Capital & Coast District Health Board

Annual Report 2020–2021

E81 Presented to the House of Representatives pursuant to section 150 of the Crown Entities Act 2004.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Glossary of acronyms:
CCDHB – Capital & Coast District Health Board
HVDHB – Hut Valley District Health Board
2DHB – Hutt Valley and Capital & Coast District Health Boards
3DHB – Wairarapa, Hutt Valley and Capital & Coast District Health Boards
MHAIDS - Mental Health, Addictions and Intellectual Disability Service

Cover photo: Pacific COVID-19 vaccination team

Chair and Chief Executive's Foreword

We are pleased to present Capital & Coast DHB's Annual Report for 2020-2021. This report outlines the progress we have made towards putting our community at the heart of the health system in our region.

Together with Hutt Valley DHB, we have been working to bring our 2DHB partnership to fruition with a shared focus on providing safe, quality health services, and striving to achieve equitable health outcomes for everyone in our region.

Our people have adapted well to change over the past 12 months including the establishment of a single Executive Leadership Team across Hutt Valley and Capital & Coast DHBs and a strategic focus on unified healthcare delivery. As a result we are improving service coordination across the region, with people and place-centric service planning and delivery focused on the specific needs of each community.

The unprecedented challenges COVID-19 presented during the past year have underscored the importance of work underway to address health inequities. Our Boards have confirmed a set of equity goals and principles which will inform and guide our service improvements.

We know outbreaks of infections such as COVID-19 disproportionately impact people and populations already facing the challenge of poorer health outcomes. This is why we have made it a priority to ensure key health messages, services and support reach Māori, Pacific and Disability communities.

We have worked closely with mana whenua partners, and Māori providers, Pacific providers and organisations providing support to disabled people. Te Upoko O Te Ika Māori Council was established to ensure hauora Māori is at the forefront of planning, funding and service delivery activities across the region.

Together our DHBs commenced rollout of the COVID-19 vaccination programme, seeking to vaccinate over 400,000 eligible people in our region, the largest ever vaccination effort we have seen. The priority has been our equity populations and we are proud of what we have achieved by working together with our primary health providers, community organisations and health sector partners. This shift to working in partnership and more intensively with communities has been a defining feature of the past year.

During 2021 we commenced planning for one of the largest changes the New Zealand health and disability system will experience. As we work towards the new entities, Health NZ and the Māori Health Authority which come into effect in mid 2022, our DHBs have set 11 strategic priorities and 5 enablers which we will focus on. These strategic priorities and work programmes are aligned with and will support this reform.

Our Board remain committed to ensuring we are in a sustainable financial position, and work continues to ensure we optimise our resources to deliver quality care.

In closing, we would like to thank all our staff for their exceptional contribution over the past year. Ehara taku toa i te toa takitahi, engari he toa takitini.

David Smol
Manukura I Board Chair

Fionnagh Dougan
Āpiha Whakahaere Mātāmua | Chief Executive

Introduction

This annual report outlines CCDHB's progress toward meeting the intentions and priorities as outlined in our Health System Plan 2030 and the New Zealand Health Strategy, while ensuring we are well-positioned to support the new Health NZ and Māori Health Authority entities that come into effective in mid 2022.

The CCDHB Health System Plan 2030 (HSP) outlines our vision and strategy to transform the health system to ensure equity amongst our populations and support better health and wellbeing throughout the lives of the people in our communities. Achieving equity and providing an integrated seamless service is embedded throughout these strategic goals. Our HSP is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

We are committed to improving health outcomes and achieving equity for our communities. We know that we need to do better for Māori, Pacific peoples, disabled people, those who have fewer resources available to them and those with enduring mental illness. We can see this in our measurement of health system performance, impacts, and outcomes.

At the core of the strategic work programme across CCDHB and HVDHB is the "five communities" vision. This is an approach that focuses on the communities [that make up the communities] with our 2DHB boundaries - Kāpiti, Upper and Lower Hutt, Porirua and Wellington. Each of these communities has its own specific set of needs and challenges, and our vision is that by planning more effectively across the whole region, we can better serve our patients and clients and improve the equitability of our system.

The Boards and joint leadership team take a community-focussed approach to planning. The specific needs of each community in the region are considered, and we take a patient-centric approach to service planning that ensures services are well joined-up and seamless. We have heightened our focus on key areas including: promoting health and wellbeing; providing people-focussed services in the community; and providing timely effective care that improves health outcomes.

Achieving equitable health outcomes for our communities requires a broader approach that breaks down traditional health sector boundaries. To respond to inequality, partnerships are required with local councils, government agencies, non-governmental organisations, and community organisations. We support these partnerships through local approaches with our communities.

An early example of our focus on providing people-focussed services in the community has been the creation of the Kāpiti Community Health Network (CHN).

This network of health providers supports and coordinates health service delivery to achieve equity and better meet the needs of the Kāpiti population. Development of the Kāpiti CHN first began in July 2020 in partnership with mana whenua partner Te Ātiawa ki Whakarongatai and Tū Ora Compass Health.

Work to date on implementing Taurite Ora, our Māori Health Strategy 2019-2030, has included identifying five key measures of equity common to CCDHB and HVDHB Māori health goals. These five key measures are: amenable mortality, avoidable hospital admissions, accessible appointments, primary care utilisation, and community-based services. These five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity.

An important development this year was the establishment of Te Upoko O Te Ika Māori Council, which has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi. We now collaborate with Te Upoko O Te Ika Māori Council, Sub-Regional Pacific Strategic

Health Group and the Sub-Regional Disability Advisory Group who provide advice on how we can improve these indicators.

The changes that feature in this annual report are about making sure healthcare is easy to access and effective for all people in our five communities. We know the most effective change will happen when we listen to and learn from feedback. We continue to work closely with a broad range of stakeholders, providers, sector and community groups and people in our five communities.

Our Vision and Strategic Direction

Capital & Coast District Health Board (CCDHB) is committed to meeting the Minister of Health's expectations and delivering our vision of:

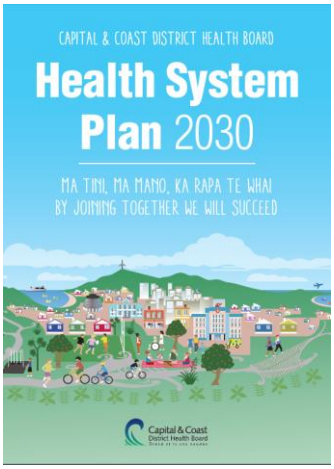
Keeping our community healthy and well

To deliver on our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many people in our success – our communities, our families, our workforce, our provider partners, our Ministry, and our social service partners. Enabling people and their whānau to take the lead in their own health and wellbeing is at the heart of this approach.

Our Health System Plan 2030

The CCDHB Health System Plan 2030 (HSP) outlines our vision and strategy to transform the health system to ensure equity amongst our populations and support better health and wellbeing throughout the lives of the people in our communities.



The HSP enables us to respond to the growing demand for healthcare, and increasing complexity of healthcare needs and is supported by this whakataukī:

Ma Tini, Ma Mano, Ka Rapa, Te Whai
By Joining Together We Will Succeed

The HSP is organised around two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. The Health System Plan outlines three broad service delivery models for the main users of our health services:

- Core health care service users. Those who require any form of urgent and planned care. The health system will be acting early to prevent illness and disability and save lives.
- Maternity services users and children, young people, and their families and whānau. The health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course.
- People who require system coordination – including those who have long-term conditions, are becoming frail or are at the end of their life. These people have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care.

This means recognising those who may need more help including Māori and Pacific Peoples in our district, people with disabilities, the socially and economically vulnerable or with an enduring mental illness and/or addiction, and refugees.

Place

Using ‘place’ as the basis for health and social supports creates immediate links to a community’s strengths. It makes it easier to recognise and value community diversity, while organising a consistent system across many groups.

Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care.

The plan centres on the following three core care settings:

- People’s homes and residential care facilities.
- Community Health Networks, including Health Care Home and the Kāpiti Health Centre.
- Wellington Regional and Kenepuru Community hospitals providing specialist care for the CCDHB region.

Strategic framework

We are guided by a series of strategies and plans to improve the performance of our health care system and encourage better health and wellbeing and more equitable health outcomes for all our communities. These plans keep us focused on people and places, and providing care in the appropriate settings. Read the strategies on our websites.

Health Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. 'Equity' recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Achieving equity in health and wellness is a focus for CCDHB. We know that we do not do as well for Māori, Pasifika People, disabled people, those who have fewer resources available to them, and those with enduring mental illness. We are committed to improving their health outcomes and achieving equity for them. We will continue to deliver against:

- Taurite Ora: CCDHB's Māori Health Strategy 2019-2030
- the Sub-Regional Pacific Health And Wellbeing Strategic Plan 2020-2025
- the Sub-Regional Disability Strategy 2017-2022
- Living Life Well – A Strategy for Mental Health and Addiction 2019-2025.

Our focus is on improving performance, ensuring we make the best use of our available resources, and achieving equity amongst our populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we will intensify resources and support for those who need us the most, and simplify for those who need us the least.

CCDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. 'Partnership' is key to success in achieving equitable health outcomes. We collaborate with our Māori Council, the Sub-Regional Pacific Strategic Health Group, and the Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We measure and report on our progress regularly.

Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities to Māori through Te Tiriti o Waitangi, the founding document of Aotearoa. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal[1] underpin the DHB's commitment to Te Tiriti, and guide the actions outlined in this annual plan. The 2019 Hauora Report[2] recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system as a whole. CCDHB values Te Tiriti and applies these the principles to our work across the health and disability system:

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection**: Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

[1] *New Zealand Māori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand M`aori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Māori Council v Attorney-General* [1991] WL 12012744; *New Zealand Māori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Māori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua fishing claim* (Waitangi Tribunal 1988).

[2] *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal* 2019).

- **Options**: Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

In planning and providing health services, we pay particular attention to the health needs and aspirations of our Māori population. There are well-documented and preventable inequities in the determinants of health between Māori and non-Māori, and these flow through to inequities in health outcomes. We aim to address this through targeting and driving our health services to create equity of health care for Māori, while developing partnerships with the wider social sector to support whole of system change.

Māori representation has been provided on all advisory committees and our Alliance Leadership Team, the Integrated Care Collaborative. We also have a 2DHB (HVDHB and CCDHB) Māori Council to formalise the relationship between local iwi and the DHB, build on relationships, and share aspirations and strategic directions.

Te Upoko O Te Ika Māori Council

Te Upoko O Te Ika Māori Council (TUI MC) was established in 2021 to represent hauora Māori across CCDHB and HVDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within CCDHB, HVDHB, and the wider community. TUI MC has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi.

TUI MC comprises up to two representatives each of the following Iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. The Chair is appointed by TUI MC members.

Māori Health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes. This applies to many Māori individuals and whānau. Life expectancy for Māori males and females living in the CCDHB area continues to lag about five years behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas. Disability is a significant issue for Māori. Nationally, approximately 200,000 Māori (26%) report having a disability.[3]

CCDHB, together with the Māori Council, has developed a Māori health strategy, Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019-2030. Taurite Ora is supported by this wero:

Kua Takoto Te Rau Tapu (The challenge of health equity for Māori is laid down)

Taurite Ora guides CCDHB activity to achieve health equity and optimal health for Māori by 2030. Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is well described in the Ministry's He Korowai Oranga: Māori Health Strategy.

The framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (healthy individuals), and Wai Ora (healthy environments), guide our activity.

[3] Ministry of Health. 2018. Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan. Wellington: Ministry of Health.

Taurite Ora describes the critical need to improve health outcomes for Māori, yet its success will be dependent upon CCDHB working with communities to ensure simple solutions, where Māori, whānau, communities, DHB staff, and providers can see themselves as part of those solutions.

Taurite Ora is tailored to the identified health needs of Māori living in its district and describes the outcomes and impacts that will be measured against in achieving health equity for Māori. Taurite Ora highlights the most critical priorities to improve health outcomes for Māori.

The strategy focuses on equity, as a value which underpins everything we do; system change through workforce development; and, funding prioritisation through commissioning of services. Taurite Ora has two outcomes:

- A stronger and more responsive CCDHB health system achieved by focusing on three strategic priorities: becoming a pro-equity health organisation; growing and empowering our workforce; and, strengthening our commissioning services.
- Improved health and wellbeing outcomes for Māori in two priority focus areas: maternal, child and youth; and mental health and addictions.

The pathway to achieving health equity for Māori requires significant shifts, not just in the way we operate and in the processes and policies we follow, but also in our attitude and our thinking. Delivering on the key outcomes outlined in Taurite Ora is fundamental to achieving equitable health outcomes for Māori. We will measure and report on our progress regularly to the Māori Council on behalf of all Māori in our district.

Staff testing out the giant bowel in the Wellington Regional Hospital atrium.

CCDHB joins the National Bowel Screening Programme

After many months of hard work and dedication from everyone involved, CCDHB started the National Bowel Screening Programme in April 2021.

New Zealand has one of the highest rates of bowel cancer in the world. Around 3,200 people are diagnosed every year. However, the chance of surviving this cancer are very good when it is found early.

The National Coordination Centre began to send out 'pre-invite' letters to people in Wellington aged between 60 and 74, who are eligible for publicly funded healthcare. These letters explained the programme and let people know that they would receive a bowel screening test kit within a couple of weeks.

Read more about the national Bowel Screening Programme at www.ccdhb.org.nz

About Capital & Coast DHB

Capital & Coast DHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services to the residents living in the Kāpiti Coast District, Porirua City and Wellington City.

Who we are

The CCDHB region is diverse. Our communities reflect many cultures, ethnicities and abilities as well as geographic settings. In 2020/21 an estimated 320,640 people called the region home. This is projected to grow by 19,160 people by 2030/31; a 6% increase.

In 2020/21 104,400 people under 25 years of age made up 32% of the region's population. Most people (58%) were aged 25-69 years (190,300). 9% were people over 70 years; 30,800 people (1% rounded out).

Wellington had a large proportion of people in the younger working age group of 20–44 years (93,500 people), while just under a quarter (22%) of the Porirua population were aged under 15 years (13,500 people). Over one-quarter (29%) of the Kāpiti Coast population were aged over 65 years; 14,000 people.

The region is ethnically diverse. In 2020/21, 38,600 people identified as Māori (12% of the population), 23,500 identified as Pacific peoples (7%) and 51,400 identified as Asian (16%); 65 percent of the population identified as non-Māori, non-Pacific, non-Asian (ie Other) category (212,000).

Porirua had a larger proportion of Māori (21% or 12,800 people) and Pacific peoples (22% or 13,700 people), while 86% of the Kāpiti Coast population identified as 'Other' ethnicities (42,000 people).

Our Māori and Pacific populations tend to be younger, with 27% of the region's Māori (10,400) and 24% of the region's Pacific people (5,700) aged under 15 years in 2020/21.

There are 72,200 people with a disability living in the CCDHB region. This is expected to increase to 84,500 by 2030; this partially reflects our ageing population.

A changing population

The CCDHB population is changing – the population is growing, ageing and becoming more diverse.

The majority of the population increase is predicted to be in our Māori and Asian communities. For Māori, we expect growth of 17% or 6,650 people. Our Asian population is predicted to grow by 27% or 13,870 people. Pacific peoples and 'Other' populations are expected to grow much more slowly and even decline in some younger age groups.

There will be significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70-79 and 80+ age groups; as our population is living to reach much older ages.

The health of our population

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 82 years, rates of premature deaths from conditions amenable to healthcare have declined by 47% between 2000 and 2018, and the majority of our population (70%) lives in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes – in particular, Māori, Pacific peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Porirua.

What we do

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- to improve, promote, and protect the health of communities
- to reduce inequalities in health status
- to integrate health services, especially primary and hospital services and
- to promote effective care or support of people needing personal health services or disability support.

DHBs act as planners, funders and providers of health services as well as owners of Crown assets.

Local services

CCDHB provides community and hospital services throughout the region. We have a range of contracts with community providers such as primary health organisations, general practices, pharmacies, laboratories and community NGOs. CCDHB operates two hospitals – Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We also operate the Kāpiti Health Centre in Paraparaumu, and Rātonga-Rua-O-Porirua, a large mental health campus based in Porirua.

We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. CCDHB also provides sub-regional, regional and tertiary services for other DHBs.

We employ 5,100 FTE and have an annual budget of $1.4 billion.

Sub-Regional services

CCDHB provides services to the people of Hutt Valley District Health Board (HVDHB) and Wairarapa District Health Board (WrDHB) under 2DHB (CCDHB and HVDHB) and 3DHB (WrDHB, HVDHB and CCDHB) models.

CCDHB and HVDHB serve populations that are geographically co-located. CCDHB provides more services to the HVDHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at HVDHB.

An estimated 157,000 people live in HVDHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. HVDHB's population is predicted to grow by 3% or 4,400 people by 2029/30.

Map of Central Region DHBs

A further 48,500 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 1,700 people (4%) by 2029/30.

Tertiary services

CCDHB is the complex care provider for the Central Region. The Central Region includes Hawkes Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs.

The Central Region has an estimated population of 940,000 people. This represents 19% of the total New Zealand population and is projected to grow by 4% by 2029/30 to just under one million people (977,800).

CCDHB is also a provider of some tertiary services outside the Central Region (for example Taranaki DHB and Nelson Marlborough DHB) as well as some national services.

Response to COVID-19

In response to community cases identified with the Delta variant of COVID-19, on 17 August 2021 all of New Zealand entered into Alert Level 4. This was the second time New Zealand had entered into Alert Level 4 since the first lockdown in March 2020. We had learnt many new ways of working and responding to COVID-19 since the first lockdown. Our COVID-19 resurgence plans were activated and our planning was quickly put into action. We again stood up our Incident Management Team and began to coordinate our response to the pandemic in partnership with HVDHB, WrDHB, and the Wellington Regional Emergency Management Office.

Regional Public Health managed the positive cases and contacts in the Wellington region and throughout New Zealand. It also provided significant support to Auckland and helped manage some of their cases.

Eleven Community Testing Centres (CTCs) were quickly established across the Wellington region to accelerate testing for COVID-19 and support general practice. As with the first lockdown, general practices continued to operate safely and effectively using telehealth and virtual tools, and general practice staff were supported by increased access to specialist advice.

We established daily meetings with a Pacific taskforce consisting of local Pacific sector experts, providers and community leaders. This enabled us to work with the Pacific community, supporting those Pacific people who had contracted COVID-19 and their families. Our Whānau Care Service helped patients stay connected to their whānau while visiting restrictions were in place. Our 3DHB Disability Strategy team worked closely with the Ministry of Health to ensure disabled people have ready access to information, including sign language and easy-read documents. Emergency packages of care and support were delivered to those who needed it, and we worked across agencies to look after our most vulnerable populations, including homeless people.

We intensified our vaccination programme across the region. This included pop-up vaccination events, and mass vaccination drive-through sites; targeted at communities with higher risk of contracting COVID-19. These were highly successful with over 67,000 vaccinations delivered over the two weeks ending 29 August and 5 September respectively throughout the Wellington region against a plan of 28,000 for each week. For example, over a three day period 1,047 people were vaccinated at our Porirua drive-through site, and 59% were Pacific and 19% Māori. We organised a pop-up event at ASB Stadium (Kilburnie) where 593 people (58% Pacific and 9% Māori) were vaccinated in one day. Our Māori and Pacific providers supported us to increase vaccination activity, including the use of outreach clinics.

CCDHB vaccination coverage data at 30 June 2021 is provided on page 62.

Our mental health and addiction services are leading the psychosocial response to the pandemic. This includes a comprehensive programme of work delivering our 3DHB Mental Health and Addictions Strategy: Living Life Well – A Strategy for Mental Health and Addiction 2019 – 2025, which aligns with the recommendations in He Ara Oranga - Report of the Government Inquiry into Mental Health and Addiction.

Read the latest updates on www.VaccinateGreaterWellington.nz

The vaccination team at a Pacific vaccination day.

Festive flavour at Pacific Vaccination days

CCDHB has started rolling out COVID-19 vaccinations to Pacific People and their families in the region, with Pacific Vaccination Festival days in Lower Hutt, Wellington and Porirua.

DHB Pacific People's Health director Tagaloa Junior Ulu said it was about equity.

"It's recognising that our Pacific People tend to get illnesses sooner than the rest of the population... but we're also bringing their families in. So you'll see it's not just people aged 55-plus, it's their whole aiga, their whole whānau here, and that's encouraged.

"This is how we are as Pacific People: we don't just work on an individualistic basis, we work on a communal basis."

Read the latest updates on www.VaccinateGreaterWellington.nz

A year at Capital & Coast DHB

2020-2021

163,868
Outpatient appointments

647,000kg
Recyclable products diverted from landfill (includes paper, plastics, glass, cardboard)

3,545
Babies were born in our units

64,060
People presented to the emergency department at Wellington Regional Hospital

TE PAI TIAKI

665,744
Meals made for patients

96,772
Meals on Wheels delivered to the community

2.32million
Laboratory tests were completed for community and outpatients

19,997
Patients had surgery

39,948
Visits were made into people's homes by community allied health workers, such as physiotherapists or social workers

799,408
Laboratory tests were completed for ED/ inpatients

Figures cover July 2020 - June 2021

Governance of Capital & Coast DHB

Role of the Board

Our Board is responsible for the governance of the organisation and is accountable to the Minister of Health. The DHB's governance structure is set out in the New Zealand Public Health and Disability Act 2000.

The board currently comprises 11 members who have overall responsibility for CCDHB's performance. Seven members are elected as part of the three-yearly local body elections and four are appointed by the Minister of Health.

Role of the Chief Executive

The Board delegates to the chief executive on such terms and conditions as are appropriate, the power to make decisions on operational and management matters within the framework of the board's agreed strategic direction as set out in the Annual Plan. It endorses the chief executive, assigning defined levels of authority to other specified levels of management within CCDHB's structure.

Governance philosophy

Over the past few years, the Wairarapa, Hutt Valley and Capital & Coast DHB Boards have taken a whole-of-health-system approach, including integrating clinical and support services where this provides benefits across the health system. Each board provides governance of local services and all three Boards provide collective governance over services that are shared or integrated, ensuring local accountability.

Integrated service approaches are intended to provide:

- preventative health and empowered self-care
- relevant services close to home
- quality hospital care, including highly complex care, for those who need it.

This requires a strong focus on relationships with primary and community care and working closely with staff and communities as we progress service design. The Boards believe this gives us the best opportunity to address the challenges of balancing quality, cost and access.

Ora Toa kaimahi in their COVID-19 vaccination clinic at Lydney Place in Porirua CBD.

Protecting whānau from COVID-19

The COVID-19 vaccination programme is the largest vaccination campaign in the history of Aotearoa New Zealand. As the rollout began in early 2021, our people across our DHBs and community partners worked tirelessly to administer the vaccination to those in groups 1 and 2.

By the end of June 2021, the rollout had widened to include older Māori and Pacific people, disabled people, those at high risk due to health conditions, and all people aged over 65. At that point more than 78,000 doses had been administered in the greater Wellington region.

Māori-led clinics played a crucial role in the rollout, taking a whole-of-whānau approach to getting people vaccinated. By the end of June 2021, four Māori-led clinics were vaccinating people in their communities, including the two marae-based clinics.

The Wainuiomata marae closed until Christmas in order to allow the community of more than 15,000 to be vaccinated.

Kokiri Marae Health and Social Services general manager Teresea Olsen, whose team is running the vaccination programme, said the sacrifice was worth it.

"I think the kaupapa is really important. The reason why we're closing the marae down is to save lives and I don't think you could have a better reason for shutting it down."

Ora Toa opened their new clinic in central Porirua, following weeks of delivering vaccinations at temporary sites at Takapuwahia Pa and a site in Cannons Creek, while the Māori-led clinic at Waiwhetu Fitness Centre in Lower Hutt opened on 9 June.

Ora Toa spokesperson Faith Woodcock said: "The community are finding it easy to navigate so far. That's our intention: to make it a community space."

Read the latest updates on www.VaccinateGreaterWellington.nz

Our People

Being a good employer

Capital & Coast DHB are committed to being a good employer that provides equal employment opportunities and create an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

Capital & Coast DHB aspires to create a thriving culture for our people that values who they are, nurtures skill development and provides an environment for them to do their best in every way, every day.

The heart of the health system is its people. A safe and supportive environment enables the delivery of high quality, compassionate and safe care to our communities.

Living our values across the 2DHB

Capital & Coast DHB values:

Hutt Valley DHB values:

Work continues by the 2DHB to further embed the values. With more employees working in a 2DHB capacity, the synergies of each DHBs values have been revealed to promote connectedness, unity and the feeling of one team.

Our values promote respect and kindness, partnership and connectedness, and doing our best to achieve excellence:

- **Manaakitanga/te atawhai tonu:** Caring for each other's mana is at the heart of this value. We do this by being kind, respectful, caring and helpful. We always ask ourselves – "is my behaviour mana-enhancing?"
- **Mahi tahi/kotahitanga:** We work collaboratively, constructively and fairly together. Communicating and listening are at the core of being able to work in partnership and unity.
- **Rangatiratanga/mahi rangatira:** We strive to be our best and bring out the best in others recognising that each of us has personal power. This value challenges us to use that with integrity to do the best work we can.

- **Mahi pai/can do:** We approach work with a positive and appreciative mind-set that fosters learning and growing.

2DHB People and Culture

The 2DHB vision identifies greater cooperation in a number of key areas across the Hutt Valley and Capital & Coast DHBs to improve the health outcomes of their communities in ways that they could not achieve alone.

The Hutt Valley DHB is a large organisation in its own right, and is expected to work closely as one team. It is vital that the DHB works in ways that enable, facilitate and promote greater collaboration with Capital & Coast DHB.

This includes a new approach for People and Culture.

A 2DHB operating model focussing on service improvement and delivery was established on 1 June 2021 following an extensive consultation process. While structural change will take the DHB part of the way in achieving its goals, good organisational structures with well-defined roles that are underpinned by clear accountability will facilitate and support high performance.

People and Culture are applying a 2DHB lens to thinking strategically about our needs, to more effectively support and develop our most important assets – our people – and, as a consequence, improve the care provided to our communities.

Workforce

The majority of staff employed at the DHB are covered by national Multi-Union Collective Agreements that set out the terms and conditions of employment.

Over the last year, a number of national Collective Agreements covering the work undertaken by our Resident Medical Officers (Junior Doctors), Psychologists, Anaesthetic Technicians and Genetic Counsellors have been settled.

Collective Agreements continue to be negotiated covering the work undertaken by senior doctors, nurses, midwives, allied health, administration and trades staff continue to be renegotiated.

A single employer Collective Agreement covering the work undertaken by Drivers and Stores staff is also currently being renegotiated.

A number of national pay equity claims covering the work undertaken by Administration, Nursing, Midwifery and Allied Health staff continue to be negotiated.

The pay equity claim covering the work undertaken by Administration staff is the most advanced of these claims, with work underway to develop new national pay and band structures.

A new 2DHB salary framework was developed to ensure a consistency of approach to remuneration decisions across the Hutt Valley and Capital & Coast DHBs. The first stage of the salary framework was applied in the 2020/2021 fiscal year for staff employed on Individual Employment Agreements in line with the Government's Public Service Pay Guidance in relation to pay restraint following the economic impact of the COVID-19 pandemic.

A union-DHB partnership approach to workforce concerns continues to be supported by regular bipartite meetings with the unions and the quarterly Joint Consultative Committee meetings with the Association of Salaried Medical Specialists (ASMS).

Work is also underway to develop a strategic approach to the attraction and retention of critical staff, with a focus on fast tracking the on-boarding process, and local and national (working with other DHBs) recruitment campaigns.

Wellbeing

Over the last year it became apparent that COVID-19 is going to be part of our lives for the foreseeable future. Balancing business-as-usual activities with maintaining a COVID-ready health system and managing the impacts on personal lives, requires a focus on supporting staff to maintain their wellbeing.

Therefore, the focus on wellbeing over the last year has been to support leaders and employees to sustain their wellbeing over the longer term.

Kotahi – Be one.

"Ki te kotahi te kākaho ka whati,
ki te kāpuia, e kore e whati.

If there is but one toetoe stem it will break,
but if they are together in a bundle
they will never break."

Kotahi

Since the initial phases of COVID-19, the Kotahi network, a group of 28 skilled professionals from across the 2DHBs, has walked alongside leaders and teams to support them in identifying welfare and wellbeing strategies.

More than 30 teams have accessed coaching support, wellbeing information and resources, and/or had the Kotahi team facilitate discussions to help defuse and debrief.

Given the success of this model, plans are now underway to explore options of embedding the Kotahi team sustainably into business as usual as one of the 2DHB internal wellbeing support options.

Supporting our leaders to create a thriving team

Fundamental to creating a thriving environment is the wellbeing of staff and people leaders play an important role in role modelling and cultivating this.

To support leaders to sustain their own wellbeing and to help their team(s) to flourish, the 'Looking after the team' eLearning programme was introduced. This 30 minutes programme is split into interactive modules and covers:

- The holistic models of wellbeing: Te whare tapa whā and Fonofale,
- The definition of what thriving means in a work environment
- The 2DHB values.
- Tips on being a compassionate leader by recognising emotions, moderating how to respond to others, and how to look after their own wellbeing.
- Ways to create a positive and safe work environment by valuing diversity, and how psychological safety helps create an environment where people feel comfortable to be themselves, and linking positive communication strategies to support this.

Streamlining our Employee Assistance Programme (EAP)

The employee assistance programme provides quality support to people in times of need. This year the EAP service transitioned to a joint 2DHB service provider ensuring a consistent and sustainable wellbeing service was accessible to all staff.

Creating a positive and safe workplace

2DHB strives to create a positive and safe workplace where everyone is treated with respect and that is reflective of our communities and where all of our people feel they belong.

Creating a positive and safe workplace policy

A collaborative approach with staff, key stakeholders and union partners was used to review and revise the Preventing and Responding to Bullying, Harassment, Discrimination and Victimisation policy.

The resultant 2DHB Creating a Positive and Safe Workplace policy ensured the diverse range of perspectives and views were captured, as well as alignment with relevant national and sector guidance.

A set of principles guide the 2DHB response to incidents or complaints of bullying, harassment, victimisation or discrimination. In particular, emphasis has been placed on cultivating a 'just culture' and a 'restorative approach'. There is also an assumption that everyone involved needs access to support to minimise secondary harm and, where possible, to restore relationships.

Further workshops have been held this year and work continues to explore options to further embed the policy and support the organisation to embrace and carry out the key principles.

Pink Shirt Day

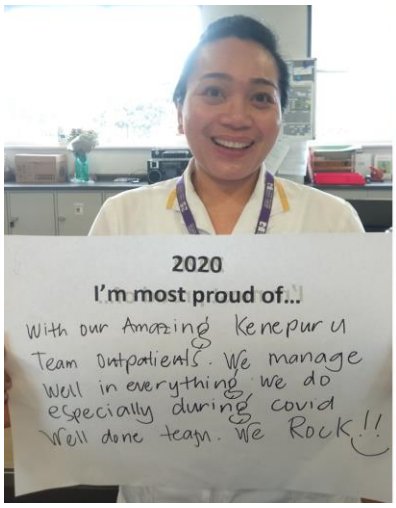
Both DHBs again turned into a sea of māwhero/pink on Pink Shirt Day to show their commitment to creating a positive workplace environment that is safe, welcoming and inclusive of everyone.

An Allied Health team participating on Pink Shirt Day

Celebrating Success Week

Celebrating Success Week 2020 provided an opportunity to acknowledge, take pride in, celebrate, appreciate and reflect on individual and group achievements.

One of the key activities as part of this week was the "I'm proud of..." campaign which encouraged our people to show what they were most proud of during 2020. Appreciation of colleagues and pride in work achievements that made a difference for our patients were key themes.



Growing great leaders

In celebration of the International Year of the Nurse and Midwife, a special edition of the Emerging Leaders Programme was run. A 3DHB collaboration between Capability Development and the Nursing Leadership team allowed 2DHB to provide an innovative and tailored development experience for 90 emerging leaders in nursing and midwifery.

The programme took a strengths-based approach to build a growth mind-set and propel these upcoming leaders to take on greater responsibilities and demonstrate visible leadership on the job. 98% of participants felt inspired for their careers in nursing or midwifery as a result of the programme.

The Frontline Leaders programme continues as a bastion of leadership development across 2DHB. Recent changes to content have strengthened alignment with the strategic priorities of equity and inclusion, and leading for wellbeing and engagement. A new selection criteria has been introduced to provide transparency and build a more rigorous and robust talent pipeline.

A 2DHB Clinical Leadership Programme was developed in preparation to be delivered from November 2021. Targeted at all leaders in clinical roles, the programme aims to build collaborative and compassionate leaders who are able to work across traditional boundaries and innovate to find new ways of delivering care. The syllabus includes formal learning, coaching and partnership workshops.

Leveraging technology to build our capability

Continuing the response to COVID-19, Capability Development has focused on making the best use of technology in orientation, on-boarding and learning programmes:

- The orientation and learning of IT-based systems is now increasingly being done through online guides complemented by drop-in coaching sessions
- Virtual reality learning is being used for more clinical teaching and the scope has been widened to include research. This tool has made accessible to 10 educators across both DHBs.

Keeping employees safe at work, and free from violence and aggression requires a whole of system approach. In response to this, a one-stop 'Keeping Everyone Safe' portal was developed. The portal, provides quick and easy access to information on processes, procedures, learning, and where to go for help all in one place. The portal is available at Capital & Coast DHB with refinements underway to tailor it for Hutt Valley DHB.

A people leader orientation designed to give leaders focus and a clear plan for their first few months is available across the 2DHBs. It enables them and their leader to work through a process to get up to speed quickly and effectively.

Participation in national collaboration initiatives ensures consistent learning packages continue to be delivered across the 20 DHBs. This year, Capital & Coast DHB contributed to the Disability Awareness and Privacy Overview learning packages.

Te Puna Huihuinga Kaimahi - Employee Led Networks

"We value having a workforce that is diverse and inclusive. This means that we will be better positioned to understand, collaborate with and serve our community. We want all of our people to be able to bring their whole selves to work so that they can enjoy their work, do their best work and are proud to work here."

– Fionnagh Dougan, Āpiha Whakahaere Mātāmua, Chief Executive

Our employee-led networks provide a means for staff to connect, share ideas, and support each other. Over the last year the employee networks have steadily grown.

Out & About Rainbow Network

2DHB has strong rainbow employee networks with members and their allies connecting on a monthly basis. In February 2021, both DHB Out & About networks joined together in a show of unity to help launch the Wellington Pride Festival and took part in the Pride Hīkoi.

Out & About members were also integral in introducing eLearning to help grow employees' knowledge of the rainbow and transgender communities. The short module provided an overview of sexuality, gender and the best language to use, so people could create a safer and more welcoming environment for everyone.

The Out and About members at the Pride Hikoi

Manawa Ora 2DHB Orchestra

Musicians and singers from Hutt Valley and Capital & Coast DHBs have come together again to perform as Manawa Ora – the 2DHB orchestra.

Staff rehearse together and perform two concerts each year. This year they were also joined by a newly created staff choir.

"Music is a simple way to connect people – patients, whānau and staff appreciate the music and are grateful for a moment of joy. It feels like we're welcoming people to a place where we want them to feel safe."

- Dr Manjula Ricciardi; 2DHB Manawa Ora Orchestra organiser

Manawa Ora is supported by Wellington Hospitals Foundation, and its name was gifted by 2DHB director of Māori Health, Arawhetu Gray. Arawhetu felt that Manawa Ora was the right name as it encompasses a sense of joy, hope, and acknowledgement that music can lighten the heart.

Manawa Ora performing in the atrium at Wellington Regional Hospital

Disability Network

Launched as part of Mental Health Awareness Week in September 2020, the CCDHB disability network aimed to connect people with disabilities, impairments and long term conditions, along with their allies and supporters.

The network meets on a monthly basis and members are interested in understanding how many people identify as having a disability, impairment or a chronic condition, and also how they can connect together, support each other and share ideas that might improve the experience of working at Capital & Coast DHB.

Employee Occupational Health and Safety

2DHB Occupational Health & Safety has sought to strengthen the COVID-19 response and planning preparation utilising learnings from the initial outbreak and national guidance.

Work has been completed to streamline procedures within the dedicated 2DHB COVID Response Centre, providing more timely responses to both employees and managers and improvements to the database have provided more relevant and useful information to managers.

COVID-19 swabbing clinics have been broadened to include weekends at times of increased transmission, and the fast-tracking of urgent results to ensure limited drain on DHB service delivery. 2DHB also progressed from a contracted service to in-house delivery of Mask Fit Testing with trained internal testers on both sites to increase access to this service both during an outbreak and on an ongoing basis.

Beginning March 2021, both DHBs have focussed on the delivery of in-house COVID-19 vaccination clinics for all employees. The 2DHB set an initial target of 80% employee vaccination, and have exceeded that total with current total vaccinated with both doses at 83%. Whilst an Influenza campaign targeting employees commenced in April, this was superseded by COVID outbreaks – and the clinical focus has been to support COVID-19 vaccination first and foremost.

Non-COVID related work has also continued with the progression of:

- Security for Safety project – a collaboration project across 2DHB with a focus on Hutt Valley DHB site to improve the safety experience of employees, staff and those visiting DHB premises.
- High performance, High Engagement trial collaboration with ACC and MHAIDS to improve understanding and application of health and safety within 2DHB against three identified key projects.
- Collaboration with 20DHB Health and Safety Teams on key national projects – Contractor Management, Lone Workers, Occupational Health Services and Hazardous Substances.
- A full Health and Safety Review. This was undertaken to ensure a 2DHB model of application for all occupational health and safety resource.

Disability Equity e-learning module available to all

The Disability Strategy Team launched an online e-learning module called Disability Equity which is being rolled out to all 20 DHBs. The module has three separate topics – Disability Explained, Engaging With Disabled People, and Working With Disabled People.

It's also available for people outside DHBs via the Ministry of Health's LearnOnline website - https://learnonline.health.nz/login/index.php You will need to create a new account if you don't already have one.

The Disability Equity module promotes appropriate interactions with disabled people coming in contact with health services, and uses rights-based language to encourage a more open mind-set.

The module reinforces both ours and the Ministry of Health's priority work on equity, and relates directly to nurses providing safe and quality care.

Our Violence Intervention Programme Coordinator in the Strategy, Planning & Performance team, Leanne Scott, (above) was the first CCDHB staff member to complete the module saying "it was enlightening and really useful for my role".

Workforce profile

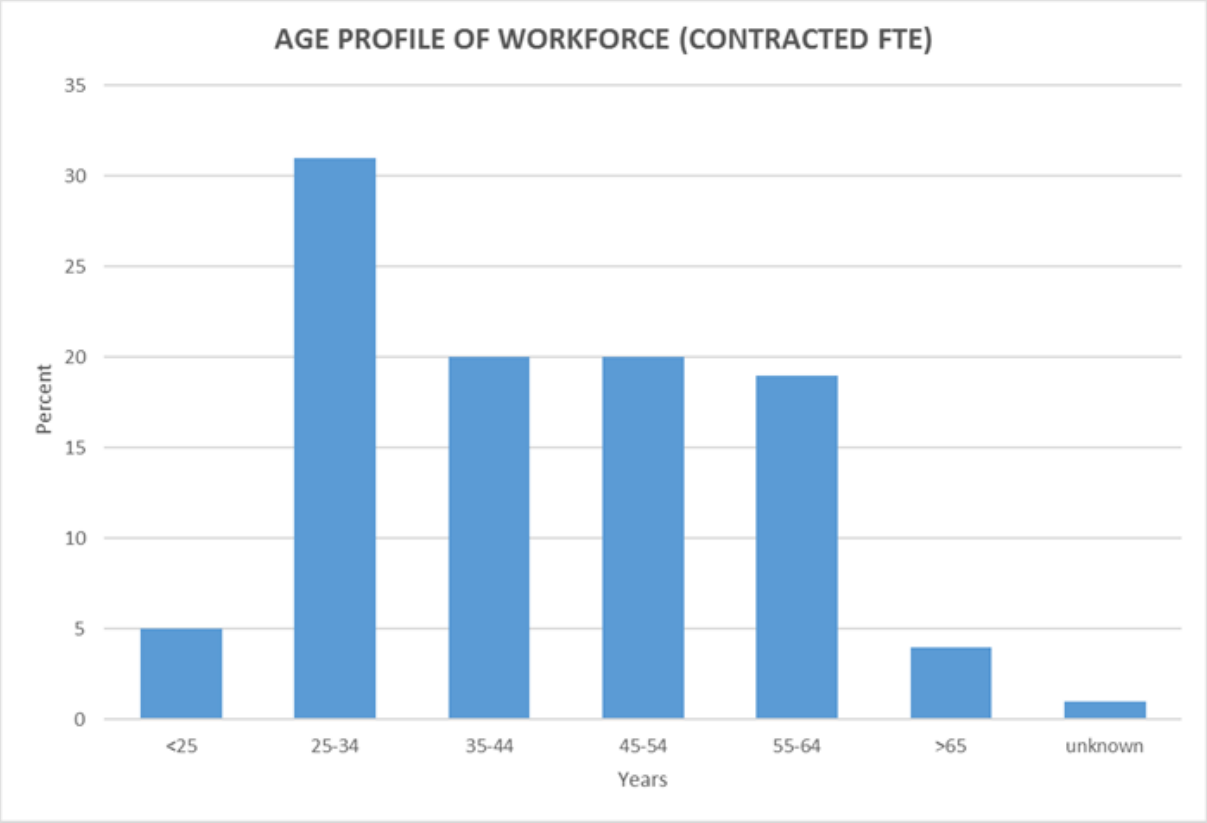
Full Time Equivalent (FTE) staff numbers

Profession	2021	2020	2019	2018	2017	2016	2015	2014
Medical	1002	977	911	900	848	832	800	781
Nursing	2493	2327	2254	2131	2043	2004	1940	1892
Allied Health	828	753	727	724	713	707	766	774
Other	1170	1052	1020	1000	950	963	997	978
Total	5493	5108	4912	4755	4554	4506	4502	4426

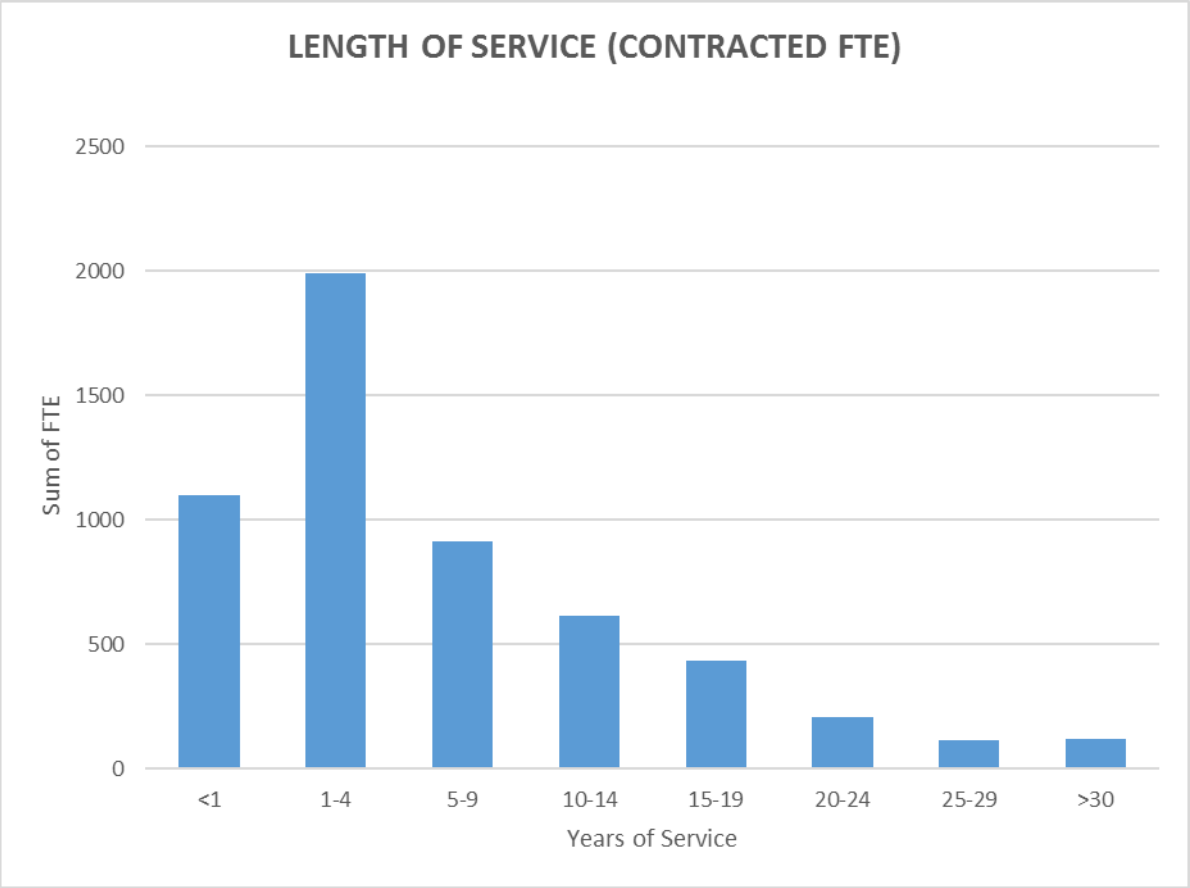
Statistics by gender (%)

Gender	2021	2020	2019	2018	2017	2016	2015	2014
Female	71%	72%	72%	72%	72%	73%	72%	72%
Male	29%	28%	28%	28%	28%	27%	28%	28%

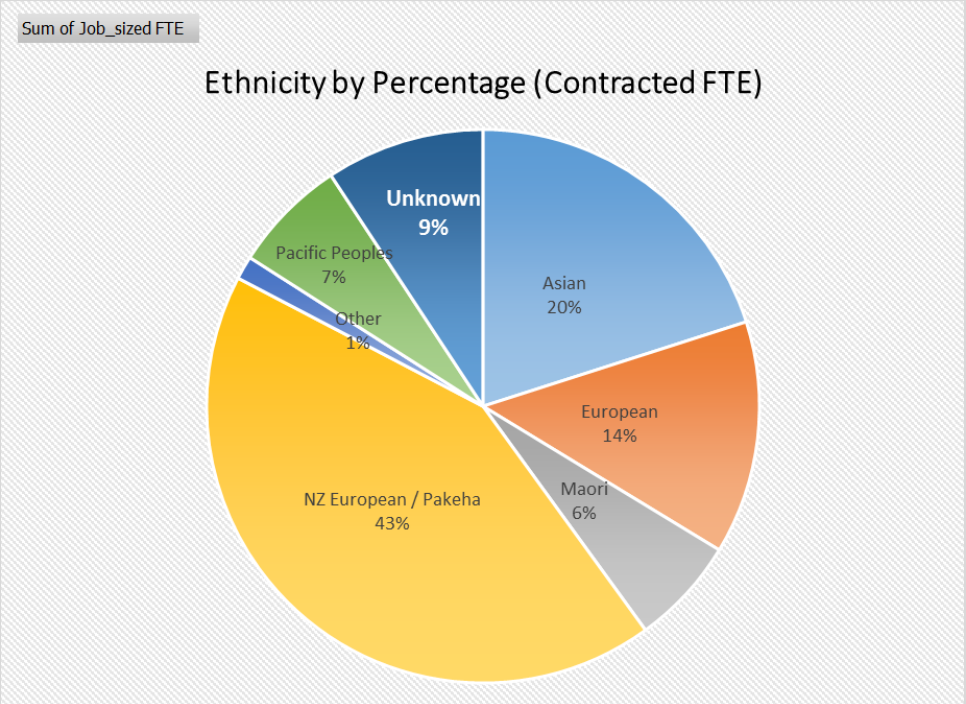
Age profile of Workforce



Length of Service (FTE)



Statistics by Ethnicity



Our Progress

This section outlines our activities and progress under the three key strategic directions in our Health System Plan.

Promote Health and Wellbeing

Promoting health and wellbeing means:

- We invest in helping people and whānau to help themselves and each other keep well
- We invest in the first three years of life
- We intensify our services for individuals and whānau most at risk of poor life outcomes
- We have shared goals for improving physical and mental health and wellbeing, and eliminating health inequalities across the health and social sector

Māori Health Strategy – Taurite Ora

Taurite Ora: Māori Health Strategy, 2019-2030 lays down the challenge of Māori health equity in CCDHB; Kua Takoto te Rau Tapu. The challenge is set to rebuild the DHB as a pro-equity organisation by:

- Redeveloping supportive organisational systems, policies, and processes.
- Actively countering racism and discrimination.
- Actively including Māori in decision-making, particularly where it relates to Māori.
- Developing a strategy to improve proportionality across all our employment groups.
- Improving the quality and efficacy of data.

Work to date on implementing Taurite Ora is outlined below.

Tāngata Whaikaha Community Engagement Programme

We have contracted the Foundation for Equity and Research (FERNZ) to undertake research with the tāngata whaikaha community to identify the gaps and barriers in disability supports for tāngata whaikaha Māori and their whānau. The research will help 2DHB planning for service for tāngata whaikaha so that we focus on achieving equitable outcomes.

Whare ki te Whare Kaiarahi – Navigation Service

We continue to work alongside the Maraeroa Marae Health Clinic in the development of the Whare ki te Whare Kaiarahi – Navigation Service to provide a community-based service to support Māori:

- who are identified as at risk of admission to hospital, and are located in areas of high need; and
- who will benefit from a more focused wraparound Whānau Ora model of support.

The service supports Māori to be healthy at home, with a strong focus on prevention, improving access to existing health services, providing linkages to services, providing holistic community based care. It works with primary care and hospital based teams to keep people stay well in their homes. The service team works with individuals and the whole whānau.

2DHB Māori Health Dashboard: Measures of Equity

We have identified five key measures of equity that are common to CCDHB amd HVDHB Māori health strategies. These five key measures are:

Amenable mortality	Avoidable hospital admissions	Accessible appointments	Primary care utilisation	Community-based services

These five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity in both the Capital and Coast and Hutt Valley regions. These measures are also aligned with the four key objectives of Whakamaua: Māori Health Action Plan, 2020-2025, which are:

1. Accelerate and spread the delivery of kaupapa Māori and whānau-centred services;
2. Shift cultural and social norms;
3. Reduce health inequities and health loss for Māori; and
4. Strengthen system accountability settings.

A sustained multi-pronged approach is required to make progress across these measures of equity. We have developed a 2DHB Māori Health Dashboard to measure our progress against these five measures of Māori health equity.

Increasing our Māori Workforce

Māori and Pacific workforce development and recruitment is a national priority for all DHBs. We aim to actively grow a Māori workforce that reflects our population. We have developed a Māori Workforce Recruitment Policy that operates across CCDHB and HVDHB. This has improved the way we recruit by making the process culturally appropriate. The policy ensures that all advertisements are designed to attract Māori applicants and include an organisation diversity statement, a Māori welcome, a whakataukī and a DHB kowhaiwhai. New guidelines and policies are being developed to enhance both DHBs' ability to attract, appoint and retain Māori staff.

Mothers, babies, children and young people

We are focused on improving health outcomes for mothers, babies, children and young people, alongside strengthening the quality of the overall system of care available to keep families well.

While many mothers, babies, children and young people across our DHBs enjoy better health outcomes than those people in other parts of New Zealand, there are some groups, in some localities, who experience persistent inequitable outcomes. We actively prioritise initiatives that redress these inequities. This involves adopting a range of approaches, including consumer-led procurement; co-design of services; pro-equity approaches to resource allocation; and using person-centred insights, analytics and evaluations to inform future commissioning decisions.

We have seen improvements in the percentage of pregnant women who have a Lead Maternity Carer (LMC) in the first trimester for both DHBs. There has also been improvement in the rates of newborn enrolment in primary care services for babies of Māori and Pacific descent, improvements in avoidable hospital readmissions for 0 to 4 year olds for both DHBs, especially for Pacific children. The percentage of children caries-free in year 8 is increasing in CCDHB, particularly for Māori and Pacific children.

We are continuing work to lift our breastfeeding rates. The DHB is supporting the training of five Māori and Pacific Lactation Consultants. The first Lactation Consultant is expected to complete the qualification in April 2022 so it will take time to see the benefits of this investment. We are also initiating a community breastfeeding

education programme for Māori and Pacific women, providing culturally appropriate education within a community context, involving both mothers and family and whānau.

We recognise the need to lift our childhood immunisation rates, particularly for tamariki Māori. We are investigating ways to support health professionals to have more meaningful dialogue with whānau regarding the importance of childhood immunisations, recognising that the reasons for vaccine uptake are complex and include a wide range of influences.

Youth One Stop Shop

The Youth One Stop Shop in Porirua was commissioned in 2020, using a co-design approach with Porirua rangatahi, led by a youth panel who call themselves #YouthQuake. All decisions in the process were supported by #YouthQuake – from writing the formal tender documents, to forming the evaluation panel, to #YouthQuake asking questions directly to applicants. CCDHB worked with the #YouthQuake panel to co-design a youth-friendly approach to Government procurement, which included 'reading parties' to go through the procurement documents, and using presentations and performances to support traditional written stages of the procurement process.

In early 2021 CCDHB finalised the contract negotiations with the successful applicant – a collaboration between Partners Porirua and Te Runanga o Toa Rangatira (Ngati Toa). An interim YOSS service will be provided to rangatahi from September 2021, with the final premises in Porirua City Centre opening in early 2022. The new service is called "the 502" and will provide a range of primary care services wrap around services that will improve the health and wellbeing of rangatahi. This team will include a mix of GPs, nurses, social workers, mental health professionals, rangatahi/peer support workers and others as required.

Mental Health and Addictions Strategy

In May 2019 we launched Living Life Well – A Strategy for Mental Health and Addiction 2019-2025 Mental Health and Addictions Strategy for the Wairarapa, Hutt Valley and Capital & Coast District Health Boards. The direction set out in Living Life Well is strongly aligned with the Government's future direction for mental health and addiction services and provides a strong platform to respond to new national priorities. Living Life Well supports the complete continuum of care, from primary and community care through to intensive inpatient services. The strategy recognises the need to sustain specialist mental health and addiction services, while improving our early response and intervention when things start to go wrong. The strategy also focuses attention on those with inequitable health outcomes.

A work programme has being developed in partnership with lived-experience leaders, Māori, Pacific, primary care, NGOs, and specialist mental health and addiction providers. Through this co-design process, we aim to create a transformational approach to shared leadership, decision making, design, delivery and funding of services over the next five years. This work includes a new sub-regional Integrated Primary Mental Health and Addiction Service, and a GP Liaison Consultant Psychiatrist Service, which began operating in July 2020.

Bowel, breast, and cervical screening

Screening and early detection of cancer gives people the best chance of successful treatment. We have rolled out and embedded the Bowel Screening Programme to detect bowel cancer at an early stage. Eligible residents (aged between 60 and 74) have been screened and, when necessary, accessed preventative treatment for bowel cancer. We are focused on lifting our breast and cervical screening rates for Māori and Pacific women. Breast and cervical screening is provided at Wellington Regional Hospital, and we fund general practices to provide free cervical screening.

We have been data matching with general practices to identify women who have not been screened, and then following up with them to offer screening and support. This includes booking clinic appointments, arranging transport and support, and referral to support services. We are continuing to open weekend and after-hours clinics to improve accessibility. Combined breast and cervical screening days on Saturdays have been well attended and helped women access screening.

Well Homes - Healthy Housing

We have continued to support and enhance the Well Homes service, which supports whānau to make their homes warmer, safer and drier. Housing assessors visit a home to conduct healthy housing assessments and provide education. They link whānau to appropriate services such as insulation, heating, curtain banks, beds, bedding, carpets, rugs, financial assistance and social housing providers. We have an automated referral system, so people admitted to hospital with respiratory problems are automatically offered the service.

Building healthy environments and promoting healthy choices

Our Regional Public Health service works with a variety of stakeholders such as early childhood centres, schools, workplaces, social support agencies, and local councils to encourage and support the development of health-focused policy and healthy environments. For example, Regional Public Health represents the DHB at council working group meetings to support collaborative activities that strengthen safe water. Health promotional activities and initiatives are also undertaken by contracted providers such as primary care, Māori and Pacific providers, and Regional Public Health. These activities raise awareness and promote healthy choices across a range of topics.

Nutrition and physical activity programmes

There are a number of nutrition and physical activity programmes in the Wellington region targeted to priority populations. We fund a free healthy eating and exercise programme, Pre-School Active Families, through Sport Wellington that incentivises whānau with obese pre-school children (identified through the B4 School Check) to enrol in and complete the programme. We also fund Sport Wellington to deliver a Maternal Green Prescription programme and the Active Families programme. The Maternal Green Prescription programme supports pregnant women to maintain healthy weight gain in pregnancy and promotes healthy eating, exercise, breastfeeding and the introduction of solids in the postpartum period. The Active Families programme helps children and their whānau create a healthier lifestyle by becoming more active and learning about healthy eating. These programmes are successfully engaging with Māori and Pacific families. Wesley Community Action, community groups and organisations work with Regional Public Health to enable locally run fruit and vegetable cooperatives to provide fresh fruit and vegetables at affordable prices.

Oral health services to children

The Bee Healthy Regional Dental Service provides free community-based dental services to children across the Wellington Region. The service operates from 13 fixed sites in the community and 12 mobile clinics that travel to primary and intermediate schools across the region. While the service has good coverage, it continues to use new approaches to increase examination numbers, prevention opportunities, and access to care year-on-year.

The Regional Dental Service has an Early Intervention and Prevention (EIP) Team that manages equity driven outreach programmes supplemental to the standard model of care that include oral health checks being provided to pre-school children onsite at Kohanga Reo, Pacific Language Nests, and other early childhood centres in high need areas. It also provides health education and information to teachers, support staff, students, and families to raise awareness of the importance of teeth and key prevention messages. Since 2020, a supported supervised tooth brushing programme is also being offered to some early childhood centres and primary schools.

Other initiatives include drop-in dental check-ups to children in community settings during school holidays, and working with Māori and Pacific providers and local councils to promote the service and increase coverage. The Bee Healthy Service is continuing to increase the number of children seen each year, and the service now reaches around 74,000 primary and intermediate school children every year.

Improving sustainability and reducing carbon emissions

CCDHB is committed to being more environmentally sustainable and has a comprehensive plan in place to measure, manage and reduce greenhouse gas emissions. In 2019 CCDHB receive a Certified Emissions Measurement and Reduction Scheme (CEMARS) programme certificate. This was received in recognition of our ongoing sustainability efforts to reduce carbon emissions by nearly 1000 tonnes annually since 2013.

CCDHB continues to make positive changes that make energy savings, reduce carbon emissions and improve recycling. Changes made in the last year include removing single use plastic from our catering services, installing energy efficient lighting and introducing the first hybrid vehicles to our fleet.

Measuring our progress: Promoting health and wellbeing

Criteria Description	Rating	Rating System
Achieved	At or above target	
Not achieved, but progress made	≤10% of target	
Not achieved	≥10.1% of target	
Demand-driven Measure	No rating applied	
Data not available by ethnicity	No rating applied	

Progress Measure	Baseline	Target 2020/21	Actual 2020/21	Trends – including equity gap	
Amenable mortality rates (rate per 100,000)	2017: Māori: 120.6 Pacific: *4 Total: 55.4	2018: Māori: 98.9 Pacific: 158.7	2018: Māori: 132.9 Pacific: 166.3 Total: 68.0	Māori	
				Pacific	
Babies breastfed at 3 months	2019/20: Māori: 43% Pacific: 50% Total: 62%	≥60%	Māori: 56% Pacific: 40% Total: 62%	Māori	
				Pacific	
				Total	
Children fully immunized at 2 years	2019/20: Māori: 90% Pacific: 93% Total: 94%	≥95%	Māori: 81% Pacific: 90% Total:91%	Māori	
				Pacific	
				Total	
Children with no cavities at 5 years of age	2019: Māori 53% Pacific 43% Total 71%	69%	2020: Māori 53% Pacific 47% Total: 71%	Māori	
				Pacific	
				Total	
Average number Diseased, Missing and Filled Teeth (DMFT) at age 5	2019: Māori: 1.94 Pacific: 2.66 Total: 1.16	Reducing trend	2020: Māori: 2.00 Pacific: 2.30 Total: 1.15	Māori	
				Pacific	
				Total	
	2019:		2020:	Māori	

*4 Suppressed due to actual volume being below 30

Progress Measure	Baseline	Target 2020/21	Actual 2020/21	Trends – including equity gap	
Reduced burden of tooth decay at year 8 (DMFT)	Māori: 0.27 Pacific: 0.26 Total: 0.33	Reducing trend	Māori 0.73 Pacific 0.90 Total 0.51	Pacific	
				Total	
Women screened for cervical cancer	2019/20: Māori 65% Pacific 64% Total 72%	>80%	Māori 66% Pacific 62% Total : 74%	Māori	
				Pacific	
				Other	
Women screened for breast cancer	2019/20: Māori: 67% Pacific: 70% Total : 72%	>70%	Māori 66% Pacific 65% Total 71%	Māori	
				Pacific	
				Total	
PHO enrolled patients who smoke and are offered help to quit	2019/20: Māori: 83% Pacific: 85% Total: 84%	≥90%	Māori: 64% Pacific: 70% Total: 66%	Māori	
				Pacific	
				Total	
Hospital patients who smoke and are offered help to quit	2019/20 Māori: 84% Pacific: 90% Total: 84%	≥95%	Māori 81% Pacific 84% Total 80%	Māori	
				Pacific	
				Total	
% of babies living in Smokefree homes at 6 week check	2019 Māori: 41% Pacific: 51% Total: 67%	Improved performance	2020 Māori: 43% Pacific: 56% Total: 60%	Māori	
				Pacific	
				Total	
% of eligible population having cardiovascular disease (CVD) risk assessment in last 5 years	2019/20 Māori: 78% Pacific: 78% Total: 87%	≥90%	Māori: 73% Pacific: 74% Total: 72%	Māori	
				Pacific	
				Total	

People-Focused Services in the Community

People-focussed services in the community means:

- Care is community-based 'by default' services are delivered closer to people and their whānau
- Enhanced primary care functions as the 'health care home' of people and their whānau
- Health professionals and community providers collaborate, and work as one team to support people in their communities
- A hospital facility footprint focused on complex care and designed for contemporary models of care.

Kāpiti Community Health Network

The Kāpiti Community Health Network (CHN) is a network of health providers who are supported to coordinate and organise health service delivery to achieve equity and better meet the needs of the Kāpiti population. Development of the Kāpiti CHN first began in July 2020 in partnership with mana whenua (Te Ātiawa ki Whakarongatai) and Tū Ora Compass Health (Tū Ora).

CHNs are a new model explicitly designed to deliver more care in the community by integrating health services to deliver the right care, to the right people in the right place. With a focus on whakawhanaungatanga, we have established a local multi-agency Network Management Team, a Network work programme and iwi and community-led local Network Governance.

The Kāpiti CHN has identified three initial focus areas for its population: the health of older people, health and social care integration, and planned care. Work is underway under each of these focus areas. One example is a direct referral project between CCDHB Community Services, Wellington Free Ambulance, supported by Kāpiti GPs and Tū Ora. This project will enable more Kāpiti residents to safely remain in their own homes and reduce ambulance transfers to Wellington Hospital. This work builds on the Kāpiti Emergency Department Diversion programme, which is focussed on making urgent and after hours primary health care more accessible to Kāpiti residents. Kāpiti residents who have been clinically assessed by Wellington Free Ambulance paramedics can now be treated closer to home by their GP or local medical centre, avoiding a trip to the Emergency Department.

The Kāpiti CHN is an early example of our goal for primary and community services to be commissioned closer to communities – through 'localities'. We are working towards health systems being delivered through networks of providers with a focus on shared outcomes, specific to their community.

The locality approach offers a platform to implement a population health approach, which aligns closely with the strategic direction of the health and disability system reforms. The Kāpiti Network experience will inform the development of other community health networks across CCDHB and HVDHB.

Three Year Plan for Planned Care Services

We are implementing our Three Year Plan for Planned Care Services, which was developed in consultation with hospital services and community providers. Planned Care encompasses all non-acute (non-urgent) health care activity delivered in hospitals, primary care, and community settings. One of the key initiatives in this area is a renewed focus on care across the system, and removing financial disincentives for delivering planned care outside of the hospital setting.

The plan was developed in collaboration with HVDHB to ensure a coordinated approach to the development of planned care services across both DHBs. The plan outlines how the DHB intends to address five nationally-set strategic priorities: understanding health need, balancing national consistency and local context, simplifying pathways for service users, optimising sector capacity and capability, and delivering sustainable and ‘fit for future’ services. The changes that will be progressively enabled by the new approach to planned care include improvements in equity of access and outcomes of care, encouraging provision non–surgical care alternatives in community settings, creating incentives to implement innovative models of care, and increasing the volume and range of interventions to meet changing population health needs.

Health Care Homes

We have invested in the sustainability and enhancement of primary care through the Health Care Home (HCH) model of care across CCDHB and HVDHB. The HCH is a team-based health care delivery model, led by primary health clinicians. Although implementation of the HCH model is in its infancy in New Zealand, evaluation of the

model is promising and suggests that acute need is being prevented or successfully dealt with out of hospital by HCH practices.

One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs alongside community services teams, who may also be high users of acute hospital services.

The HCH model includes a telephone triage service, where patients calling the practices may talk directly to a registered health professional, typically a general practitioner. Talking to a health professional means some issues may be resolved over the phone, saving people the time and effort of going to the practice. The HCH practices also offer extended opening hours, increasing the opportunity for patients to see their doctor outside normal working hours. They also use patient portals, so patients can go online to order repeat prescriptions, book appointments, check results and message their GP or nurse directly. HCH practices also offer telehealth options as alternatives to face-to-face appointments where appropriate, making healthcare more affordable and accessible.

The investment in the HCH model meant that CCDHB and HVDHB general practices were well prepared to operate effectively using telehealth services and virtual tools during the COVID-19 lockdown (Alert Levels 3 and 4). Thirty-three practices across CCDHB, and 15 across HVDHB are HCH practices, covering approximately 80 percent of both the CCDHB and HVDHB population.

Falls prevention and management

We have partnered with ACC to establish and embed a Falls prevention and management programme across Hutt Valley, Capital & Coast, and Wairarapa DHBs. The programme is delivered in the community and aims to reduce the incidence and impact of falls and fractures in older people. The programme includes risk-of- falling screening, assessment, triage and management of frail elderly delivered in primary care; a 10 week in- home strength and balance programme delivered by our community physiotherapy team; and group-based strength and balance classes, provided at various locations across the district, delivered by local providers and coordinated by Sports Wellington. We are working to improve access to strength and balance activities and programmes, particularly for Māori and Pacific older peoples.

Community-based support for people with mental health or addiction issues

In addition to providing our specialist mental health and addiction treatment services, we also fund a number of support services in community settings for people with mental health or addiction issues.

In July 2020 we began operating a new primary mental health and addiction service, under the ‘Access and Choice’ initiative, which is being rolled out nationally over five years. It aims to expand the access to, and choice of, primary mental health and addiction services in New Zealand. The investment in the Access and Choice model of care is designed to address the long-standing gap in the mental health and addiction continuum of service delivery by investing in primary mental health services, which is where most people initially present with mental health and addiction issues. So far 40 FTE have been established to the Access and Choice service across both CCDHB and HVDHB. There are plans to add another 20 FTE over the next two years. The investment in Access and Choice complements our investment in primary care addiction services.

Implementation of the Access and Choice initiative will be supported by the establishment of locality-based mental health and addiction networks. Current initiatives or smaller existing networks will be incorporated into more integrated 2DHB networks to ensure a range of connected services.

The Advancing Wellness at Home Initiative

The Advancing Wellness at Home Initiative (AWHI) is a programme led by Allied Health that involves community nurses and other community services. The team includes physiotherapists, occupational therapists, social workers and liaison nurses, and is part of the Wellington Community Older Adult, Rehabilitation and Allied Health Services (ORA) team. AWHI supports people living in Wellington who are medically fit for discharge but might need help to get home and to return to their functional and social activities. AWHI approaches discharge with a 'can do' attitude, problem solving any barriers to discharge. AWHI can take people home, liaise with community nursing and/or home and community support providers to ensure care is provided, provide and set up equipment, and provide in-home rehabilitation to support people to return to their previous activities.

Measuring our progress: People-focussed services in the community

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	Māori: 5833 Pacific: 9577 Total: 4991	Māori: 6422 Pacific: 10866 Total: 5581	Māori: 5437 Pacific: 7179 Total: 4957	Māori	●
				Pacific	●
				Total	●
ASH Rates (avoidable hospitalisations) for 45-64 years	Māori: 6308 Pacific: 7409 Total: 3100	≤2623	Māori: 5671 Pacific: 6887 Total: 2966	Māori	●
				Pacific	●
				Total	●
Well-managed diabetes in primary care	Māori: 50% Pacific: 44% Total: 55%	≥60%	Māori: 51% Pacific: 49% Total: 61%	Māori	●
				Pacific	●
				Total	●
Acute hospital bed days per 1,000	Māori: 316 Pacific: 419 Total: 300	Decreased Trend	March 2021: Māori: 441 Pacific: 501 Total: 290	Māori	●
				Pacific	●
				Total	●
Acute readmissions to hospital	Māori: 13.8% Pacific: 11.9% Total: 12.9%	Decreasing Trend	March 2021 Māori: 13.4% Pacific: 13.0% Total: 12.8%	Māori	●
				Pacific	●

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
				Total	
Acute readmissions to hospital age 0-4	Māori: 12.8% Pacific: 14.6% Total: 14.0%	Decreasing Trend	Māori: 11.0% Pacific: 11.8% Total: 11.0%	Māori	
				Pacific	
				Total	
PHO enrolment	Māori: 89% Pacific: 100% Total: 92%	95%	Māori: 93% Pacific: 103% Total: 97%	Māori	
				Pacific	
				Other	
Newborn PHO enrolment	90.6%	Increasing Trend	91%	Total	
Proportion of dispensed asthma medications that were a preventer rather than reliever	54%	Increasing Trend	65%	Total	
Cancer mortality	2017: 483	Decreasing Trend	2018: 509	Total	
Decrease in avoidable hospitalisation for cardiovascular disease	Māori: 352 Pacific: 310 Total: 3592	Decreasing Trend	Māori: 464 Pacific: 446 Total: 4409	Māori	
				Pacific	
				Total	
Decrease in avoidable hospitalization for Chronic Obstructive Respiratory Disease	Māori: 121 Pacific: 69 Total: 578	Decreasing Trend	Māori: 97 Pacific: 55 Total: 507	Māori	
				Pacific	
				Total	

Timely Effective Care that Improves Health Outcomes

Timely effective care that improves health outcomes means:

- People and whānau can communicate with a wider range of health providers electronically
- Patients, their whānau and health professionals engage in informed conversations about treatments and interventions that add value to care
- Individualised shared care plans are built around what's important to people and whānau
- Primary and community services coordinate care across a wide range of health and social services based on a shared care plan
- All health professionals within the system engage and collaborate in training, leadership and quality improvement activities and opportunities.

2DHB Work Programme

2DHB is a joint programme of work currently underway between HVDHB and CCDHB. This work is focussed on 3 major themes:

1. Improving patient access to healthcare - including making the system more equitable for Māori and Pacific patients
2. Working together across the two DHBs and making the most of limited resources
3. Planning together for the region, with a joined-up leadership and vision for healthcare.

Five Communities, One Vision

At the core of this change is the "five communities" vision. This is an approach that focuses on the communities [that make up the communities] with our DHB boundaries - Kāpiti, Upper and Lower Hutt, Porirua and Wellington. Each of these communities has its own specific set of needs and challenges, and our vision is that by planning more effectively across the whole region, we can better serve our patients and clients and improve the equitability of our system.

In this vision, our patient pathway will be simplified, particularly for patients who would previously have had to cross DHB boundary lines to receive care. At the same time we hope to make life simpler for our clinical and administrative staff, by removing some red tape along the way.

Making the most of a limited resource

Both DHBs have been making the most of what they can with the resources available to them, but it is clear that this approach will not continue to be sustainable into the future. In order to maximise the resource available to our staff and patients, CCDHB and HVDHB will be looking at areas where it makes sense to work together. This may be in areas like human resources or communications, where having a common work approach will also help in other ways.

Planning together

One of the ways we will work towards a more sustainable and equitable service is through joined-up leadership and planning. The boards of HVDHB and CCDHB have appointed a single CEO, Fionnagh Dougan, to oversee both organisations. We also have a new 2DHB leadership team that has responsibility for healthcare in both DHBs and supports the CEO. The leadership team takes a community-focussed approach to planning. The specific needs of

each community in the region are considered, and we take a patient-centric approach to service planning that ensures services are well joined-up and seamless.

The changes we are making are about making sure healthcare is easy to access and effective for all people in our five communities. We will work with everyone involved as we design the new approach. This means not just doctors and nurses, but all hospital staff, the five communities, families, patients, and external experts. The most effective change will happen when we listen to and learn from feedback.

Te Wao Nui - Child Health Service

Te Wao Nui is the name for our integrated Child Health Service that will be housed in Wellington's new children's hospital building. Our child health services are currently located in different parts of Wellington Regional Hospital. Te Wao Nui is a new purpose-built facility that will place our child health services under one roof for the very first time.

The new children's services and inpatient facilities will offer a number of benefits, including:

- improved quality and experience of care for children and family/whānau
- a more child and adolescent friendly environment with ability for a parent/caregiver to stay by every bedside
- a larger, more functional unit for observing and assessing children
- co-location of children's services in one facility to improve coordination and teamwork
- increased ensuite bathrooms, and greater numbers of single bedrooms, to better support patient care.

The new hospital has been designed with tamariki, rangatahi and whānau at the centre. Te Wao Nui allows for the provision of high-quality services and brand new equipment. It includes an outdoor Playscape, providing a play area as well as rehabilitation. Interactive features include bongos, a climbing frame, a fort and a slide. The name, Te Wao Nui, reflects the ecosystem of integrated health services designed for tamariki, rangatahi and whānau of central New Zealand. We acknowledge Mark Dunajtschik's unprecedented and incredibly generous donation that has allowed this wonderful project to come to fruition. Te Wao Nui will open in 2022.

Care Capacity Demand Management

We have advanced the Care Capacity Demand Management (CCDM) programme in partnership with the New Zealand Nurses Organisation, the Public Service Association and the Safe Staffing Healthy Workplaces Unit. The CCDM programme helps the DHB match the capacity to care with patient demand, and supports staff to provide high-quality and safe care to our patients, while improving the work environment and organisational efficiency. CCDM enables the DHB to invest effectively by getting an accurate forecast of patient demand, removing as much variability as possible from the system, and matching the required resources as closely as possible (in staff numbers and skill mix).

Capacity at a Glance screens are used to monitor current capacity (the staff) against demand (the patients in the ward), visualise the performance of the ward at a glance, and identify opportunities for improvement. Variance Response Management processes and tools enable the DHB to quickly respond to workforce demands and therefore improve patient flow. The CCDM programme helps the hospital run more effectively, improves our patients' experience and outcomes, and makes working at Capital & Coast DHB more satisfying for our staff.

New Kaupapa Māori Forensic Mental Health Service for Wellington Region

CCDHB has contracted Te Waka Whaiora Trust to develop and implement a forensic step-down service for Tangata Motuhake — those who identify as Māori experiencing mental illness. Te Waka Whaiora is a current provider of Kaupapa Māori community mental health and addiction services in the greater Wellington region and specialises in the delivery and design of services for Māori.

The 4 to 6 bed service will be managed by Te Waka Whaiora in partnership with CCDHB's Te Korowai Whāriki — Regional Forensic Service. The new service will provide forensic transitional care for Tangata Motuhake as they begin their integration journey back into their community and reconnect with their culture and whānau. Kaupapa Māori concepts using Te Whare Tapa Wha will be combined with expertise in community residential rehabilitation in a safe and secure home-like accommodation. Tangata Motuhake will be supported by Kaitautoko using whānaungatanga principles to gain skills and functional independence through structure, supervision and holistic assistance.

Forensic mental health services are a highly specialised component of New Zealand's mental health assessment, treatment and rehabilitation services. They exist at the interface between the mental health and criminal justice sectors and focus on managing and providing expert advice in a variety of settings including prisons, courts, specialised inpatient units, and the community.

New procedure suite to increase surgical capacity

We have begun planning for a new purpose-built procedure suite at Hutt Hospital. The new facility will increase the capacity of the hospital's surgical services by freeing up space in the main operating theatres. The development will include five procedure rooms (one of which is larger for laser use), dedicated patient change facilities for each procedure room, a central three lazi-boy chair recovery room with a beverage bay, and a main waiting room.

The purpose-built facility will improve patient experiences when undergoing surgical procedures under local anaesthetic. It is expected that approximately 500 surgical procedures will be undertaken in the procedure suite per year—increasing the capacity for minor surgery across the region. The new procedure suite will improve outcomes for people across the wider region and ensure that services are accessible and delivered in the most appropriate setting. The additional capacity created will address the increased demand from an ageing and growing population and improve elective surgery and cancer treatment timeframes.

Measuring our progress: Timely effective care that improves health outcomes

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○

Progress Measure	Baseline 2019/20	Target 2020/21	Actual 2020/21	Trends – including equity gap	
Length of inpatient stay in hospital (average days)	Acute: 2.27 Elective: 1.54	Acute: 2.4 Elective: 1.5	Acute: 2.65 Elective: 0.99	Acute	●
				Elective	●
Time patient is in ED (6 hour discharge or transfer)	78%	95%	66%	●	

Waiting time to access Mental Health/ Addiction Services. (Referred and seen within 3 and 8 weeks)	3 Weeks: 60% 8 Weeks: 83%	3 weeks: 80% 8 Weeks: 95%	3 Weeks: 73% 8 Weeks: 92%	3 Weeks	
				8 Weeks	
Readmission to Mental Health services within 28 days	10.5%	<9%	10.6%		
Access to electives	95.4%	100%	106.4%		
Patient experience in hospital (average patient score out of 10 across four domains)	Communication: 8.4 Coordination: 8.6 Partnership: 8.4 Physical and Emotional Needs: 8.8	Communication: 8.5 Coordination: 8.5 Partnership: 8.6 Physical and Emotional Needs: 8.6	Data no longer recorded		
Percentage of patients receiving their first cancer treatment within 31 days of decision to treat	89%	≥85%	90%		
Age of entry into age Residential Care	83.8	Increasing Trend	84		

From left: David Smol - Board chair, Dorothy Clendon - Strategy, Planning and Performance, Dr Chris Fawcett - clinical lead Kāpiti CHN, Martin Hefford - chief executive Tu Ora Compass Health, Fionnagh Dougan - chief executive 2DHB and Andre Baker - Te Atiawa ki Whakarongotai Charitable Trust board chair.

Kāpiti Community Health Network (CHN) launch

Capital & Coast and Hutt Valley DHBs' joint chief executive Fionnagh Dougan and joint board chair David Smol hosted a launch event in December 2020 to mark the establishment of a Community Health Network for Kāpiti – a collaboration of health providers with an interest in improving the health and wellbeing of the local population and achieving equitable health outcomes.

Te Ātiawa ki Whakarongotai, CCDHB, and Tū Ora Compass Health have developed and are implementing the network in partnership with other health providers – including GPs, community pharmacists, Aged Residential Care facilities, home and community support services, and NGOs.

This is a significant step forward for Kāpiti healthcare services, and builds on the strong partnerships and good work happening in the region. Kāpiti is the first network to be established in our region. Impacting on equity of health outcomes is an expectation in all that the network does, and informs how we approach networks in other areas.

Prior to the network, a lot of good work was already underway in Kāpiti, and there were many established connections and collaborations. We built a strong foundation through the Health Care Home programme, which has strengthened primary care across the district.

Quality Improvement and Patient Safety

The Quality Improvement and Patient Safety Directorate leads the quality improvement and patient safety work across the DHB using quantitative and qualitative measures to support evidence-based decision making and practice change, as well as streamlining systems and data reporting mechanisms.

Over the last 12 months, our focus has been to build on the Clinical Governance and 2DHB Quality & Safety frameworks, that were established in 2019/2020. Building clinical governance has further strengthened our focus on the quality and safety of services, with the newly formed Clinical Advisory Group engaging with consumers/whānau to reduce inequities for priority groups including Māori, Pacific people and those with a disability.

Consumer engagement

Consumer engagement is viewed nationally and internationally as a critical component of patient safety and quality improvement. In August 2019 CCDHB appointed a Consumer Engagement Manager, which sits within Quality Improvement Patient Safety (QIPS) directorate.

An important development this year was the establishment of a consumer advisory group, which is a sub-group of the Clinical Board. This group has representation from Māori, Pacific Peoples, Disability, Mental Health & Addictions, Rainbow, Asian, and youth communities. Consumers are embedded at many levels of the organisation including: involvement with serious event reviews, members of sub-committees, participation in service credentialing, supporting co-design projects and being part of strategic groups. A project manager who worked alongside a consumer said: “the best thing about consumer engagement is hearing the ideas of patients, their families and whānau tell us about what really matters to them….. The things consumers tell us is not the same things as doctors, allied health professionals or nurses. It’s the things you don’t learn in your undergrad about what’s important. We could read studies about what’s important, but nothings more powerful than sitting in a room and hearing these orators tell us like it is.”

The consumer voice is valued and leads conversations around equity and quality improvement in our hospitals:

“Consumers share their unique perspectives that guide quality improvements. Without their experience, we are merely implementing what we as health professionals judge is best for people. Implementing change without consumer advisement runs the risk of implementing change that is unhelpful, biased, inequitable and/or culturally inappropriate.” Registered nurse.

Hospital surveillance

In May 2021 CCDHB underwent a Ministry of Health Surveillance audit, against NZS 8134:2008 Health and Disability Services Standard. The three-day surveillance audit included a review of quality and risk management systems, staffing requirements, aspects of clinical care, infection prevention and control, and restraint minimisations and safe practice. The mental health services were included as part of CCDHB’s audit in May. Work has progressed in most of the previous areas identified for improvement and thirteen previous corrective actions were closed (consent, document control, audit, discharge planning, and restraint management).

The auditors noted that there was increased 2DHB integration, with some services working well together, and processes starting to align. The quality and risk management system was developing well between the 2DHBs with a consistent quality and risk framework and a developing clinical governance model. Improvement activity

was evident at both DHBs, from large projects across the continuum of care, to smaller ward-based initiatives. MHAIDS were commended for their amazing improvement projects. Patient tracer methodology was used across services at both DHBs and is being used to bring about change. The audit activity was noted as‘a real strength to the 2DHBs. Another highlight was increased consumer engagement including: project work, reviewing policies, membership of committees, and involvement with reportable events and adverse event reviews at CCDHB and notably in MHAIDS.

Areas for improvement focused on several areas where patient demand was impacting on the ability to supply enough staff with the right skills to safely provide care 24 hours a day seven days a week. At CCDHB increases in demand in nursing, midwifery, allied health and medical staff were observed in all clinical and MHAIDS facilities. The auditors praised the workforce for several innovative and thorough ways to address this demand.

Patient and system tracer audits

Patient tracer methodology was commenced across services in 2019 and is being used to bring about change and effective monitoring of the patient journey. The audit activity was noted as ‘a real strength’ to the CCDHB and has expanded to focus on risk assessment such as medication and Know your IV lines. Tracer audits provide an accurate assessment of the systems and processes for the delivery of care, treatment, and services. Tracer audits are recorded in real-time and paint a powerful snap-shot of the challenges and successes experienced within a ward.

In February 2021, the system tracer expanded to ambulatory care and MHAIDS with a focus on improvement of monitoring and transparent self audits. The auditing team followed the experience of a sample of patients, as they interacted with the health care system. Feedback was provided to the Manager in real-time, so that identified safety issues and risks were acted upon quickly.

Further development is underway to support the same approach in monitoring Pathways to Wellbeing, Patient-Centered and Safe Environment, and Infection Prevention and Anti-Microbial Stewardship; and aligning current process with the new Ngā Paerewa Health and Disability Services Standard 2021. A tracer audit schedule was implemented across the inpatient areas, with development of training, tools to online solutions and policy to guide and support practice.

Improvement

Healthcare professionals and regulators are increasingly turning their focus to creating a safer medication management environment, by reducing opportunities for error. This represented a prime opportunity to improve healthcare delivery and outcomes for patients.

The Medication Safety Campaign Group was formed with representatives from across CCDHB who wanted to help support the organisation to achieve greater medication safety.

Medication management is one of the most complex systems in hospitals, with the delivery of each dose of medicine involving as many as 30 steps and almost as many people. Because they are so commonly used, medicines give a higher incidence of errors and adverse events than other healthcare interventions.

The Medication Safety Campaign group focussed on four workstreams to promote the highest standards in safe and effective use of medications:

1. Acute pain management: Redeveloped the Acute Pain in Adults Inpatients guideline (2DHBs). The guideline has been rewritten by expert SMOs in emergency medicine, anaesthesia and clinical

pharmacology. Staff were educated on changes to practice through face-to-face sessions, intranet articles and a recorded webinar.

2. Paracetamol: Improved safe prescribing and administration of paracetamol for adult inpatients through an awareness campaign - posters, intranet article and education sessions including the clinical forum.
3. Nursing workstream: Work included development of a Foundations of Medication Administration, four week programme – a tool kit for clinical areas. Administrating high risk medications focussed teaching. Four clinical areas also focussed on medication safety improvement work identified through both audit and incident data. Learning has been shared through presentations at Senior Nursing meeting/ forums.
4. Oxygen: Improvement projects have been led by PGY2 doctors who worked with staff to improve oxygen prescribing and documentation of target saturations in patients receiving supplemental oxygen on medical and surgical wards at CCDHB.

Open Communication programme

Open Communication is an integral part of ensuring we deliver safe, quality health care to our patients and whānau. It refers to open and transparent discussion between patients and staff, and is particularly important when things do not go as expected in the health care setting. Both patients and staff can be adversely affected in many ways. The aim of the Open Communication programme is to help staff respond effectively to minimise harm to all parties involved in situations where there has been an upsetting outcome or expectations have not been met.

Over the past year, QIPS has worked with Capability Development and other experts to refresh Open Communication training across 2DHB. Open Communication facilitators from both CCDHB and HVDHB were trained by an external expert who delivered theory-based sessions over a 6 month period. Using a train-the-trainer model, facilitators then went on to learn how to train other staff in Open Communication in practical workshops. A new model has been established whereby any staff member can now undertake an online learning module, followed by a practical workshop led by an Open Communication facilitator, to hone their skills. The refreshed Open Communication course was officially launched by the Executive Leadership Team in July 2021. It is now available via ConnectMe to staff across 2DHB.

Research

The Research team have had another busy year as described in the Annual Research Report 2019-2020. You can read the report on our website here: www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/

Statement of Performance

The Statement of Performance Expectations (SPE) presents a snapshot of the services provided for our population and how these services perform. The SPE is grouped into four output classes: prevention services; detection and management; intensive assessment and treatment; and rehabilitation and support services. Each output class includes measures that help to evaluate our performance over time, recognising the funding received, government priorities, national decision-making and board priorities.

We have a particular focus on improving health outcomes and improving health equity for Māori and Pacific peoples. Therefore, a range of measures are used to monitor progress in improving the health and wellbeing of our Māori and Pacific populations. Equity is a priority and the targets set for Māori and Pacific reflect a pathway to achieving equity, or are universal and apply to all population groups. In some cases, data is not available by ethnicity. We are in the process of developing a programme of work to monitor and report our performance by ethnicity, and understand our performance for our Māori and Pacific populations.

Output Classes contributing to desired outcomes

In this section we evaluate measures across four output classes that provide an indication of the volume and coverage of services funded and delivered by the CCDHB, alongside service quality indicators. These Output Classes follow the classification established by the Ministry of Health for use by all DHBs as a logical fit with stages spanning the continuum of care.

The four Output Classes and their related services are:	
Prevention Services • Health protection and monitoring services • Health promotion services • Immunisation services • Smoking cessation services • Screening services ***Early Detection and Management services*** • Primary care (GP) services • Oral health services • Pharmacy services	***Intensive Treatment and Assessment Services*** • Medical and surgical services • Cancer services • Mental Health and Addiction services ***Rehabilitation and Support services*** • Disability services • Health of older people services

Within these Output Classes, the measures we have chosen reflect activity across the whole of the CCDHB health system and help us to monitor that we are on track to achieve positive long-term outcomes.

Interpreting our performance

Types of measures

Evaluating performance is more than measuring the volume of services delivered or the number of patients cared for. In monitoring our progress we want to be sure that the people who most need services are getting those services in a timely way, and that these services are delivered to the right quality standard. In the following tables, we note the types of output measure, and where appropriate the results are detailed for different ethnicities.

Criteria Description	Rating	Rating System
Achieved	At or above target	●
Not achieved, but progress made	≤10% of target	●
Not achieved	≥10.1% of target	●
Demand-driven Measure	No rating applied	●
Data not available by ethnicity	No rating applied	○
New measure in 2020/21 or no data available in 2019/20	-	★

Class	Class Description
Q	Quality
V	Volume
T	Timeliness
C	Coverage

Standardisation, targets and estimates

In some cases the results are standardized for population characteristics, such as age, to allow meaningful comparison between different populations, for example, to compare between two or more districts that may have different age group profiles.

Some measures reflect our pursuit of a target, such as aiming to screen 70% or more eligible women for breast cancer in the last two years. Other measures are more simply an estimate of the volume of a service rather than a target and are included to provide an indication of the extent of services funded or undertaken by the DHB, such as the number of prescription items filled in one year. We report on these measures by commenting if the volume is in line with our estimate, lower or higher than estimated.

Output Class 1: Prevention Services

Preventative health services promote and protect the health of the whole population or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Immunisation Services					
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	CCDHB Baseline 2019/10	CCDHB Target 2020/21	CCDHB Result 2020/21[5]	Achievement
% of eight month olds fully vaccinated	Māori	87%	≥95%	82%	●
	Pacific	91%		90%	●
	Non-Māori, Non-Pacific	96%		94%	●
	Total	94%		92%	●
% of two year olds fully immunised	Māori	90%	≥95%	81%	●
	Pacific	93%		90%	●
	Non-Māori, Non-Pacific	95%		94%	●
	Total	94%		91%	●
% of five year olds fully immunised	Māori	91%	≥95%	84%	●
	Pacific	87%		83%	●
	Non-Māori, Non-Pacific	91%		89%	●

[5] Result data is always from Q4 2020/21 data unless otherwise stated.

	Total	91%		87%	
% of children aged 11 years provided Boostrix vaccination	Māori	73%	≥70%	73%	
	Pacific	67%		57%	
	Non-Māori, Non-Pacific	67%		73%	
	Total	68%		71%	
% of children (girls and boys aged 12 years) provided HPV vaccination (*one dose)	Māori	62%	≥75%	74%	
	Pacific	61%		75%	
	Non-Māori, Non-Pacific	67%		79%	
	Total	66%		77%	
% of population aged 65 years and over immunised against influenza	Māori	45%	≥75%	59%	
	Pacific	64%		75%	
	Non-Māori, Non-Pacific	58%		64%	
	Total	57%		64%	

Health Promotion Services					
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of infants fully or exclusively breastfed at 3 months*	Māori	43%	≥70%	56%	
	Pacific	50%		40%	
	Non-Māori, Non-Pacific	67%		66%	
	Total	62%		62%	
% of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention	Māori	92%	≥95%	86%	
	Pacific	86%		91%	
	Non-Māori, Non-Pacific	90%		84%	
	Total	90%		87%	
% of PHO-enrolled patients who have quit smoking in the last 12 months	Māori	11%	≥12%	8%	
	Pacific	11%		9%	
	Non-Māori, Non-Pacific	17%		13%	
	Total	12%		11%	
% of PHO-enrolled patients who smoke and have been offered help to quit by a health practitioner in the last 15 months	Māori	83%	≥90%	64%	
	Pacific	85%		70%	
	Non-Māori, Non-Pacific	84%		65%	
	Total	84%		66%	
% of hospitalised smokers offered advice to help quit	Māori	83%	≥95%	81%	
	Pacific	90%		84%	
	Non-Māori, Non-Pacific	78%		78%	
	Total	82%		80%	
% of pregnant women who identify as smokers upon registration with a DHB midwife or Lead Maternity Carer offered advice to quit	Māori	100%	≥90%	100%	
	Total	100%		100%	

* Result data for this measure is from Q3 2020/21, as this was the most recent data available at the time of writing this report.

Population-based Screening Services					
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of eligible children receiving a B4 School Check	Māori	60%	≥90%	69%	
	Pacific	54%		78%	
	Non-Māori, Non-Pacific	70%		95%	
	Total	62%		88%	
% of eligible women (25-69 years old) having cervical screening in the last 3 years	Māori	65%	≥80%	66%	
	Pacific	64%		62%	
	Non-Māori, Non-Pacific	75%		76%	
	Total	72%		74%	
% of eligible women (50-69 years old) having breast cancer screening in the last 2 years	Māori	67%	≥70%	66%	
	Pacific	70%		65%	
	Non-Māori, Non-Pacific	72%		72%	
	Total	72%		71%	

Oral Health Services					
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of children under 5 years enrolled in DHB-funded dental services	Māori	72%	≥95%	70%	
	Pacific	84%		78%	
	Non-Māori, Non-Pacific	104%		98%	
	Total	95%		90%	
% of children caries free at 5 years*	Māori	53%	≥69%	53%	
	Pacific	43%		47%	
	Non-Māori, Non-Pacific	78%		78%	
	Total	71%		71%	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8*	Māori	0.27	≤0.49	0.73	
	Pacific	0.26		0.90	
	Non-Māori, Non-Pacific	0.35		0.41	
	Total	0.33		0.51	
	Māori	8%	≤10%	24%	
	Pacific	7%		19%	

% of children (0-12) enrolled in DHB oral health services overdue for their scheduled examinations**	Non-Māori, Non-Pacific	5%		24%	
	Total	6%		24%	
% of adolescents accessing DHB-funded dental services	Māori	N/A	≥85%	58%	
	Pacific	N/A		66%	
	Non-Māori, Non-Pacific	N/A		69%	
	Total	77%		66%	

***** Result data for this measure is from the 2020 calender year, as this was the most recent data available at the time of writing this report.

****** Result data for this measure is from Q3 2020/21, as this was the most recent data available at the time of writing this report.

Output Class 2: Early Detection and Management

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Primary Care Services					
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of new born enrolment with general practice by three months of age	Māori	65%	≥85%	72%	
	Pacific	78%		81%	
	Non-Māori, Non-Pacific	101%		98%	
	Total	91%		91%	
% of the DHB-domiciled population that is enrolled in a PHO	Māori	89%	≥94%	93%	
	Pacific	100%		103%	
	Non-Māori, Non-Pacific	91%		98%	
	Total	92%		97%	
% of people with diabetes aged 15-74 years enrolled with a PHO whose latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	50%	≥60%	51%	
	Pacific	44%		49%	
	Non-Māori, Non-Pacific	59%		65%	
	Total	55%		61%	
% of the eligible population assessed for CVD risk in the last 5 years	Māori	78%	≥90%	73%	
	Pacific	78%		74%	
	Non-Māori, Non-Pacific	89%		72%	
	Total	87%		72%	
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Māori	5,833	≤6422	5437	
	Pacific	9,577	≤10981	7179	
	Non-Māori, Non-Pacific	4,033	≤4743	4455	
	Total	4,991	≤5415	4957	
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)	Māori	6,308	≤2,623	5671	
	Pacific	7,409		6887	
	Non-Māori, Non-Pacific	2,460		2395	
	Total	3,100		2966	
Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age	Māori	17.2	≤10	7.6	
	Pacific	21.3	≤16	7.0	
	Non-Māori, Non-Pacific	7.2	≤3	3.7	
	Total	10.6	≤6	4.8	
Primary Care Patient Experience scores	Communication	Data no longer reported			
	Partnership				
	Physical and Emotional Needs				
	Coordination				

Pharmacy Services					
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of the DHB-domiciled population that weredispensed at least one prescription item	Māori	72%	78%	72%	●
	Pacific	79%		77%	●
	Non-Māori, Non-Pacific	75%		77%	●
	Total	75%		76%	●
% of people aged 65+ years receiving five or more long-term medications	Māori	32%	25%	38%	●
	Pacific	49%		49%	●
	Non-Māori, Non-Pacific	29%		31%	●
	Total	30%		32%	●
Number of people registered with a Long Term Conditions programme in a pharmacy	Total	6,956	6,604	7879	●
Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Total	257	250	246	●

Maternity Services					
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of maternity deliveries made in Primary Birthing Units	Māori	18%	≥10%	18%	●
	Pacific	18%		17%	●
	Non-Māori, Non-Pacific	7%		6%	●
	Total	10%		9%	●

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals mostly in a hospital setting where clinical expertise (across a range of areas) and specialist equipment are located in the same place. These services include inpatient, outpatient, emergency and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population.

Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Acute and Urgent Services					
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
Number of Community Acute Response Packages provided in community setting	Total	1181	1,368	1319	
Number of zero-fee consultations at after-hours services by children under 14 years	Māori	2,849	≥3019	2510	
	Pacific	2,837	≥3924	2446	
	Non-Māori, Non-Pacific	10,432	≥14486	8761	
	Total	16,118	≥21429	13717	
Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals	Māori	211	≤149	206	
	Pacific	246		220	
	Non-Māori, Non-Pacific	143		149	
	Total	156		158	
% of patients admitted, discharged or transferred from ED within 6 hours	Māori	76%	≥95%	67%	
	Pacific	74%		64%	
	Non-Māori, Non-Pacific	78%		66%	
	Total	78%		66%	
Standardised acute readmission rate within 28 days*	Total	12.9%	≤12.4%	12.8%	

***** Result data for this measure is from Q3 2020/21, as this was the most recent data available at the time of writing this report.

Elective and Arranged Services					
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
Number of surgical elective discharges	Total	14,373	10718	16563	
% of patients given a commitment to treatment but not treated within four months	Total	22.9%	0%	12.6%	
% of "DNA" (did not attend) appointments for FSA (first specialist appointments)	Māori	9.8%	12%	13.8%	
	Pacific	8.9%	13%	13.8%	
	Non-Māori, Non-Pacific	3.5%	5%	3.9%	
	Total	4.8%	7%	6.0%	
% of patients waiting longer than four months for their first specialist assessment	Total	12.7%	0%	3.3%	
% of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Māori	63%	≥90%	74%	
	Pacific	38%		86%	
	Non-Māori, Non-Pacific	76%		89%	
	Total	73%		87%	
% of patients receiving their first cancer treatment (or other management) within 31 days from date of decision to treat	Total	91%	≥85%	90%	

Mental Health, Addictions and Wellbeing Services						
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service.		Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
Access to mental health services: Number of mental health services users		Māori	2500	2600	2701	
		Pacific	803	800	864	
		Non-Māori, Non-Pacific	7811	7850	8773	
		Total	11202	11250	11474	
% of patients 0-19 referred to non-urgent child and adolescent services that were seen within eight weeks*	Mental health services	Māori	85%	≥95%	81%	
		Pacific	89%		90%	
		Non-Māori, Non-Pacific	82%		73%	
		Total	83%		76%	
	Addiction services	Māori	94%		98%	
		Pacific	89%		97%	
		Non-Māori, Non-Pacific	92%		97%	
		Total	92%		97%	
% of population accessing community mental health services	Mental health services	Māori	1.5%	1.7%	0.9%	
		Pacific	1.0%	1.1%	0.5%	
		Non-Māori, Non-Pacific	0.5%	0.6%	0.4%	
		Total	0.7%	0.7%	0.4%	

	Addiction services	Māori	1.4%	1.4%	0.5%	
		Pacific	0.7%	0.8%	0.2%	
		Non-Māori, Non-Pacific	0.3%	0.3%	0.1%	
		Total	0.4%	0.5%	0.2%	
% of population accessing secondary:	Mental health services	Māori	7.1%	4.7%	2.5%	
		Pacific	3.5%	2.2%	1.3%	
		Non-Māori, Non-Pacific	2.9%	2.4%	1.2%	
		Total	3.4%	2.7%	1.4%	
	Addiction services	Māori	2.0%	0.4%	0.2%	
		Pacific	0.9%	0.1%	0.1%	
		Non-Māori, Non-Pacific	0.5%	0.2%	0.1%	
		Total	0.7%	0.2%	0.1%	
% of people admitted to an acute mental health inpatient service that were seen by mental health community team:	7 days prior to the day of admission	Māori	72%	≥75%	72%	
		Pacific	67%		73%	
		Non-Māori, Non-Pacific	N/A		78%	
		Total	75%		75%	
	7 days following the day of discharge	Māori	79%	≥90%	82%	
		Pacific	71%		83%	
		Non-Māori, Non-Pacific	82%		82%	
		Total	80%		82%	
% of clients with a transition (discharge) plan		Total	50%	≥95%	61%	
% of clients with a wellness plan		Total	67%	≥95%	47%	
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	495	446	582	

***** Result data for this measure is from Q3 2020/21, as this was the most recent data available at the time of writing this report.

Quality, safety and patient experience					
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
Rate of inpatient falls resulting in a fracture per 1000 bed days	Total	0.05	0.05	Data no longer Reported	
Rate of hospital acquired pressure injuries per 1,000 bed days	Total	TBC	TBC	Data No longer Reported	
Rate of in-hospital falls with fractured neck of femur, per 100,000 admissions	Total	7.1	≤5	6.6	
Rate of staphylococcus aureus bacteraemia, per 1,000 bed days	Total	0.15	0.1	0.18	
Rate of surgical site infections for hip and knee operations, per 100 procedures	Total	1.7	0.8	1.2	
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, per 1,000 admissions	Total	1.0	1.2	1.1	

Rate of rapid response escalations, per 1000 admissions	Total	48	47	67.9	
Number of deep vein thrombosis/pulmonary embolus	Total	49	48	58	
The weighted average score in the Inpatient Experience Survey by domain	Data no longer Reported				

Output Class 4: Rehabilitation and
Output Class 4: Rehabilitation and Support

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home, as personal care, community nursing, or community services.

Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Disability Support Services					
These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	46%	33%	30%	
Number of subregional Disability Forums	Total	0	1	0	
Number of people with a Disability Alert	Total	9083	9500	9144	
% of the CCDHB domiciled population with a Disability Alert who are Māori or Pacific	Māori	11.1%	15%	11.2%	
	Pacific	5.7%	10%	5.7%	

Home-based and Community Support Services					
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of people 75+ living in their own home	Māori	93%	90%	91%	
	Pacific	93%		93%	
	Non-Māori, Non-Pacific	94%		91%	
	Total	94%		91%	
Acute bed day rate per 1000 for people 75+	Māori	1,930	≤1,670	1,850	
	Pacific	1,893		2,096	
	Non-Māori, Non-Pacific	1,670		1,750	
	Total	1,695		1,764	
Standardised acute readmission rate for people 75+*	Māori	11.6%	≤12%	10.4%	
	Pacific	8.3%	≤9%	11.1%	
	Non-Māori, Non-Pacific	12.3%	≤12%	11.5%	
	Total	12.1%	≤12%	11.4%	
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+	Māori	C..	≤2.3	C..	
	Pacific	C..		C..	
	Non-Māori, Non-Pacific	C..		C..	
	Total	2.1		1.98	

* Result data for this measure is from Q3 2020/21, as this was the most recent data available at the time of writing this report.

Aged Residential Care Services					
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Target Group	CCDHB Baseline 2019/20	CCDHB Target 2020/21	CCDHB Result 2020/21	Achievement
% of residential care providers meeting 3 year (or more) certification standards	Total	59%	95%	97%	

Asset Performance Measures

Assets have been grouped into Property, Information Communication and Technology (ICT) and Clinical Equipment portfolios. This grouping reflects the underlying asset management practices within Capital & Coast District Health Board. Other asset have been excluded for reporting due to their lesser significance (criticality) to delivering our core services.

Property asset performance measures			
Measure Portfolio: Property	Indicator	2020/21 Target	2020/21 Outcome
% of buildings with a condition rating equal to or better than 2	Condition	**≥60%**	64%
M2 of buildings that are not earthquake prone or risk*	Condition	**≥90%**	89%
% occupancy rate of our buildings	Utilisation	**≥97%**	99%
M2 of buildings that meet current and foreseeable service delivery requirements (>10 years - A) *	Functionality	**≥41%**	42%
M2 of buildings that meet current service delivery requirements but may fall short in the foreseeable future (5–10 years - B) *	Functionality	**≥45%**	47%
M2 of buildings that meet current service delivery requirements greater than 10 years and those that meet current service delivery requirement but may fall short in next 5–10 years*[1]	Functionality	**≥85%**	89%

* Excludes buildings that are vacant and tagged for demolition.

ICT asset performance measures			
Measure ICT asset portfolio	Indicator	2020/21 Target	2020/21 Outcome
% availability of critical systems	Functionality	≥80%	99.81%
% of ICT hardware at a condition level of 'Acceptable' or better (a rating of three or lower)	Condition	≥99.9%	71%
% usage of storage data network (SAN)	Utilisation	≥75% peak	Not Available

Clinical equipment asset performance measures			
Measure Asset portfolio: Clinical equipment (CE)	Indicator	2020/21 Target	2020/21 Outcome
Average of Financial Year – Statutory Compliance Is the asset compliant to AS/NZS 3551	Functionality	**93%**	96%
% of CE assets that have passed indicated life expectancy *[1]	Condition	**≥37%**	26%

% of CE assets with a physical condition rating equal to or better than three (average) *[2]	Condition	**96%**	95%
Time MRI is in operation expressed as a % of available time*[3]	Utilisation	**≥34.5%**	29%

***[1]** Over 4000 new assets purchased in the past 18 months primarily due to COVID-19, increasing the overall numbers and reducing the % difference of assets past their life expectancy.

*[2] 455 Assets have a physical condition that is "poor or very poor" 431 of these assets are Beds, Plinths, Trollies and Stretchers and this has been identified to the capital committee

*[3] Lower outcome impacted by COVID-19 and MIT strikes.

CCDHB COVID-19 Vaccine Data at 30 June 2021

Vaccine doses administered by DHB **DHB of service**	**Dose 1**	**Dose 2**	**Total**
Capital & Coast DHB	**27,694**	**22,204**	**49,898**

By DHB: Eligible population fully vaccinated by DHB of residence (note 1) (note 5) **DHB of residence**	**Proportion fully vaccinated (note 1)**
Capital & Coast DHB	**8.90%**

Vaccine doses administered by sequencing group (note 4). **Sequencing group (note 3)**	**Dose 1**	**Dose 2**	**Total**
Group 1	3,667	3,300	6,967
Group 2	18,138	16,420	34,558
Group 3	5,362	2,205	7,567
Group 4	527	279	806
Total	**27,694**	**22,204**	**49,898**

Vaccine doses administered by ethnicity (note 4) **Ethnicity**	**Dose 1**	**Dose 2**	**Total**
Asian	4,100	3,679	7,779
European or other	17,621	14,984	32,605
Māori	3,166	1,805	4,971
Pacific peoples	2,540	1,515	4,055
Unknown	267	221	488
Total	**27,694**	**22,204**	**49,898**

Note 1: Fully vaccinated means two doses have been administered to an individual.

Note 2: The health service user (HSU) population used for COVID-19 vaccine coverage reporting provides information about the number of people in New Zealand who used health services in 2020. People are included if they were alive as at 30 June 2020, were 12 years of age as of 30 June 2020, (note that this was initially 16 years but was reduced to 12 years when the eligibility criteria changed), and if they were enrolled with a primary health organisation or received health services in the 2020 calendar year. There are other data sets that estimate the total number of people in New Zealand.

These include three datasets produced by StatsNZ: Estimated Resident Population (produced every 5 years, following each Census), Subnational Population Estimates (produced every year), and non-official population projections produced by StatsNZ for the Ministry of Health (produced every year).

The Stats NZ population estimates are based on Census data adjusted for the number of people who are born, who have died, and who have migrated to or from New Zealand. The Stats NZ population estimates and projections are of people usually resident in New Zealand, including those usually resident who are temporarily overseas, while the HSU includes everyone in New Zealand who used health services in a given period.

The HSU was chosen by the Ministry of Health as the denominator for COVID-19 vaccine coverage reporting because it allows for the assignment of the same demographics (eg, location and ethnicity) to people in the numerator (the number of people vaccinated) as the denominator (reference population). The HSU is available for every demographic contained in health data including age, ethnicity, DHB, and gender, separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is possible to generate flags for health-related information on the HSU, for example, those who are likely to have a long-term condition. Official Stats NZ estimates are not as flexible. For example, StatsNZ estimates by age, sex and Statistical Area 2/Territorial Authority/DHB are produced every year, but estimates that also include ethnicity are only produced every 5 years, the most recent being estimates for 2018. The projections StatsNZ produces for the Ministry every year do provide information by age, sex and broad ethnic group, but are only available at the DHB level.

The Total population estimate based on HSU as at 30 June 2020 is 315,241. This is 9,459 below the Stats NZ total projected population of 324,700 (from the non-official population projections StatsNZ produced in 2020). When classifying the population into ethnicity, age and DHB there are further differences. For example, a summary of the differences by ethnicity are summarised in the table below. These differences arise as the populations are derived from different sources. For example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census declaration.

By definition, the HSU is not a total population estimate and is likely to miss highly marginalised groups. For example, analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicity.

The HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage, as it removes bias from calculated rates by ensuring demographic information in the numerator and denominator is consistent. For example, the ethnic group(s) with which someone identifies, and their location.

Total CCDHB population	HSU	Stats NZ	Difference
Māori	34,718	38,300	(3,582)
Pacific	23,745	23,400	345
Asian	43,884	50,900	(7,016)
Other	212,894	212,100	794
Total	315,241	324,700	(9,459)

Note 3: Group 1 includes border and managed isolation and quarantine employees and the people they live with. Group 2 includes high-risk frontline health care workforces; workers and residents in long-term residential environments; older Māori and Pacific peoples cared for by whānau, the people they live with, and their carers; people aged 65 years and older; people with relevant underlying health conditions. Group 3 includes people aged 65 years and older; people with relevant underlying health conditions; disabled people; and adults in

custodial settings. Group 4 includes people aged 16 years and over. These definitions and population groups were occasionally updated based on operational and Cabinet decisions or updated estimates of the sizes of each group.

Note 4: The data in this table is based on the DHB of service (where the vaccine dose was administered).

Note 5: The data in this table is based on the DHB of residence of the individual receiving the vaccines. Ethnicity is based on the prioritised ethnicity classification system which allocates each person to a single ethnic group, based on the ethnic groups they identify with. Where people identify with more than one group, they are assigned in this order of priority: Māori, Pacific peoples, Asian, and European/Other. So, if a person identifies as being Māori and New Zealand European, the person is counted as Māori.

FINANCIAL STATEMENTS

Statement of comprehensive revenue and expense

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Revenue	2	1,358,764	1,274,560	1,218,189
Total revenue		**1,358,764**	**1,274,560**	1,218,189
Expenditure				
Clinical supplies		133,754	131,797	122,741
Personnel costs	3	616,902	577,988	554,959
Infrastructure and non-clinical expenses		94,813	73,402	69,231
Other operating expenses	4	9,654	6,827	5,944
Outsourced services		47,125	41,806	39,765
Payments to other district health boards		108,768	107,584	102,847
Payments to non-health board providers		338,357	317,042	307,256
Capital charge	5	19,316	22,729	24,407
Depreciation and amortisation expense	6,7	36,574	35,200	35,212
Total expenses		**1,405,263**	**1,314,375**	**1,262,362**
Deficit		**(46,499)**	**(39,815)**	**(44,173)**
Other comprehensive revenue and expense				
Revaluation of land and buildings	18	72,804	-	(702)
Impairment losses	6	(10,000)	-	-
Total other comprehensive revenue and expense		**62,804**	**-**	**(702)**
Total comprehensive revenue and expense		**16,305**	**(39,815)**	**(44,875)**

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

The accompanying notes form part of these financial statements.

Statement of financial position

As at 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Assets				
Current assets				
Cash and cash equivalents	12	-	-	6,553
Trade and other receivables	11	60,022	49,375	46,342
Prepayments		7,142	6,257	6,257
Inventories	8	9,394	8,995	8,995
Trust and special funds	13	13,391	11,683	11,683
Total current assets		**89,949**	**76,310**	**79,830**
Non-current assets				
Property, plant and equipment	6	661,858	663,571	564,080
Intangible assets	7	18,103	30,442	27,842
Investment in associate	9	1,150	1,150	1,150
Total non-current assets		**681,111**	**695,163**	**593,072**
Total assets		**771,060**	**771,473**	**672,902**
Liabilities				
Current liabilities				
Cash and cash equivalents	12	28,843	39,708	-
Trade and other payables	16	107,926	79,775	91,584
Employee entitlements	14	175,765	169,030	161,006
Provisions	15	731	593	681
Patient and restricted funds	17	90	95	92
Total current liabilities		**313,355**	**289,201**	**253,363**
Non-current liabilities				
Employee entitlements	14	16,287	6,564	14,589
Provisions	15	500	605	559
Total non-current liabilities		**16,787**	**7,169**	**15,148**
Total liabilities		**330,142**	**296,370**	**268,511**
Net assets		**440,918**	**475,103**	**404,391**
Equity				
Crown equity	18	822,164	920,266	801,942
Property revaluation reserves	18	193,463	130,659	130,659
Accumulated deficit	18	(574,709)	(575,822)	(528,210)
Total equity		**440,918**	**475,103**	**404,391**

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

The accompanying notes form part of these financial statements.

Statement of changes in equity

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Balance at 1 July		404,391	407,425	424,523
Total comprehensive revenue and expense		16,305	(39,815)	(44,875)
Transfer from revaluation reserves		-	-	368
Owner transactions				
Contributions from the Crown		23,706	110,977	27,859
Repayment of equity		(3,484)	(3,484)	(3,484)
Balance at 30 June	18	**440,918**	**475,103**	**404,391**

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

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2021

	Note	2021 Actual $000	2021 Budget $000	2020 Actual $000
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		1,328,031	1,316,509	1,205,327
Other receipts		34,169	23,989	23,420
Payments to suppliers		(727,456)	(769,692)	(654,353)
Payments to employees		(599,227)	(551,693)	(530,469)
Cash generated from operations		**35,517**	**19,113**	**43,925**
GST (net)		3,197	(1,641)	(1,595)
Capital charge		(31,174)	(34,829)	(12,297)
Net cash flows from operating activities		**7,540**	**(17,357)**	**30,033**
Cash flows from investing activities				
Interest received		207	756	762
Dividend received		-	139	138
Purchase of property, plant and equipment		(60,109)	(119,803)	(41,230)
Purchase of intangible assets		(1,539)	(17,489)	(3,871)
Net cash flows from investing activities		**(61,441)**	**(136,397)**	**(44,201)**
Cash flows from financing activities				
Contributions from the Crown		23,705	110,977	27,859
Repayment of borrowing		-	-	(55)
Repayment of equity		(3,484)	(3,484)	(3,484)
Interest paid		(8)	-	-
Net cash flows from financing activities		**20,213**	**107,493**	**24,320**
Net (decrease)/increase in cash and cash equivalents		(33,688)	(46,261)	10,152
Cash and cash equivalents at beginning of year		18,236	18,236	8,084
Cash and cash equivalents at the end of the year		**(15,452)**	**(28,025)**	**18,236**
Represented by:				
Cash and cash equivalents	12	(28,843)	(39,708)	6,553
Trust and special funds	13	13,391	11,683	11,683

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

The accompanying notes form part of these financial statements.

Reconciliation of net deficit to net cash flows from operating activities

For the year ended 30 June 2021

	2021 Actual $000	2020 Actual $000
Net deficit	(46,499)	(44,173)
Add non-cash items		
Depreciation and amortisation	36,574	35,212
Total non-cash items	36,574	35,212
Add/(less) items classified as investing activities		
Net loss/(gain) on disposal of property, plant and equipment	96	2
Interest revenue on financial assets	(172)	(655)
Total items classified as investing activities	(76)	(653)
Add/(less) movements in working capital		
(Increase)/decrease in trade and other receivables	(13,680)	5,524
(Increase)/decrease in prepayments	(885)	(2,060)
(Increase)/decrease in inventories	(399)	50
Increase/(decrease) in trade and other payables	16,057	17,998
Increase/(decrease) in employee entitlements	16,457	17,310
(Decrease)/increase in provisions	(9)	825
Net movements in working capital	17,541	39,647
Net cash flows from operating activities	**7,540**	**30,033**

Statement of contingent liabilities and contingent assets

As at 30 June 2021

Quantifiable contingent liabilities

	2021 Actual $000	2020 Actual $000
Legal proceedings against the DHB	-	800
Total quantifiable contingent liabilities	**-**	**800**

The DHB are not aware of any potential claims at 30 June 2021 (2020: 1).

Unquantifiable contingent liabilities

At 30 June 2021, there were two employment-related issues pending resolution. It is difficult to predict the final outcome of these matters with any great degree of certainty. Therefore, any possible financial reparations eventuating from the settlement decision of these matters are currenly unquantifiable.

Contingent assets

As as 30 June 2021, DHB has no contingent assets (2020: 1 unquantifiable).

Corrosion in the copper pipes at the Wellington Regional Hospital have resulted in failure of its domestic hot water systems and leaks throughout the building. Legal proceedings were commenced in late 2020, to recover the cost of replacing the hot water pipes from the head contractor who constructed the building, the copper pipe manufacturer, the installer and the designer. As the amount wasn't able to be quantified, an unquantifiable contingent asset was disclosed in the 2020 financial year. A confidential settlement was reached this financial year.

NOTES TO THE FINANCIAL STATEMENTS

1. 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 as defined by the Crown Entities Act 2004, and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. The DHB does not operate to make a financial return. The DHB is designated as a public benefit entity (PBE) for financial reporting purposes.

The financial statements for the year ended 30 June 2021 were approved for issue by the Board on 25 February 2022.

BASIS OF PREPARATION

Health Sector Reforms
On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions. As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Letter of Comfort
The Board has received a letter of comfort, dated 13 October 2021 from the Ministers of Health and Finance which states that the Crown acknowledges that additional support may be required and is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary.

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Presentation currency and rounding
The financial statements are presented in New Zealand dollars (NZ dollars) and all values are rounded to the nearest thousand dollars ($000).

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

Standards issued that are not yet effective and not early adopted
Standards and amendments, issued but not yet effective that have not been early adopted, and which are relevant to the DHB are:

Amendment to PBE IPSAS 2 Statement of Cash Flows
An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for the year ended 30 June 2022, with early application permitted. The DHB does not intend to early adopt the amendment.

PBE FRS 41 Financial Instruments
PBE IPSAS 41 replaces PBE IFRS 9 Financial Instruments and is effective for the year ending 30 June 2023, with earlier adoption permitted. Although the DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9. The DHB does not intend to early adopt the amendment.

PBE FRS 48 Service Performance Reporting
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance. It does not intend to early adopt the amendment.

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies are included in the notes to which they relate.

Significant accounting policies that do not relate to a specific note are outlined below**.**

Foreign currency
Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ dollars (the functional currency) using the spot exchange rate prevailing at the date of the transaction. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in surplus or deficit.

Goods and services tax
All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue (IR) is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax
The DHB is a Crown entity under the New Zealand Public Health and Disability Act 2000 and is therefore exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

Budget figures
The budget figures are derived from the the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZGAAP. They comply with PBE standards 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.

Critical accounting estimates and assumptions
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.

Management has 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.

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 in respect of:

- Estimating the fair value of land and buildings – refer to Note 6.
- Measuring the liabilities for Holidays Act 2003 remediation, long service leave, retirement gratuities, sabbatical leave, and continuing medical education leave – refer to Note 14.

2 Revenue

Accounting policy
The specific accounting policies for significant revenue items are explained below.

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. The DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

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.

Revenue from other DHBs
Inter-district patient inflow revenue occurs when a patient treated within the DHB region is domiciled outside of the DHB region. The Ministry of Health credits the DHB with a monthly amount based on estimated patient treatment for non-DHB residents within the Capital & Coast region. An annual wash-up occurs at year end to reflect the actual number of non-DHB patients treated at the DHB.

Rental revenue
Rental revenue under an operating lease is recognised on a straight-line basis over the term of the lease.

Donated 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 revenue. Such assets are recognised as revenue when control over the asset is obtained.

	2021 Actual $000	2020 Actual $000
Ministry of Health contract funding	1,007,207	934,493
Other government	14,056	12,944
Inter-district flows (other DHBs)	298,635	247,096
Non-government and Crown agency sourced	38,680	22,956
Interest revenue	172	655
Donations received	14	45
Total revenue	**1,358,764**	**1,218,189**

3 Personnel costs

Accounting policy

Salaries and wages
Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

DEFINED CONTRIBUTION SCHEMES
Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in surplus or deficit as incurred.

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 DHB has no legal or constructive obligation to pay further contributions in relation to employee service in the current and prior periods.

DEFINED BENEFIT PLAN CONTRIBUTOR SCHEMES
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.

	2021 Actual $000	2020 Actual $000
Direct staff costs (excluding increases in employee entitlements)	574,680	518,031
Indirect staff costs (excluding defined contribution plan employer contributions and increases in employee entitlements)	12,854	12,413
Defined contribution plan employer contributions	20,323	16,735
Increase in liability for employee entitlements	9,045	7,780
Total personnel costs	**616,902**	**554,959**

The increase in liability for employee entitlements includes a $8.661 million increase (2020: $12.635 million) in the Holidays Act 2003 remediation liability.

3 Personnel costs (continued)

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:

Salary band $000	2021 Number of Employees	2020 Number of Employees	Salary band $000	2021 Number of Employees	2020 Number of Employees
100 – 110	440	410	360 – 370	7	4
110 – 120	223	233	370 – 380	6	8
120 – 130	171	140	380 – 390	6	8
130 – 140	132	124	390 – 400	6	6
140 – 150	87	62	400 – 410	3	7
150 – 160	64	52	410 – 420	3	4
160 – 170	53	54	420 – 430	5	3
170 – 180	43	38	430 – 440	2	5
180 – 190	39	32	440 – 450	1	3
190 – 200	30	25	450 – 460	2	1
200 – 210	24	21	470 -- 480	2	1
210 – 220	30	28	480 – 490	3	2
220 – 230	18	11	490 – 500	3	3
230 – 240	18	21	500 – 510	-	3
240 – 250	23	25	510 – 520	1	-
250 – 260	17	13	520 – 530	-	2
260 – 270	15	19	530 – 540	-	1
270 – 280	13	21	540 – 550	1	-
280 – 290	21	14	550 – 560	-	1
290 – 300	20	17	580 – 590	1	-
300 – 310	9	9	590 – 600	-	2
310 – 320	9	11	600 – 610	2	1
320 – 330	8	6	610 – 620	1	-
330 – 340	9	12	630 – 640	-	2
340 – 350	9	8	**Total employees**	**1,592**	**1,477**
350 – 360	12	4			

Of the 1,592 employees shown above, 688 were medical or dental employees and 904 were neither medical nor dental employees. This represents an increase of 115 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 2,320 compared with the actual total number of 1,592.

During the year ended 30 June 2021, 13 employees (2020: 13) received compensation and other benefits in relation to cessation totalling $0.2 million (2020: $0.2 million).

4 Other operating expenses

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the DHB.

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

	Note	2021 Actual $000	2020 Actual $000
Provision for impairment of receivables	11	2,785	1,047
Loss on disposal of property, plant and equipment		96	2
Audit NZ fees for audit of financial statements		303	246
Audit NZ fees for other assurance services		190	136
Board member fees	21	284	288
Operating lease expense		4,573	2,747
Other operating expenses		1,423	1,478
Total other operating expenses		**9,654**	**5,944**

5 CAPITAL CHARGE

Accounting policy

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

Further information

The DHB pays a capital charge to the Crown every six months. The charge is now based on the actual closing equity balance excluding the value of donated assets. The capital charge rate for the period ended 30 June 2021 was 5% (2020: 6%).

6 Property, plant and equipment

Accounting policy

Property, plant and equipment consists of the following asset classes: freehold land, freehold buildings, leasehold improvements, plant and equipment, furniture and fittings, and work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in surplus or deficit will be recognised first in surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gain or loss on disposals is determined by comparing the proceeds with the carrying amount of the asset. Net gain or loss on disposals is reported in surplus or deficit. When revalued assets are sold, the amounts included in the property revaluation reserves in respect of those assets are transferred to accumulated surplus or deficit in equity.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

6 Property, plant and equipment (continued)

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment, other than land, at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives.

The useful lives and associated depreciation rates of major classes of property, plant, and equipment have beenestimated as follows:

Asset class	Useful life
Freehold buildings	1 to 60 years (1.6% to 100%)
Leasehold improvements	1 to 20 years (5% to 100%)
Plant and equipment	1 to 25 years (4% to 100%)
Furniture and fittings	1 to 40 years (2.5% to 100%)

The residual value and useful life of an asset is reviewed, and adjusted if applicable, at each financial year-end.

Impairment of property, plant, and equipment

Property, plant, and equipment are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount might not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value, less costs to sell, and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, a restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable service amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue and expense and decreases the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is recognised in other comprehensive revenue and expense and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit, a reversal of an impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in surplus or deficit.

Critical accounting estimates and assumptions

Estimating the fair value of land and buildings

The most recent full valuation of land and buildings was performed by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand Limited, as at 30 June 2021.

The valuation conforms to international valuation standards. Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values.

The revaluation of buildings was based on depreciated replacement cost methodology. Specialised hospital buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

The valuation conducted by Colliers International New Zealand Limited is reported on the basis of some degree of "material valuation uncertainty" due to the current COVID-19 situation. Therefore, the valuer has recommended CCDHB to "keep the valuation of all property under frequent review as valuation advice may be outdated significantly more quickly than is normally the case".

6 Property, plant and equipment (continued)

	Freehold land $000	Freehold buildings $000	Leasehold Improvements $000	Plant and equipment $000	Furniture and fittings $000	Work in Progress $000	Total $000
Cost or valuation							
Balance at 1 July 2019	41,165	477,131	1,191	114,356	32,222	26,345	692,410
Additions	-	5,899	-	8,406	295	27,710	42,310
Disposals	(813)	(955)	-	(757)	(1)	-	(2,526)
Balance at 30 June 2020	**40,352**	**482,075**	**1,191**	**122,005**	**32,516**	**54,055**	**732,194**
Additions	89	3,562	-	13,326	978	50,970	68,925
Disposals	-	(1,302)	-	(5,158)	(34)	-	(6,494)
Impairment losses	-	(10,000)	-	-	-	-	(10,000)
Revaluation increase/(decrease)	25,024	(28,589)	-	-	-	-	(3,565)
Transfers	-	-	-	370	-	-	370
Balance at 30 June 2021	**65,465**	**445,746**	**1,191**	**130,543**	**33,460**	**105,025**	**781,430**
Accumulated depreciation							
Balance at 1 July 2019	-	(30,116)	(568)	(77,806)	(27,831)	-	(136,321)
Depreciation	-	(23,403)	(64)	(8,025)	(732)	-	(32,224)
Disposals	-	377	-	53	1	-	431
Balance at 30 June 2020	**-**	**(53,142)**	**(632)**	**(85,778)**	**(28,562)**	**-**	**(168,114)**
Depreciation	-	(23,327)	(65)	(8,809)	(793)	-	(32,994)
Disposals	-	100	-	5,062	5	-	5,167
Reversal on revaluation	-	76,369	-	-	-	-	76,369
Balance at 30 June 2021	**-**	**-**	**(697)**	**(89,525)**	**(29,350)**	**-**	**(119,572)**
Carrying amounts							
As at 1 July 2019	41,165	447,015	623	36,550	4,391	26,345	556,089
As at 30 June 2020	40,352	428,933	559	36,227	3,954	54,055	564,080
As at 30 June 2021	**65,465**	**445,746**	**494**	**41,018**	**4,110**	**105,025**	**661,858**

6 Property, plant and equipment (continued)

Restrictions

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

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

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2021 was $nil (2020: $nil).

Capital commitments

	2021 Actual $000	2020 Actual $000
Buildings	24,229	-
Plant and equipment	612	6,325
Intangible assets	-	16
Total capital commitments	**24,841**	**6,341**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred.

7 Intangible assets

Accounting policy

Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the costs of materials and services, employee costs, and any directly attributable overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the software.

Costs associated with developing and maintaining the DHB's website are recognised as an expense when incurred.

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

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Asset class	Useful life
Software	3 – 10 years (10% to 33%)
Licences	3 – 10 years (10% to 33%)

Impairment of intangible assets
Refer to the policy for impairment of property, plant, and equipment in Note 6. The same approach applies to the impairment of intangible assets, except for intangible assets that are still under development.

Intangible assets that are under development and not yet ready for use are tested for impairment annually, irrespective of whether there is any indication of impairment.

7 Intangible assets (continued)

	Software $000	NOS shared services rights $000	Licenses $000	Work in progress $000	Total $000
Cost					
Balance at 1 July 2019	31,803	7,399	3,993	15,770	58,965
Additions	4,394	-	734		5,128
Disposals	-	(7,399)	-	(882)	(8,281)
Balance at 30 June 2020	**36,197**	**-**	**4,727**	**14,888**	**55,812**
Additions	2,685	-	215	1,841	4,741
Transfers	(370)	-	-	-	(370)
Impairment				(10,530)	(10,530)
Balance at 30 June 2021	**38,512**	**-**	**4,942**	**6,199**	**49,653**
Amortisation and impairment losses					
Balance at 1 July 2019	(21,948)	(7,399)	(3,034)	-	(32,381)
Amortisation	(2,668)	-	(320)	-	(2,988)
Disposals	-	7,399	-	-	7,399
Balance at 30 June 2020	**(24,616)**	**-**	**(3,354)**	**-**	**(27,970)**
Amortisation	(3,191)	-	(389)	-	(3,580)
Balance at 30 June 2021	**(27,807)**	**-**	**(3,743)**	**-**	**(31,550)**
Carrying amounts					
As at 1 July 2019	9,855	-	959	15,770	26,584
As at 30 June 2020	11,581	-	1,373	14,888	27,842
As at 30 June 2021	**10,705**	**-**	**1,199**	**6,199**	**18,103**

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

National Oracle Solution (NOS) shared service rights

Health Benefits Limited (HBL) was established in July 2010 to undertake a range of shared services for DHBs. This included the NOS shared services project aimed at reducing costs in administrative support and procurement for the public health sector. The NOS project was funded by the 20 DHBs across the country who would be the beneficiaries of these savings. In June 2015, HBL was wound down and its assets and liabilities were transferred to a new company, New Zealand Health Partnerships Limited (NZHPL). Following advice from NZHPL and PWC, CCDHB has written off its investment in the National Oracle Solution (NOS), as the DHB is not expected to derive further benefit from this investment.

Work in progress

Regional Health Informatics Programme (RHIP) is a programme to move the Central Region District Health Boards from a current state of disparate, fragmented and, in some cases obsolescent, clinical and administrative information systems to a future state of shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable regionalisation of services and reduce current operational risks. It was originally agreed that Technical Advisory Services Limited (TAS) would create the RHIP assets and provide services in relation to those assets to the DHBs. Each DHB would provide funding to TAS and in return for the funding relating to capital items the DHBs would be provided with Class B Redeemable Shares in TAS. The agreement to provide the RHIP assets and services was amended on 1 December 2014 to transfer the ownership of RHIP assets to the DHBs jointly. As at 30 June 2021, CCDHB had contributed $14,797 million towards capital expenditure which has been recognised as work in progress in respect of intangible assets. The investment has been tested for impairment during the year by DHB management and $10.5 million was written off as CCDHB's contribution to the regional Clinical Portal, WebPAS and RADA IT applications.

8 Inventories

Accounting policy

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.

	2021 Actual $000	2020 Actual $000
Pharmaceuticals	3,663	3,271
Surgical and medical supplies	5,404	5,378
Other supplies	327	346
Total inventories	**9,394**	**8,995**

The amount of inventories recognised as an expense during the year ended 30 June 2021 was $131 million (2020: $103 million). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2020: $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 Investment in associate

Accounting policy

An associate is an entity over which the DHB has significant influence, and that is neither a subsidiary nor an interest in a joint venture.

Breakdown of investment in associate and further information

The DHB has a 16.67% interest in an associate entity, Allied Laundry Services Limited. The principal activity of the associate is the provision of laundry services. There are no significant restrictions on the ability of the associate to transfer funds to the DHB in the form of cash dividends. The results of the associate company have not been included in the financial statements as they are not considered significant.

	2021 Actual $000	2020 Actual $000
Allied Laundry Services Limited unlisted ordinary shares	6,900	6,900
Capital & Coast DHB's share of ownership	16.67%	16.67%
Carrying amount of investment in associate	**1,150**	**1,150**

Summarised financial information of Allied Laundry Services Ltd (100%)

	2021 Actual $000	2020 Actual $000
Revenue	13,031	11,761
Expense	12,396	11,006
Surplus	635	755
Non-current assets	10,810	10,347
Current assets	2,216	1,552
Non-current liabilities	(2,638)	(2,153)
Current liabilities	(2,013)	(2,411)
Equity	8,375	7,335
Contingent liabilities	-	-
Commitment	-	-

10 OTHER FINANCIAL ASSETS

CCDHB holds a 16.67% shareholding in Central Region's Technical Advisory Services Limited (TAS) and participates in its commercial and financial policy decisions. The five other district health boards in the central region each hold 16.7% (2020: 16.67%) of the shares. TAS was incorporated on 6 June 2001.

TAS has total ordinary share capital of $600, which remains uncalled. As a result, no investment has been recorded in the Statement of financial position for this investment.

11 Trade and other receivables

Accounting policy

Short-term receivables are recorded at the amount due, less an allowance for credit losses. The DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables.

In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due.

Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation or a failure to make contractual payments for a period of greater than 90 days past due.

	2021 Actual $000	2020 Actual $000
Trade receivables from non-related parties	5,238	8,176
Ministry of Health receivables	30,081	9,609
Other DHB receivables	9,015	12,358
Less allowance for credit losses	(4,075)	(2,228)
Accrued revenue	19,763	18,427
Total receivables	**60,022**	**46,342**
Receivables comprises of:		
Receivable from the sale of goods and services (exchange transactions)	29,941	36,733
Receivable from Ministry funding (non-exchange transactions)	30,081	9,609
Total receivables	**60,022**	**46,342**

The allowance for credit losses based on the DHB's credit loss matrix is as follows:

Receivables days past due	Amount $000	Estimate of losses	Impaired credit loss $000	Expected credit loss $000
Current	50,141	0.0%	-	-
Past due < 6 months	3,598	2.8%	-	99
Past due 6 months – 1 year	1,066	34.1%	-	364
Past due 1 – 2 years	688	76.3%	-	525
More than 2 years	4,529	68.2%	-	3,087
Identified bad debts		100.0%	937	-
Total	**60,022**		**937**	**4,075**

Expected losses are assessed on an individual basis for large receivables, whilst for small debts the historical pattern is used to assess expected losses on a collective basis.

11 Trade and other receivables (continued)

The movement in the allowance for credit losses is as follows:

	2021 Actual $000	2020 Actual $000
Balance at 1 July	2,227	1,522
Additional allowance made during the year	2,785	1,047
Receivables written off during period	(937)	(342)
Balance at 30 June	**4,075**	**2,227**

12 Cash and cash equivalents

Accounting policy

Cash and cash equivalents include cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. 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.

	2021 Actual $000	2020 Actual $000
Petty cash	13	13
Bank accounts	21	10
NZHPL call deposits	(28,877)	6,530
Total cash and cash equivalents	**(28,843)**	**6,553**

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 New Zealand Health Partnership Limited and the participating DHBs. This Agreement enables NZHPL 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 negative balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum working borrowing facility available to the DHB is $71.3 million. (2020:$ 67.5 million). The highest overdrawn bank balance during financial year 2020/21 was $44.7 million. (2020: $20.6 million).

While cash and cash equivalents at 30 June 2021 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

13 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 revenue and expense.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the statement of comprehensive revenue and expense, 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 $000	Patient funds $000	Total $000
Balance at 1 July 2019	10,687	67	10,754
Monies received	4,365	178	4,543
Interest received	282	-	282
Payments made	(3,743)	(153)	(3,896)
Balance at 30 June 2020	**11,591**	**92**	**11,683**
Monies received	3,953	159	4,112
Interest received	71	-	71
Payments made	(2,310)	(165)	(2,475)
Balance at 30 June 2021	**13,305**	**86**	**13,391**

14 Employee entitlements

Accounting policy

Short term employee entitlements
Employee entitlements that are expected to be settled wholly before 12 months after the end of the reporting period in which the employee renders the related service are measured 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, continuing medical education leave, and sick leave.

Long term employee entitlements

Employee entitlements that are not expected to be settled wholly before 12 months after the end of the reporting period in which the employee renders the related service, such as sabbatical leave, sick leave, continuing medical education leave, long service leave, and retirement gratuities,have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement, and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements
Sick leave, continuing medical education leave, annual leave, long service leave, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

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.

Critical accounting estimates and assumptions

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.

Other employee entitlement liabilities
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 1.9%, (2020:1.9%) and a discount rate ranging from 0.38% to 2.98% (2020: 0.22% to 1.60%) from 1-10+ years.

If the discount rate were to differ by 1% from that used, with all other factors held constant, the carrying amount of the retirement and long service leave liability would be an estimated $0.4 million higher/lower.

If the salary inflation factor were to differ by 1% from that used, with all other factors held constant, the carrying amount of the retirement and long service leave liability would be an estimated $0.3 million higher/lower.

Holidays Act 2003 Provision
A number of New Zealand's public and private organisations have identified issues with the calculation of leave entitlements under the Holidays Act 2003 (the Holidays Act).

Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions, health sector unions and Ministry of Business Innovation and Employment Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-

14 Employee entitlements (continued)

compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance.

For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated.

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance progressed during the 2019/20 and current financial years. The. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

As a result the DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine the liability based on its own review of payroll processes which identified instances of non-compliance with the Holidays Act and the requirements of the MOU. The liability was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result.

This liability recognised is the DHB's best estimate at this stage of the outcome from this project. However, until the project has progressed further, there remain substantial uncertainties as to the actual amount the DHB will be required to pay to current and former employees.

The estimates and assumptions may differ to the subsequent actual results as further work is completed. This may result in further adjustment to the carrying amount of the liability within the next financial year or payments to current and former employees that differ significantly from the estimation of the liability.

	2021 Actual $000	2020 Actual $000
Current entitlements		
Accrued salaries and wages	17,750	19,878
Annual leave	61,418	53,455
Holidays Act 2003 remediation	86,988	79,525
Sick leave	490	615
Sabbatical leave	389	400
Continuing medical education leave and expenses	4,064	2,843
Long service leave	3,609	3,340
Retirement gratuities	1,057	950
Total current entitlements	175,765	161,006
Non-current entitlements		
Sick leave	1,935	2,336
Sabbatical leave	484	528
Continuing medical education leave and expenses	8,131	5,688
Long service leave	4,744	4,888
Retirement gratuities	993	1,149
Total non-current entitlements	16,287	14,589
Total employee entitlements	**192,052**	**175,595**

15 Provisions

Accounting policy

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in "finance costs".

	2021 Actual $000	2020 Actual $000
Current provisions		
ACC Partnership Programme	731	681
Non-current provisions		
ACC Partnership Programme	500	559
Total provisions	**1,231**	**1,240**
ACC Partnership Programme		
Undiscounted amount of claims at balance date	952	975
Discount	3%	2%
Central estimate of present value of future payments	1,103	1,111
Risk margin	128	129

The movement in provisions is represented by:

	ACC Partnership Programme $000
Balance as at 1 July 2019	1,180
Additional provisions during the year for the risks borne in current period	636
Additional provisions relating to a reassessment of risks in a previous period	218
Amounts used during the year	(794)
Balance as at 30 June 2020	**1,240**
Additional provisions during the year for the risks borne in current period	726
Additional provisions relating to a reassessment of risks in a previous period	437
Amounts used during the year	(1,172)
Balance as at 30 June 2021	**1,231**

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 (policy holder) 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 S Ferry, FNZSA 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 1.85% for the year ended 30 June 2021. A discount rate of 0.50% has been used for the year ended 30 June 2021. The value of the liability is not material for the DHB's financial statements, therefore any changes in assumptions will not have a material impact on the financial statements.

16 Trade and other payables

Accounting policy

Short-term payables are measured at the amount payable.

	2021 Actual $000	2020 Actual $000
Payables under exchange transactions		
Trade payables	17,568	3,067
Capital charge due to the Crown	-	12,110
Other non-trade payables and accrued expenses	62,521	52,359
Total payables under exchange transactions	80,089	67,536
Payables under non-exchange transactions		
Revenue in advance	958	1,277
GST and other tax payables	26,879	22,771
Total payables under non-exchange transactions	27,837	24,048
Total trade and other payables	**107,926**	**91,584**

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

	2021 Actual $000	2020 Actual $000
Patient funds		
Balance at 1 July	92	67
Monies received	159	178
Payments made	(165)	(153)
Total patient funds	86	92
Holiday home funds due to Hutt Valley DHB	4	-
Total patient and restricted funds	**90**	**92**

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 2021 are not recognised in the Statement of comprehensive revenue and expense, but are recorded in the Statement of financial position as at 30 June 2021, both as an asset and a liability.

18 Equity

	2021 Actual $000	2020 Actual $000
Contributed capital		
Balance at 1 July	801,942	777,567
Capital contributions	23,706	27,859
Conversion of loans to equity	-	-
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	822,164	801,942
Property revaluation reserves		
Balance at 1 July	130,659	131,361
Revaluations	72,804	-
Impairments	(10,000)	-
Disposals	-	(702)
Balance at 30 June	193,463	130,659
Accumulated deficit		
Balance at 1 July	(528,210)	(484,405)
Deficit for the year	(46,499)	(44,173)
Transfer from revaluation reserves	-	368
Balance at 30 June	(574,709)	(528,210)
Total equity	**440,918**	**404,391**

Capital management

The DHB's capital is its equity, which is comprised of Crown equity, accumulated surplus or deficit, and property revaluation reserves. Equity is represented by net assets.

The DHB is subject to 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, while remaining a going concern.

19 Operating lease commitments

Accounting policy

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the DHB. 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 surplus or deficit as a reduction of operating lease expense over the lease term.

Operating lease commitments as lessee

The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:

	2021 Actual $000	2020 Actual $000
Less than one year	6,193	3,808
Between one and five years	13,817	5,725
More than five years	15,578	1,012
Total operating lease commitments as lessee	**35,588**	**10,545**

During the year ended 30 June 2021, $4.6 million (2020: $2.7 million) was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases.

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.
Leased properties are not subleased by the DHB.

Operating lease commitments as lessor

The DHB leases out various surplus properties under operating leases. The future minimum lease payments under non-cancellable operating leases as lessor are as follows:

	2021 Actual $000	2020 Actual $000
Less than one year	3,338	3,539
Between one and five years	10,613	8,929
More than five years	43,488	1,997
Total operating lease commitments as lessor	**57,439**	**14,465**

The leases are comprised of:

- 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
- a mix of short and medium term leases to both clinical and commercial tenants.

20 Financial instruments

Financial instrument categories

The carrying amounts of financial assets and liabilities in each of the financial instrument categories are as follows:

	Note	2021 Actual $000	2020 Actual $000
Financial assets measured at amortised cost			
Cash and cash equivalents	12	-	6,553
Trade and other receivables	11	60,022	46,342
Total		**60,022**	**52,895**
Financial liabilities measured at amortised cost			
Cash and cash equivalents	12	28,843	-
Trade and other payables (excluding revenue in advance and taxes)	16	80,089	67,536
Total		**108,932**	**67,536**

Financial instrument risks

The DHB's activities expose it to a variety of financial instrument risks, including market risk, credit risk, and liquidity risk. The DHB has a series of policies to manage the risks associated with financial instruments and seeks to minimise exposure from financial instruments. These policies do not allow any transactions that are speculative in nature to be entered into.

Market risk

Price risk

Price risk is the risk that the value of a financial instrument will fluctuate as a result of changes in market prices. The DHB has no financial instruments that give rise to price risk.

Fair value interest rate risk

Fair value interest rate risk is the risk that the fair value of a financial instrument will fluctuate due to changes in market interest rates. The DHB's exposure to fair value interest rate risk arises from bank deposits that are at fixed rates of interest. The exposure to fair value interest rate risk is not actively managed by the DHB, as investments are generally held to maturity.

Cash flow 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. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

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 $0.32 million in 2021 (2020: $0.37 million).

20 Financial instruments (continued)

Credit risk

Credit risk is the risk that a third party will default on its obligation to the DHB, causing it to incur a loss.

Due to the timing of the DHB's cash inflows and outflows, surplus cash is invested with registered banks or NZHPL. In the normal course of business, exposure to credit risk arises from cash and term deposits with banks and NZHPL, and receivables. For each of these, the maximum credit risk exposure is best represented by the carrying amount in the statement of financial position.

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 74.42% in 2021 (2020: 21.22%). 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.

No collateral or other credit enhancements are held for financial instruments that give rise to credit risk.

Credit risk exposure by credit risk grades, excluding receivables

The gross carrying amount of financial assets, excluding receivables, by credit rating is provided below by reference to Standard & Poor's credit ratings.

	2021 Actual $000	2020 Actual $000
Counterparties with credit ratings		
Cash at bank and term deposits		
AA- (Standard & Poor's)	13,119	17,609
Total cash at bank and term deposits	**13,119**	**17,609**

Maximum exposure to credit risk for each class of financial instrument

	2021 Actual $000	2020 Actual $000
Cash and cash equivalents	-	6,553
Trade and other receivables	60,022	46,342
Trust and special funds – bank	7,919	656
Trust and special funds – term deposit	5,200	10,400
Trust and special funds – debtors	244	517
	73,385	**64,468**

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.

20 Financial instruments (continued)

Liquidity risk

Management of liquidity risk

Liquidity risk is the risk that the DHB will encounter difficulty raising liquid funds to meet commitments as they fall due. Prudent liquidity risk management implies maintaining sufficient cash, availability of funding through an adequate amount of committed credit facilities, and the ability to close out market positions.

The DHB mostly manages liquidity risk by continuously monitoring forecast and actual cash flow requirements and through the "DHB Treasury Services Agreement" with NZHPL as described in Note 12.

Contractual maturity analysis of financial liabilities

The table below analyses 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

	Carrying amount $000	Contractual cash flows $000	Less than 1 year $000	1-2 years $000	2-5 years $000	More than 5 years $000
2021						
Cash and cash equivalents	28,843	28,843	28,843	-	-	-
Trade and other payables	80,089	80,089	80,089	-	-	-
Patient and restricted funds	90	90	90	-	-	-
Total	**109,022**	**109,022**	**109,022**	**-**	**-**	**-**
2020						
Trade and other payables	67,536	67,536	67,536	-	-	-
Patient and restricted funds	92	92	92	-	-	-
Total	**67,628**	**67,628**	**67,628**	**-**	**-**	**-**

21 Related party transactions and key management personnel

CCDHB is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier relationship on terms and condition no more or less favourable than those that it is reasonable to expect the DHB would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

	2021 Actual $000	2020 Actual $000
Board members		
Remuneration	284	288
Full-time equivalent members	0.8	0.9
Leadership team		
Remuneration	4,723	4,536
Less: Amount paid by Hutt Valley DHB	(879)	(475)
Less: Amount paid by Wairarapa DHB	(6)	(23)
Amount paid by Capital & Coast DHB	3,838	4,038
Full-time equivalent members	12	13
Total key management personnel remuneration	4,122	4,326
Total full-time equivalent personnel	12.8	13.9

The full-time equivalent for Board members has been determined based on the frequency and length of Board meetings and the estimated time for Board members to prepare for meetings.

During the year, Capital & Coast DHB, Hutt Valley DHB and Wairarapa DHB shared some leadership team members, and recharge or recover the remuneration between DHBs.

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 covering personal accident and travel risk for Board members, Board Committee members and employees where injury or loss occurs whilst on DHB business.

22 Board member remuneration and meeting attendance

The total value of remuneration paid or payable to each Board member during the year was:

		Board fees		Committee fees	
		2021 $000	2020 $000	2021 $000	2020 $000
Board members as at 30 June 2021					
Mr David Smol, Chair	Appointed	45.5	24.6	4.4	-
Ms Stacey Shortall, Deputy Chair	Appointed	6.0	-	0.3	
Ms Kathryn Adams	Elected	23.2	24.3	2.5	1.5
Mr Roger Blakeley	Elected	23.2	24.3	7.0	3.0
Mr Hamiora Bowkett	Appointed	23.2	13.0	3.5	-
Mr Brendan Boyle	Appointed	4.8	-	0.3	-
Ms ‘Ana Coffey	Elected	23.2	24.3	4.4	1.4
Dr Tristram Ingham	Appointed	23.2	13.0	3.2	0.9
Mr Chris Kalderimis	Elected	23.2	13.0	3.9	-
Ms Sue Kedgley	Elected	23.2	24.3	5.8	1.2
Ms Vanessa Simpson	Elected	23.2	13.0	4.9	-
Board member who left during 2020/21					
Dr Ayesha Verrall, Deputy Chair	Elected	1.7	16.4	2.1	-
Board member who left during 2019/20					
Mr Andrew Blair	Appointed	-	26.4	-	1.8
Ms Eileen Brown	Elected	-	11.0	-	1.7
Mrs Sue Driver	Elected	-	11.0	-	0.8
Ms Kim Ngarimu	Appointed	-	11.0	-	2.1
Mr Darrin Sykes	Appointed	-	2.1	-	0.9
Dame Fran Wilde	Elected	-	13.8	-	2.3
Mr Kim von Lanthen	Appointed	-	5.3	-	-
Total Board member remuneration		**243.6**	**270.8**	**42.3**	**17.6**

	Committee fees	
	2021 $000	2020 $000
Committee members (other than Board members and employees)		
Mr Fa’amatuainu Tino Pereira	0.7	0.2
Ms Suzanne Jane Emirali	2.5	1.3
Dr Paula King	2.3	-
Total Committee member remuneration	**5.5**	**1.5**

No Board members (2021: $nil) received compensation or other benefits in relation to cessation (2020: $nil).

22 Board member remuneration and meeting attendance (continued)

Key:

DSAC	Disability Services Advisory Committee
FRAC	Finance, Risk, Audit Committee
HSC	Health Systems Committee
MCPAC	Major Capital Projects Advisory Committee
-	Not a member

Board Member	Position	Meetings Attended				
		Board	FRAC	HSC	DSAC	MCPAC
1 July 2020 to 30 June 2021						
David Smol	Chair – HVDHB and CCDHB	9/9	6/6	-	-	6/6
Stacey Shortall	Board Deputy Chair – Current Member *Appointed 16/04/2021*	2/2*	1/1*	-	-	-
Ayesha Verrall	Board Deputy Chair – Previous Member *Resigned on 19/10/2020*	2/2*	-	1/1*	-	-
'Ana Coffey	Current Member	6/9	-	4/6	3/3	-
Brendan Boyle	Current Member *Appointed 16/04/2021*	2/2*	-	-	-	2/2*
Chris Kalderimis	Current Member	7/9	-	6/6	-	-
Hamiora Bowkett	Current Member	9/9	6/6	-	-	5/6
Kathryn Adams	Current Member	9/9	-	6/6	-	-
Roger Blakeley	Current Member	7/9	6/6	-	-	-
Sue Kedgley	Current Member HSC Chair	9/9	-	6/6	3/3	-
Tristram Ingham	Current Member	9/9	6/6	-	3/3	-
Vanessa Simpson	Current Member	9/9	-	5/6	2/3	-

*Only meetings that occurred while the person was a Board member are included.

23 Explanations of major variances from budget

Explanations for major variances from the DHB's budgeted figures in the statement of performance expectations are as follows:

Statement of comprehensive revenue and expense

The DHB recorded a deficit of $46.5 million compared with a budgeted deficit of $39.8 million.

Revenue was $84.2 million higher than budget mainly due to :

- funding changes with CCDHB becoming 3DHB lead of MHAIDs and the ICT directorate
- additional funding for COVID-19 response costs for community, MIQ and the vaccine rollout
- revenue from settlement of legal case regarding the hospital's leaking copper pipes.

Personnel costs were $38.9 million higher than budget mainly due to the transfer of MHAIDs staff and ICT staff to CCDHB, increase in the Holidays Act 2003 remediation liability, and COVID-19 response costs.

Infrastructure and non-clinical expenses were $21.4 million higher than budget due to costs relating to the DHB's new role as lead for the 3DHB MHAIDs and ICT, and COVID-19-related costs not budgeted for.

Payments to non-health board providers were $21.3 million higher than budget due to COVID-19-related costs.

Statement of financial position

Employee entitlements are higher than budget, mainly due to a $8.7 million increase in the Holidays Act 2003 remediation provision, and 3DHB ICT staff being transferred to CCDHB.

Statement of changes in equity

The variance in equity movement for the year was due to $87.3 million less capital injections from the Crown than budgeted, and a deficit $6.7 million greater than budgeted, which is explained above.

Statement of cash flows

Net cash flow from operating activities was higher than budget mainly due to higher cash receipts from the Ministry of Health and other sources.

Net cash flow from investment activities was lower than budget due to decreased capital expenditure.

Net cash flow from financing activities was less than budget due to less equity injection from the Crown.

24 Events after balance date

The Health Sector Reforms are scheduled to come into effect on 1 July 2022, refer to note 1 for more detail.

In response to COVID-19, on 17 August 2021, the Wellington region moved to Alert Level 4 for two weeks, then to Alert Level 3 for one week and then down to Alert Level 2.

On 3 December 2021 the alert levels were replaced with a traffic light system. Subsequently, New Zealand moved into the highest COVID-19 setting (red light) on 24 January 2022. At the time of publication, there has been no widespread community transmission in the Wellington region, and therefore no changes have been made to the DHB's services or visitor policy. The DHB continues to monitor the situation closely, and has the ability to extend testing hours or increase testing capacity in the community if required.

For details on the impact of COVID-19 during the year, refer to note 26. The impact of COVID-19 is considered a non-adjusting event for the purposes of these financial statements.

There have been no other material events subsequent to balance date.

25 Summary cost of services by output class

Accounting policy

Cost of service
The cost of service statements, as reported in the statement of performance, report the revenue and expenses 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 determined the cost of outputs using the cost allocation system outlined below.

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

Direct costs are charged directly to outputs. Indirect costs are charged to output categories based on cost drivers and related activity or usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

25 Summary cost of services by output class (continued)

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000	2021 Actual $000	2020 Actual $000
Revenue										
Crown	47,856	11,404	197,067	198,521	961,185	850,923	115,978	135,436	1,322,086	1,196,284
Other	-	-	-	-	36,678	21,905	-	-	36,678	21,905
Total revenue	**47,856**	**11,404**	**197,067**	**198,521**	**997,863**	**872,828**	**115,978**	**135,436**	**1,358,764**	**1,218,189**
Expenditure										
Personnel	145	144	2,741	2,722	603,888	538,271	1,467	1,457	608,241	542,594
Depreciation	-	-	-	-	36,574	35,212	-	-	36,574	35,212
Capital charge	-	-	-	-	19,316	24,407	-	-	19,316	24,407
Provider payments	45,752	10,190	183,358	175,300	109,968	104,716	108,047	119,897	447,125	410,103
Other	1,959	660	10,968	12,299	265,955	215,900	6,464	8,822	285,346	237,681
Total expenditure	**47,856**	**10,994**	**197,067**	**190,321**	**1,035,701**	**918,506**	**115,978**	**130,176**	**1,396,602**	**1,249,997**
Net surplus/(deficit) before extraordinary item	**-**	**410**	**-**	**8,199**	**(37,838)**	**(45,678)**	**-**	**5,260**	**(37,838)**	**(31,808)**
Extraordinary item										
Holidays Act 2003 remediation	-	-	-	-	(8,661)	(12,365)	-	-	(8,661)	(12,365)
Net surplus/(deficit)	**-**	**410**	**-**	**8,199**	**(46,499)**	**(58,043)**	**-**	**5,260**	**(46,499)**	**(44,173)**

Actual revenue and expenditure has been mapped to output classes in accordance with guidance on classifications from the Ministry of Health. All expenditure paid is matched to a purchase unit code, and then mapped to the relevant output class classification. 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 intensive assessment and treatment output class.

26 Impact of COVID-19

During August and September 2020 and February and March 2021, the Auckland Region moved into Alert Levels 3 and 2 and other parts of the country, which includes the DHB's service area, moved into Alert level 2.

At Alert Level 2, the operating capacity of the DHB was reduced. At Alert Level 1, the DHB resumed to normal business activity and in some instances at a higher level than pre-COVID-19. This was because planned care that was delayed during Alert Levels 3 and 4 in the prior financial year was rescheduled to take place at lower Alert levels.

COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management.

Note 23 includes commentary on major variances against budget, including significant variances as a result of COVID-19.

COVID-19 and its effect on the economy has the potential to affect the estimates and assumption used in the determining the carrying value of the DHB's assets and liabilities.

Note 6 Property, plant and equipment, incudes additional commentary on uncertainty in the carrying value of land and building due to COVID-19.

27 Late signing of Annual Report

Capital & Coast District Health Board was required under section 156 (3) of the Crown Entities Act 2004 to adopt its audited financial statements and service performance information by 31 December 2021. This timeframe was not met because Audit New Zealand was unable to complete the audit within this timeframe due to an auditor shortage and the consequential effects of COVID-19, including lockdowns.

Statement of Responsibility

We are responsible for the preparation of Capital & Coast District Health Board's financial statements and statement of performance, and for the judgements made in them.

We are responsible for any end-of-year performance information provided by the District Health Board under section 19A of the Public Finance Act 1989.

We are responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In our opinion, these financial statements and statement of performance fairly reflect the financial position and operations of the Capital & Coast District Health Board for the year ended 30 June 2021.

Signed on behalf of the Board:

David Smol,
Chair
25 February 2022

Roger Blakeley,
Chair Finance, Risk and Audit Committee
25 February 2022

Independent Auditor's Report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

To the readers of the Capital and Coast District Health Board's financial statements and performance information for the year ended 30 June 2021

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

We have audited:

- the financial statements of the Health Board on pages 65 to 104, that comprise the statement of financial position as at 30 June 2021, the statement of comprehensive revenue and expense, 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 on pages 48 to 64 and 103.

Opinion

In our opinion:

- the financial statements of the Health Board on pages 65 to 104, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2021; and
        - its financial performance and cash flows for the year then ended; and
    - comply with generally accepted accounting practice in New Zealand in accordance with Public Benefit Entity Reporting Standards; and
- the performance information of the Health Board on pages 48 to 64 and 103:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2021, including:
        - for each class of reportable outputs:
            - its standards of delivery performance achieved as compared with forecasts included in the statement of performance expectations for the financial year; and

- its actual revenue and output expenses as compared with the forecasts included in the statement of performance expectations for the financial year; and
- what has been achieved with the appropriation; and
- the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure; and

- complies with generally accepted accounting practice in New Zealand.

Our audit was completed late

Our audit was completed on 25 February 2022. This is the date at which our opinion is expressed. We acknowledge that our audit was completed later than required by the Crown Entities Act 2004, section 156(3)(a). This was due to an auditor shortage in New Zealand and the consequential effects of COVID-19, including lockdowns.

The basis for our opinion is explained below, and we draw attention to other matters. In addition, we outline the responsibilities of the Board and our responsibilities relating to the financial statements and the performance information, we comment on other information, and we explain our independence.

Emphasis of matters

Without modifying our opinion, we draw attention to the following disclosures.

The financial statements have been appropriately prepared on a disestablishment basis

Note 1 on page 71 outlines the health sector reforms announced by the Minister of Health on 21 April 2021. Legislation to disestablish all District Health Boards and establish a new Crown entity, is expected to come into effect on 1 July 2022. The Health Board therefore prepared its financial statements on a disestablishment basis. The values of assets and liabilities have not changed because these will be transferred to the new Crown entity.

Uncertainties in estimating the holiday pay provision under the Holidays Act 2003

Note 14 on pages 88 and 89 outlines that the Health Board has been investigating issues with the way it calculates holiday pay entitlements under the Holidays Act 2003, as part of a national approach to remediate these issues. The Health Board has estimated a provision of $87 million, as at 30 June 2021 to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

The Health Board is reliant on financial support from the Crown

Note 1 on page 77 outlines the Health Board's financial performance difficulties. There is uncertainty whether the Health Board will be able to settle its liabilities, including the estimated historical Holidays Act 2003 liability, if they were to become due prior to its disestablishment. The Health Board therefore obtained a letter of comfort from the Ministers of Health and Finance, which confirms that the Crown will provide the Health Board with financial support, where necessary.

HSU population information was used in reporting COVID-19 vaccine strategy performance results

Pages 62 to 64 outlines the information used by the Health Board to report on its COVID-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 63. The note outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

Impact of COVID-19

Notes 24 and 26 on pages 101 and 104 of the financial statements which outlines the impact of COVID-19 on the Health Board. We draw specific attention to note 6 on page 78 which outlines that there is some degree of material valuation uncertainty in estimating the fair value of the Health Board's land and buildings due to the current COVID-19 situation.

Basis for our opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and the International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Board for the financial statements and the performance information

The Board is responsible on behalf of the Health Board for preparing financial statements and performance information that are fairly presented and comply with generally accepted accounting practice in New Zealand.

The Board is responsible for such internal control as it determines is necessary to enable it to prepare financial statements and performance information that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements and the performance information, the Board is responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. If the Board concludes that the going concern basis of accounting is inappropriate, the Board is responsible for preparing financial statements on a disestablishment basis and making appropriate disclosures.

The Board's responsibilities arise from the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000 and the Public Finance Act 1989.

Responsibilities of the auditor for the audit of the financial statements and the performance information

Our objectives are to obtain reasonable assurance about whether the financial statements and the performance information, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements and the performance information.

For the budget information reported in the financial statements and the performance information, our procedures were limited to checking that the information agreed to the Health Board's statement of performance expectations.

We did not evaluate the security and controls over the electronic publication of the financial statements and the performance information.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements and the performance information, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board.

- We evaluate the appropriateness of the reported performance information within the Health Board's framework for reporting its performance.

- We conclude on the appropriateness of the use of the disestablishment basis of accounting by the Board.

- We evaluate the overall presentation, structure and content of the financial statements and the performance information, including the disclosures, and whether the financial statements and the performance information represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibilities arise from the Public Audit Act 2001.

Other Information

The Board is responsible for the other information. The other information comprises the information included on pages 3 to 47 and 105, but does not include the financial statements and the performance information, and our auditor's report thereon.

Our opinion on the financial statements and the performance information does not cover the other information and we do not express any form of audit opinion or assurance conclusion thereon.

In connection with our audit of the financial statements and the performance information, our responsibility is to read the other information. In doing so, we consider whether the other information is materially inconsistent with the financial statements and the performance information or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on our work, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Independence

We are independent of the Health Board in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1: International Code of Ethics for Assurance Practitioners issued by the New Zealand Auditing and Assurance Standards Board.

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

Andrew Clark
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Ministerial Directions

Capital & Coast District Health Board complies with the following Ministerial Directions:

- The 2011 Eligibility Direction issues under s.32 of the NZ Public Health and Disability Act 2000
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of Government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Hutt Valley DHB
- The direction on the use of authentication services issued in July 2008, which continues to apply to all Crown agencies apart from those with sizable ICT business transactions and investment specifically listed within the 2014 direction.

Directory

Postal address: Capital & Coast District Health Board Private Bag 7902 Wellington 6242 **Website:** www.ccdhb.org.nz **Facebook:** www.facebook.com/CCDHB	**Wellington Regional Hospital physical address:** Riddiford Street, Newtown, Wellington 6021 **Phone:** (04) 385 5999
Bankers: Bank of New Zealand	**Auditor:** Audit New Zealand Wellington, on behalf of the Controller and Auditor-General

CCDHB Board Members as at 30 June 2021	
The Board has eleven members. Seven are elected. Four are appointed by the Minister of Health *(marked*)*	
David Smol, Chair Hutt Valley and Capital & Coast DHB*	
Stacey Shortall, Deputy Chair*	**Kathryn Adams**
'Ana Coffey	**Roger Blakeley**
Brendan Boyle*	**Sue Kedgley**
Chris Kalderimis	**Tristram Ingham***
Hamiora Bowkett*	**Vanessa Simpson**

Executive Leadership Team for Hutt Valley and Capital & Coast DHBs as at 30 June 2021			
Fionnagh Dougan	2DHB Chief Executive Officer	**Rosalie Percival**	2DHB Chief Financial Officer
Joy Farley	2DHB Director Provider Services	**Sarah Jackson**	2DHB Acting Director Clinical Excellence
Chris Kerr	2DHB Director of Nursing	**Arawhetu Gray**	2DHB Director of Māori Health
John Tait	2DHB Chief Medical Officer	**Junior Ulu**	2DHB Director of Pacific People's Health
Christine King	2DHB Director of Allied Health	**Rachel Haggerty**	2DHB Director Strategy Planning and Performance
Declan Walsh	2DHB Director People, Culture and Capability	**Steve Earnshaw**	Acting Chief Digital Officer, 3DHB
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disabilities, 3DHB	**Sally Dossor**	2DHB Director of the Office of the Chief Executive
Helen Mexted	2DHB Director, Communications and Engagement		

3DHB Disability Support Advisory Committee as at 30 June 2021			
'Ana Coffey (Chair)	Capital & Coast DHB	**Yvette Grace**	Hutt Valley DHB
Sue Kedgley	Capital & Coast DHB	**John Ryall**	Hutt Valley DHB
Tristram Ingham	Capital & Coast DHB	**Naomi Shaw**	Hutt Valley DHB
Vanessa Simpson	Capital & Coast DHB	**Ryan Soriano**	Wairarapa DHB
Jill Pettis	Wairarapa DHB	**Jill Stringer**	Wairarapa DHB
Sue Emirali	Chair, Sub-regional Disability Advisory Group	**Jack Rikihana**	Te Upoko o te Ika A Maui Māori Council
Bernadette Jones	Chair, Sub-regional Disability Advisory Group	**Marama Tuuta**	Chair of Kaunihera Whaikaha, Wairarapa

Combined Health System Committee as at 30 June 2021			
Sue Kedgley	Chair, Capital & Coast DHB	**Ken Laban**	Deputy, Hutt Valley DHB
Josh Briggs	Hutt Valley DHB	**Keri Brown**	Hutt Valley DHB
'Ana Coffey	Capital & Coast DHB	**Chris Kalderimis**	Capital & Coast DHB
Vanessa Simpson	Capital & Coast DHB	**Richard Stein**	Hutt Valley DHB
Ria Earp	Hutt Valley DHB	**Roger Blakeley**	Capital & Coast DHB
Paula King	Te Upoko o te Ika A Maui Māori Council	**Fa'amatuainu Tino Pereira**	Sub-regional Pacific Strategic Health Group
Sue Emirali	Sub-regional Disability Advisory Group	**Bernadette Jones**	Sub-regional Disability Advisory Group
Teresea Olsen	Community Māori Representative, Hutt Valley		

Chief Executive Employment Committee (CEEC) as at 30 June 2021. Members are:	
David Smol – Chair, Capital & Coast and Hutt Valley District Health Boards	
Wayne Guppy – Deputy Chair, Hutt Valley DHB	Stacey Shortall – Deputy Chair, Capital & Coast DHB

Finance Risk and Audit Committee as at 30 June 2021 - CCDHB	
Roger Blakeley – Chair, Capital & Coast DH)B	Stacey Shortall – Capital & Coast DHB
Tristram Ingha – Capital & Coast DHB	Kathryn Adams – Capital & Coast DHB
Hamiora Bowkett – Capital & Coast DHB	

Major Capital Projects Advisory Committee as at 30 June 2021	
Brendan Boyle – Chair, Capital & Coast DHB)	Wayne Guppy – Hutt Valley DHB
Hamiora Bowkett – Capital & Coast DHB	David Smol – Hutt Valley DHB
Tony Lloyd – Ministry of Health	Bruce McLean – appointed independent expert