Act.

19. FINANCIAL INSTRUMENTS

Exposure to credit, interest rate and currency risks arise in the normal course of the DHB's operations. Derivative financial instruments are used to hedge exposure to fluctuations in foreign exchange rates and interest rates.

Credit risk

Financial instruments, which potentially subject the DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The DHB places its cash and short term deposits with high quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 61.24% in 2013 (2012: 44%). 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 2013 was nil (2012: $0.2m)

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 $0.29m in 2013. (2012: $0.02m).

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 2013, it is estimated that a general increase of one percentage point in interest rates would decrease the DHB's surplus by approximately $3.5m (2012: $3.4m). 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 $0.00042m for the year ended 30 June 2013 (2012: $0.0002m).

in thousands of New Zealand Dollars

19. FINANCIAL INSTRUMENTS (CONTINUED)

Effective interest rates and repricing analysis

In respect of interest-bearing financial liabilities, the following table indicates their effective interest rates at balance sheet date and the periods in which they reprice.

	2013 Actual							2012 Actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Loans:														
NZD fixed rate loan*	5.16	28,000				28,000		5.16	28,000				28,000	
NZD fixed rate loan*	3.43	6,000				6,000		3.16	55,000	55,000				
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		3.72	25,000				25,000	
NZD fixed rate loan*	3.61	8,000					8,000	6.075	70,000		70,000			
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		6.37	62,000					62,000
NZD fixed rate loan*	6.295	20,000			20,000			6.295	20,000				20,000	
NZD fixed rate loan*	7.13	12,000			12,000			7.13	12,000				12,000	
NZD fixed rate loan*	6.57	11,000			11,000			6.57	11,000				11,000	
NZD fixed rate loan*	6.95	19,400			19,400			6.95	19,400				19,400	
NZD fixed rate loan*	6.39	8,600			8,600			6.39	8,600				8,600	
NZD fixed rate loan*	2.74	28,000	28,000					4.54	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			6.50	539	147	147	238	7	
		348,896	37,262	180	71,113	130,315	110,026		339,539	83,147	70,147	238	124,007	62,000

* These liabilities bear interest at fixed rates.

in thousands of New Zealand Dollars

19. FINANCIAL INSTRUMENTS (CONTINUED)

Contractual maturity analysis of financial liabilities

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

2013	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
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
2012						
Creditors and other payables	69,210	69,210	69,210	-	-	-
Secured loans	339,000	391,113	169,795	11,058	146,269	63,991
Finance leases	539	592	313	270	9	-
Patient and restricted funds	161	161	161	-	-	-
Total	408,910	461,076	239,479	11,328	146,277	63,991

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.

2013	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
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	-	-	-
2012						
Cash and cash equivalents	252	252	252	-	-	-
Debtors and other receivables	39,789	39,789	39,789	-	-	-
Trust and special funds - bank	279	279	279	-	-	-
Trust and special funds – term deposit	7,300	7,402	7,402	-	-	-
Trust and special funds – debtors	55	55	55	-	-	-
Total	47,675	47,777	47,777	-	-	-

in thousands of New Zealand Dollars

19. FINANCIAL INSTRUMENTS (CONTINUED)

Maximum exposure to credit risk

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

	2013 Actual	2012 Actual
Cash and cash equivalents	74	252
Debtors and other receivables	42,765	39,789
Trust and special funds – bank	134	279
Trust and special funds – term deposit	6,350	7,300
Trust and special funds – debtors	242	55
	49,565	47,675

	2013	2012
Counterparties with credit ratings		
Cash at bank and term deposits	6,558	7,831
AA- (Standard & Poor)	6,558	7,831

Counterparties with no credit ratings	2013	2012
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 U.S. Dollars and AUD Dollars.

The DHB hedges large transactions denominated in a foreign currency. The DHB uses forward exchange contracts to hedge its foreign currency risk. The DHB has no forward exchange contracts as at the balance sheet date.

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2013 was $nil (2012: $nil), comprising assets of $nil (2012: $nil) and liabilities of $nil (2012: $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 2013 was $nil (2012: $nil) recognised in fair value derivatives.

in thousands of New Zealand Dollars

19. FINANCIAL INSTRUMENT (CONTINUED)

Fair values

The fair values together with the carrying amounts shown in the statement of financial position are as follows:

	Note	Carrying amount 2013 Actual	Fair value 2013 Actual	Carrying amount 2012 Actual	Fair value 2012 Actual
Trade and other receivables	10	42,765	42,765	39,789	39,789
Cash and cash equivalents	11	74	74	252	252
Secured loans	13	(348,110)	(363,021)	(339,000)	(365,951)
Unsecured loans	13	(525)	(525)	-	-
Finance leases	13	(261)	(279)	(539)	(592)
Trade and other payables	16	(63,238)	(63,238)	(69,210)	(69,210)
		(369,295)	(384,224)	(368,708)	(395,712)
Unrecognised (losses)/gains			(14,929)		(27,004)

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 2013 plus an adequate constant credit spread to discount financial instruments. The interest rates used are as follows:

	2013 Actual %	2012 Actual %
Derivatives	N/A	N/A
Loans and borrowings	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	3.16, 3.72, 4.54, 5.16, 6.075, 6.295, 6.37, 6.39, 6.57, 6.95, 7.13.

in thousands of New Zealand Dollars

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 is the Chairman of Hutt Valley District Health Board. She is also a Health Programme Leader in the Institute of Environmental Science and Research.
- Peter Glensor is a member of the Hutt Valley District Health Board. He is also the Deputy Chair of the Greater Wellington Regional Council.
- Dr Judith Aitken and Barbara Donaldson are both members of the Greater Wellington Regional Council.
- Peter Douglas is a member of Hutt Valley District Health Board.
- Keith Hindle is a Board Member of Hutt Valley District Health Board. He is also a Consultant for the Wellington Tenths Trust and a Director of Metlifecare Palmerston North.
- Helene Ritchie is Councillor at Wellington City Council.
- Darrin Sykes is director of New Zealand Touch Board of Directors.
- Margaret Faulkner is a trustee of Whitireia Foundation and a community representative of Social Welfare Benefit Review Committee.
- Debbie Chin is a Crown monitor for Hutt Valley District Health Board and the CEO of Standards New Zealand.

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

- 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.
- Mary Bonner is a trustee of The Wellington Hospitals and Health Foundation and a board member of Health Roundtable and Technical Advisory Services.

Remuneration

Key management personnel remuneration is as follows:

	2013 Actual	2012 Actual
Short-term employee benefits	2,876	2,683
Post-employment benefits	20	19
Termination benefits	-	-
Executive team	2,896	2,702
Board members	391	371
	3,287	3,073

Key management personnel include all Board members, the Chief Executive, and the other 15 members of the executive management team.

in thousands of New Zealand Dollars

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 2013			**2013**	**2012**	**2013**	**2012**
Dr Virginia Hope	Elected	Board Chair from 1 Dec 2010 Chair HAC to 30 Nov 2010	50	50	7	6
Mr Peter Glensor	Appointed	Deputy Chair from 1 Dec 2010 Deputy Chair HAC from 1 Dec 2010	31	35	6	6
Dr Judith Aitken	Elected	Chair DSAC to 30 Nov 2010 Deputy Chair CPHAC from 1 Dec 2010	25	25	4	4
Mr David Choat	Elected	Member from 1 Dec 2010	25	25	2	3
Ms Barbara Donaldson	Elected	Member from 1 Dec 2010	25	25	3	2
Mr Peter Douglas	Appointed	Chair HAC from 1 Dec 2010	25	25	4	5
Ms Margaret Faulkner	Elected	Chair DSAC from 1 Dec 2010 Deputy Chair FRAC until 30 Nov 2011	25	25	7	6
Mr Keith Hindle	Appointed	Chair FRAC	25	24	6	5
Ms Helene Ritchie	Elected	Member from 2001	25	25	2	4
Mr Darrin Sykes	Appointed	Member from 1 Dec 2010	25	25	4	4
Mr Robert Frances	Appointed	Member from 1 Aug 2012	23	-	1	-
Board members who resigned/left during the year						
Dr Donald Urquhart-Hay	Elected	Passed away Aug 2011	-	2	-	-
Crown monitor						
Ms Debbie Chin	Appointed	Crown Monitor	35	35	6	5
			339	321	52	50

Legend:
DSAC – Disability Support Advisory Committee
HAC – Hospital Advisory Committee
CPHAC – Community and Public Health Advisory Committee
FRAC – Finance Risk & Audit Committee

in thousands of New Zealand Dollars

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

Committee members (other than Board members and employees)	2013 Actual	2012 Actual
Community and Public Health Advisory Committee		
Herani Demuth	-	2
Tavita Filemoni	-	1
Jack Rikihana	2	7
Disability Support Advisory Committee		
Nathan Bond	1	-
Sere Tapu- Ta'ala	1	-
James Webber (from March 2011)	1	2
Hospital Advisory Committee		
Tavita Filemoni	1	-
Hilda Broadhurst	-	3
Malakai Jiko	-	1
Lynn McBain	2	2
Karen Coutts	2	4
	10	22

Sales to related parties	2013 Actual	2012 Actual
Compass Health Wellington Trust	91	154
Compass Primary Health Care Network	3	-
Mary Potter Hospice	46	-
MATPRO Ltd	-	1
Medical Research Institute of New Zealand	170	104
Ora Toa PHO	14	10
Southern Cross Hospital	6	1
Spotless Service (NZ) Ltd	272	-
The Health Roundtable	1	-
Wakefield Hospital	6	1
Well Health	10	-
Wellington Free Ambulance	26	135
Wellington Hospitals & Health Foundation	121	685
	766	1,091

in thousands of New Zealand Dollars

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

Purchases from related parties	2013 Actual	2012 Actual
Age Concern New Zealand	991	-
Compass Health	17,432	-
Compass Health Wellington Trust	1,720	6,314
Compass Primary Health Care Network	31,995	43,048
Greater Wellington Regional Council	-	1
Mary Potter Hospice	4,828	-
MATPRO	40	119
Medical Council of New Zealand	1	-
Medical Research Institute of New Zealand	1	87
Metlife Care Palmerston North	1,196	1,205
Ora Toa PHO	4,771	3,568
Porirua Union and Community Health Service Inc	147	551
Southern Cross Hospital	4,255	1
Spotless Services	7,153	-
Te Runanga O Toa Rangatira Inc	1,620	190
The Health Roundtable	51	56
The Royal Australasian College of Medical Administrators	2	-
Wakefield Hospital Limited	1,938	430
Well Health PHO	6,239	387
Wellington City Council	897	823
Wellington Free Ambulance	1,591	1,114
Wellington Hospitals and Health Foundation	200	358
Wellington Tenths Trust	188	161
Wellington Riding For The Disabled Association	6	-
Wesley Community Action	522	510
	87,784	58,924

in thousands of New Zealand Dollars

20. RELATED PARTIES TRANSACTIONS (CONTINUED)

Outstanding balances to related parties	2013 Actual	2012 Actual
Age Concern New Zealand	76	-
Compass Health	792	-
Compass Health Wellington Trust	277	533
Compass Primary Health Care Network	183	377
MATPRO	-	10
Medical Research Institute of New Zealand	-	101
Metlife Care Palmerston North	-	4
Ora Toa PHO	159	59
Porirua Union and Community Health Service Inc	13	25
Southern Cross Hospital	104	-
Spotless Service	1,537	-
Te Runanga O Toa Rangatira Inc	103	180
Wakefield Hospital Limited	36	175
Well Health PHO	285	220
Wellington City Council	81	19
Wellington Free Ambulance	121	70
Wellington Hospitals & Health Foundation	2	-
Wellington Tenths Trust	40	40
Wellesley Community Action	18	29
	3,827	1,842

Outstanding balances from related parties	2013 Actual	2012 Actual
Compass Health Wellington Trust	13	(42)
Mary Potter Hospice	37	-
Medical Research Institute of New Zealand	1	33
Ora Toa PHO	4	1
Southern Cross Hospital	5	2
Spotless Service (NZ) Ltd	21	-
Wakefield Hospital	5	-
Wellington Free Ambulance	20	15
Wellington Hospital and Health Foundation	108	19
	214	28

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 (2012: $nil).

in thousands of New Zealand Dollars

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.

	2013 Actual	2012 Actual
Purchases from CRTAS related entities	1,755	1,981
Sales to CRTAS related entities	39	47
Outstanding balances to CRTAS related entities	113	757
Outstanding balances from CRTAS related entities	17	-

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 $720m (2012: $691m) to provide services to the public for the year ended 30 June 2013.

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.

	2013 Actual	2012 Actual
Purchases from government related entities	325,822	286,153
Sales to government related entities	216,913	225,495
Outstanding balances to government related entities	17,455	21,964
Outstanding balances from government related entities	33,170	23,088

in thousands of New Zealand Dollars

21. EMPLOYEE REMUNERATION

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

	Number of Employees 2013	Number of Employees 2012
100 – 110	95	108
110 – 120	71	47
120 – 130	41	39
130 – 140	54	43
140 – 150	32	17
150 – 160	13	17
160 – 170	19	17
170 – 180	21	11
180 – 190	9	8
190 – 200	8	13
200 – 210	15	20
210 – 220	22	16
220 – 230	15	15
230 – 240	23	20
240 – 250	16	15
250 – 260	19	18
260 – 270	12	11
270 – 280	12	16
280 – 290	12	8
290 – 300	11	11
300 – 310	11	10
310 – 320	8	7
320 – 330	8	4
330 – 340	10	6
340 – 350	7	6
350 – 360	7	4
360 – 370	3	4
370 – 380	4	-
380 – 390	4	5
390 - 400	1	4
400 - 410	2	2
410 – 420	7	3
420 -- 430	2	-
430 – 440	3	2
470 - 480	1	-
490 -- 500	1	-
560 – 570	1	-
590 - 600	-	1
650 - 660	1	-
660 - 670	-	1
	601	529

21. EMPLOYEE REMUNERATION (CONTINUED)

Of the 601 employees shown above, 408 are or were medical or dental employees and 193 are or were neither medical nor dental employees. This represents an increase of 72 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 1,424, compared with the actual total number of 601.

22. TERMINATION PAYMENTS

During the year ended 30 June 2013, 4 (2012: 13) employees received compensation and other benefits in relation to cessation totalling $0.05m (2012: $0.3m).

No Board members (2012: nil) received compensation or other benefits in relation to cessation (2012: 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 2013 are provided below.

Statement of comprehensive income

The DHB recorded a deficit of $10.77m compared with the budgeted deficit of $10m.

Revenue for 12/13 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 targeted savings initiatives.
- Increased outsourced services were contracted to meet health targets.

Statement of financial position

Major variances were:

- Property, plant and equipment values were lower due to lower expenditure on capital items which was partly offset by a revaluation of land & buildings.
- Crown equity is lower due to no draw down of deficit support.

Statement of cash flows

Major variances were:

- Operating cash flows were lower due to higher payments to clinical suppliers.
- Cash outflow from investing activities is lower than budget due to lower capital expenditure.
- Cash flow from financing activities is lower due to no draw down of deficit support.

24. CAPITAL MANAGEMENT

The DHB's capital is its equity, which is comprised of equity contribution, accumulated funds and other reserves. Equity is represented by net assets.

The DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

in thousands of New Zealand Dollars

25. SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and mangement		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2013 Actual	2012 Actual	2013 Actual	2012 Actual	2013 Actual	2012 Actual	2013 Actual	2012 Actual	2013 Actual	2012 Actual
Revenue										
Crown	7,768	8,516	183,476	175,275	615,530	603,276	100,175	102,534	906,949	889,601
Other	-	-	-	-	51,585	29,722	686	-	52,271	29,722
Total revenue	**7,768**	**8,516**	**183,476**	**175,275**	**667,115**	**632,997**	**100,861**	**102,534**	**959,220**	**919,322**
Expenditure										
Personnel	-	-	-	-	387,121	366,036	4,329	3,751	391,450	369,787
Depreciation	-	-	1	1	41,861	41,640	-	-	41,862	41,641
Capital charge	-	-	-	-	9,408	9,629	-	-	9,408	9,629
Provider payments	7,247	8,004	160,184	154,682	57,755	70,312	90,912	85,638	316,098	318,636
Other	624	513	23,296	20,594	182,262	164,750	4,994	13,718	211,176	199,574
Total expenditure	**7,871**	**8,516**	**183,481**	**175,277**	**678,407**	**652,366**	**100,235**	**103,107**	**969,994**	**939,267**
Net surplus/(deficit)	**(103)**	**-**	**(5)**	**(1)**	**(11,292)**	**(19,369)**	**626**	**(573)**	**(10,774)**	**(19,944)**

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid from the Funder Arm is matched to a purchase unit code, and then mapped to the relevant output class. This is done at a detailed transactional level and accounts for the majority of the DHB's revenue and expenditure.

The DHB's remaining activity is within the Provider arm, and as a result has been assumed to come under the Hospital Services output class or Intensive assessment and treatment.

For 2012-13 the description of the four output classes were changed to better reflect the nature of the service provided. The expenditure by output class for 2012-13 has used the original description for comparison to prior year actual and budget in addition to the new description for 2012-13 actual expenditure.

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

in thousands of New Zealand Dollars

25. SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS (CONTINUED)

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2013 Actual	2013 Budget	2012 Actual	2013 Actual	2013 Budget	2012 Actual	2013 Actual	2013 Budget	2012 Actual	2013 Actual	2013 Budget	2012 Actual
Opening balance	(285,241)	(292,536)	(274,642)	(17,764)	(19,879)	(18,338)	(9,450)	(7,794)	469	(312,455)	(320,209)	(292,511)
Surplus/(deficit) for the year	(4,496)	(2,400)	(10,599)	543	-	574	(6,821)	(7,614)	(9,919)	(10,774)	(10,014)	(19,944)
Closing balance	**(289,737)**	**(294,936)**	**(285,241)**	**(17,221)**	**(19,879)**	**(17,764)**	**(16,271)**	**(15,408)**	**(9,450)**	**(323,229)**	**(330,223)**	**(312,455)**

26. STATEMENT OF GOING CONCERN

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2012/13 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, 23 September 2013 from the Ministers of Health and Finance.

Operating and cash flow forecasts

The Board has considered forecast information relating to operational viability and cash flow requirements. The Board is satisfied that there will be sufficient cash flows generated from operating activities to meet the investing and financing cash flow requirements of the DHB as set out in its current Statement of Intent. Based on the Letter of Comfort, the Board is confident that the equity injections in 2013/14 year related to operating cash flows will be forthcoming if required.

Borrowing covenants and forecast borrowing requirements

The forecasts for the next 3 years prepared by the DHB show that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions.

While the Board is confident in the ability of the DHB to continue as a going concern if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern.

If the DHB was unable to continue as a going concern adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.


The National Immunisation Schedule
Childhood Immunisation
Immunise your children
Childhood Immunisation