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Capital & Coast District Health Board

Annual Report 2019–2020

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: A Wellington family, featured in Taurite Ora. Photographer – Adrian Heke

Chair and Chief Executive's Foreword

What an astonishing year it has been. Shortly after the new Board took office late last year, the health landscape was changed forever with the emergence of COVID-19. While we are in a comparatively fortunate position globally, the pandemic has had a huge impact, and will affect the way we deliver services and work with our communities for a long time to come.

At Capital & Coast District Health Board (CCDHB) we are focused on providing safe, quality health services, and strive to achieve equitable health outcomes for all. We provide a range of services across our community including outpatient clinics, maternity and mental health services and, at Wellington Regional Hospital, tertiary level care. The new Board has a commitment to making sure we are in a sustainable financial position, and work continues to make sure we are living within our means while meeting our obligations and continuing to deliver good quality care.

We are proud of how our people stood strong and supported the 'team of five million' to stop community transmission of COVID-19 in Aotearoa. Together with Hutt Valley District Health Board (HVDHB), we delivered a coordinated response to the pandemic, from establishing Community Based Assessment Centres (CBACs) across the region, to providing support to Managed Isolation Facilities (MIFs), and helping provide emergency supplies to people struggling as a result of the outbreak.

Our Public Health Unit – Regional Public Health, played a vital role in our COVID-19 response. Helping protect the Wellington Region from further spread of COVID-19 through contact tracing of COVID-19 cases and their contacts, health screening of international passengers arriving at Wellington Airport and providing daily health monitoring to COVID-19 cases who were self-isolating at home or in quarantine.

During lockdown in April a significant number of elective procedures were deferred, resulting in an influx of patients after lockdown was lifted. Ensuring that we catch up and respond to our patients requiring treatment and care will be a priority over the next year.

We continue to maintain our readiness to respond should anything change. In the meantime we are able to focus our attention on our plans for the future. New ways of working that developed during COVID-19 are now being embedded into our business-as-usual practice. This includes greater use of telehealth and increasing the availability of specialist support and advice to primary care.

Together with HVDHB, we have been working to bring our partnership as a 2DHB organisation to fruition following appointment of a joint chief executive last year. Over the last year we have recruited a number of 2DHB executive leadership team positions, while also welcoming a joint chair and more closely aligning the two Boards.

The release this year of the Health and Disability System Review has signalled change for DHBs. CCDHB's Health System Plan 2030 builds on our strategic priorities to deliver and implement a health system that focuses on equity, prevention and early intervention, supporting our provider system, optimal flow of care, improved systems, and building capability and capacity of community health networks, while allowing hospitals to refine specialist care.

A year of unprecedented challenges has underscored the importance of our equity work. Outbreaks of infections like COVID-19 disproportionately impact our priority populations, and key health messages can struggle to reach our Māori, Pacific and Disability communities. Our expert teams continue to work with providers and use tried-and-tested communications tools to reach these communities, from Pacific Radio broadcasts to sign-language video translations.

Historical disadvantage and alienation, poverty, and poor living environments lead to sustained poor health outcomes. This applies to many Māori and whānau. Life expectancy for Māori living in the CCDHB area continues to lag behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas.

CCDHB has developed a long-sighted Māori health strategy to tackle these inequities. Our Māori Health Development Group launched Taurite Ora: Maori Health Strategy 2019-2030 in 2019. Taurite Ora is supported by this wero: Kua Takoto Te Rau Tapu: The challenge of health equity for Māori is laid down. It challenges CCDHB to tackle inequity, in the context of the founding document of Aotearoa: Te Tiriti o Waitangi.

Our Pacific Directorate is also preparing to release its long-term health strategy. Its team members have led the way ensuring equity of messaging, and strengthened relationships with and between providers, to reach Pacific communities during the COVID-19 outbreak.

Our Mental Health, Addictions and Intellectual Disability Service (MHAIDS) team is working through a process of change to shape the services it provides our communities. As part of that, MHAIDS launched a GP Liaison service this year to ensure provision of specialist mental health and addictions advice to general practices across the 3DHBs (including Wairarapa).

Tremendous work has also been done this year by our 3DHB Disability Strategy team. Its ongoing role is to ensure disabled people have ready access to information, but also that barriers experienced in their daily lives are addressed. Team members continue to work with people across the 3DHBs to achieve this goal, and this year were seconded to the Ministry of Health to assist with communications during the first COVID-19 outbreak.

The new Wellington Children's Hospital project is at a very exciting stage in its development. Over the last 12 months foundations have been completed, the outdoor structure erected, and indoor structuring commenced. Services installation work, such as heating, plumbing and cabling, is also moving forward. Thanks are due to philanthropist Mark Dunajtschik, who committed an extraordinary $50 million towards the build.

While it has been a challenging year, our people have risen to the challenge, and we are optimistic about the potential of working together across our 2DHBs for a stronger healthcare system. We are very pleased to present our annual report for the year ending June 2020.

Ma tini, ma mano, ka rapa te whai – by joining together, we will succeed.

Fionnagh Dougan – Chief Executive

David Smol – Board Chair

Introduction

This annual report outlines CCDHB's progress towards meeting the intentions and priorities as outlined in the New Zealand Health Strategy and our Board's vision: Keeping our Community Healthy and Well.

To deliver our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means using our resources in the most effective manner. We want to ensure that service delivery occurs in the most appropriate setting for our people and communities, and achieves equitable and improved health outcomes.

We recognise the role of many people in our success: our communities, families, workforce, provider partners, Ministry of Health, and our social service partners. At the heart of this approach is enabling people and their whānau to take the lead in their own health and wellbeing. As we implement our Health System Plan and long-term vision of how services will be delivered for our population, we are well-positioned to successfully deliver against the New Zealand Health Strategy's objectives. We have a work programme that builds on existing successes and finds new ways of using existing resources wisely.

Overall, CCDHB's population is experiencing good health. Our residents are living longer and experiencing better health. However, inequities remain a significant challenge. Achieving equity is a priority for us. We know that we do not do as well for Māori, Pacific Peoples, people with disabilities, 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. We are committed to improving health outcomes and achieving equity for our communities. Our focus is on improving performance, ensuring we make best use of our available resources and, ultimately, achieving equity for our populations.

We will continue to focus on:

- Taurite Ora: Māori Health Strategy 2019-2030.
- Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020–2025.
- Health and Disability System Review
- Living Life Well – A Strategy for Mental Health and Addiction 2019-2025.

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

We collaborate with our Māori Partnership Board, Sub-Regional Pacific Strategic Health Group and Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent.

CCDHB, together with the Māori Partnership Board, has developed Taurite Ora: Māori Health Strategy 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*.

Taurite Ora focuses on equity as a value which underpins everything we do system change through workforce development and funding prioritisation through commissioning of services.

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.

To meet our responsibilities to the Minister, the region and our communities, we use our resources wisely and strategically to:

- promote health and wellbeing
- achieve equitable health outcomes
- prevent the onset and development of avoidable illness
- strengthen the wellbeing and health outcomes of people who are experiencing illness
- support dignity at the end of life.

We operate with a long-term view and have a programme of work that builds on existing successes and finds new ways to:

- work with communities to improve health and wellbeing with a focus on preventing or delaying the onset of avoidable illness or disability
- simplify service delivery for those people who don't have good health literacy and health behaviours
- intensify service delivery for those who are more vulnerable and have greater health needs to reduce inequalities and improve health gain
- implement models of care that promote early intervention closer to home and result in improved health outcomes
- organise technology and interdisciplinary teams in communities, people's homes, community health networks, and our hospitals to ensure resources are used efficiently by reducing duplication and improving integration.

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:

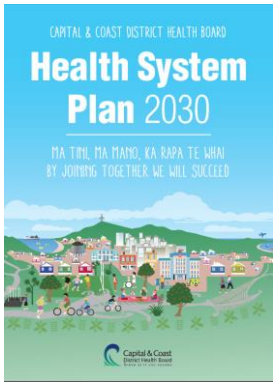
Keeping our community healthy and well

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

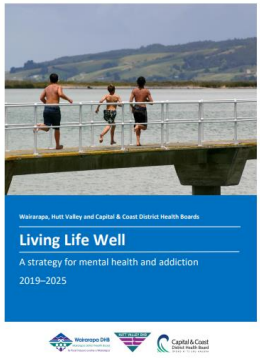
We have developed a number of plans to support us to meet the challenges ahead and achieve Our Vision for Change. Together these plans reflect CCDHB's strategic framework.

[Taurite Ora: Māori Health Strategy 2019-2030]

[Pacific Health And Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025.]

[The Sub-Regional Disability Strategy 2017-2022]

[Living Life Well – A Strategy for mental health and addiction 2019-2025]



Read the strategies on our website: [www.ccdhb.org.nz]

Health Equity

Achieving equity is a priority for CCDHB. We know that we do not do as well for Māori, Pacific people, people with disabilities, 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.

Our focus is on improving performance, ensuring we make best use of our available resources and ultimately achieving equity amongst our populations. We will continue to deliver against:

- Taurite Ora: Māori Health Strategy 2019-2030.
- Sub-Regional Pacific Health And Wellbeing Strategic Plan 2020-2025.
- Sub-Regional Disability Strategy 2017-2022.
- Living Life Well – A strategy for mental health and addiction 2019-2025.

We will develop models of care and commission services that achieve equity for our people and communities by optimising the configuration of existing investment and services, prioritising new investment when resources are available to services that have the greatest impact on health outcomes for Māori, Pacific people, people with disabilities, those who have fewer resources available to them, and those with enduring mental illness.

We will support having a workforce that is reflective of the populations we serve. We prioritise a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff as well as our staff with disabilities thereby ensuring the right mix of staff and skills in the places where they are needed most to achieve equitable health outcomes.

Partnership is key to success in achieving equitable health outcomes. We collaborate with our Māori Partnership Board, Sub-Regional Pacific Strategic Health Group, and Sub-Regional Disability Advisory Group,

who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We will measure and report on our progress regularly.

We will contribute to equity priorities through the specific actions and milestones outlined in the section below. We will measure and report on our progress regularly.

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.

CCDHB, together with the Māori Partnership Board, has developed a Māori health strategy, Taurite Ora: Māori Health Strategy 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.

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 Partnership Board on behalf of all Māori in our district.

Te Tiriti o Waitangi

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.

Our intention is that we will target, plan, and drive our health services to create equity of health care for Māori to attain good health and wellbeing, while developing partnerships with the wider social sector to support whole-of-system change.

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through this founding document of Aotearoa. CCDHB values Te Tiriti and the principles of:

- *Partnership* – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing.
- *Participation* – involving Māori at all levels of decision-making, planning, development and service delivery.
- *Protection* – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Māori representation has been provided on all advisory committees and the Integrated Care Collaborative Alliance Leadership Team (ICC ALT). CCDHB has a Māori Partnership Board to formalise the relationship between local iwi and the DHB, build on relationships, and share aspirations and strategic directions.

New health strategy gives a voice to Māori

CCDHB Kaihautu Peter Jackson, Māori Health Development Group members Doris Tuifao and Jim Wiki, and Māori Health Director Arawhetu Gray at the Taurite Ora launch at Maraeroa Marae in Porirua

CCDHB's bold new Māori Health Strategy, Taurite Ora, had a community launch in November 2019 at Maraeroa Marae in Porirua. The strategy challenges CCDHB to rebuild itself as a pro-equity organisation from the ground up.

"Taurite Ora acknowledges the system is persistently not meeting the needs of Māori and that health outcomes are not improving. That has to change," says director of the Māori Health Development Group, Arawhetu Gray. "The bottom line is we have to improve outcomes for Māori."

While it builds on previous strategies, it is more specific in its data mapping and context setting around poor health outcomes for Māori, and bolder in calling out racism and structural inequality as causes.

"It acknowledges we can do better," says Arawhetu. "It gives a voice to Māori in that it sets the context for poor health without victim-blaming."

Developed by the Māori Health Development Group under the korowai, or cloak, of the Māori Partnership Board – and Taurite Ora is more than just a strategy – it sets out approximately 150 actions for the DHB and its people to undertake to achieve real change. "It's a handbook for everyone at CCDHB who works with Māori," says Arawhetu. "It sets out concrete actions that our people can take."

It pinpoints equity, workforce development and commissioning as areas where real change can be achieved. Equity as a value must truly underpin everything we do. Workforce development must ensure representative numbers of Māori are employed by the DHB, that non-Māori are equipped to give culturally appropriate care, and commissioning of services must be addressed through funding.

"Everyone at CCDHB needs to read this and understand their role in how we make it easier to accommodate Māori," says Arawhetu. "Everyone has a part to play."

You can read Taurite Ora here: www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/

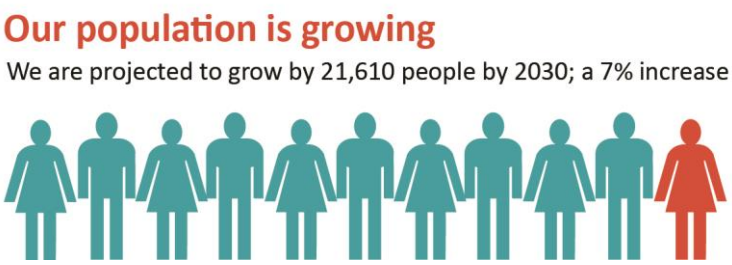
About Capital & Coast DHB

CCDHB 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 2019/20 an estimated 324,000 people called the region home. This is projected to grow by 21,610 people by 2029/30; a 7% increase.

In 2019/20, 106,200 people under 25 years of age made up 33% of the region's population. Most people (58%) were aged 25-69 years (187,100). The remaining 9% were people over 70 years; 30,500 people.



Wellington had a large proportion of people in the younger working age group of 20–44 years (88,400 people), while just under a quarter (24%) of the Porirua population were aged under 15 years (13,400 people). Over one-quarter (26%) of the Kāpiti Coast population were aged over 65 years; 14,100 people.

The region is ethnically diverse. In 2019, 36,900 people identified as Māori (11% of the population), 22,300 identified as Pacific peoples (7%) and 51,400 identified as Asian (16%); 66 % of the population identified as non-Māori, non-Pacific, non-Asian (ie Other) category (213,100).

Porirua had a larger proportion of Māori (22% or 12,500 people) and Pacific peoples (26% or 14,800 people), while 92% of the Kāpiti Coast population identified as 'Other' ethnicities (49,800 people).

Our Māori and Pacific populations tend to be younger, with 29% of the region's Māori (10,800) and 27% of the region's Pacific people (6,000) aged under 15 years in 2019/20.

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 20% or 7,300 people. Our Asian population is predicted to grow by 43% or 20,300 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.

CCDHB population change by 2030

CCDHB population	**+21610**	**7%**
Aged 0-14 years	-2330	4% decrease
Aged 15-24 years	+360	1% increase
Aged 25-69 years	+10710	6% increase
Aged 70-79 years	+6570	33% increase
Aged 80 plus years	+6300	59% increase

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 45% between 2000 and 2015, and the majority of our population (64%) 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. These expectations are reflected in our vision:

Keeping our Community Healthy and Well

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.

CCDHB has 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 Kapiti 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 around 5,700 staff and have an annual budget of $1.2 billion in 2019/20.

Sub-Regional services

CCDHB provides services to the people of Hutt Valley DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB (Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB) models.

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

In 2019/20 an estimated 151,500 people lived in HVDHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. Hutt Valley DHB's population is predicted to grow by 3% or 4,400 people by 2029/30.

A further 46,500 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.

In 2019/20, the Central Region population was 937,100 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).

Map of Central Region DHBs

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.

Our response to COVID-19

We delivered a coordinated response to the pandemic in partnership with Hutt Valley DHB, Wairarapa DHB, and the Wellington Regional Emergency Management Office (WREMO). Ten Community-Based Assessment Centres (CBACs) were established across the region to test for COVID-19 and support general practice. Emergency packages of care and support were delivered to Māori, Pacific, and disabled people.

COVID-19 had a significant impact on the delivery of health care services across the region. During the pandemic a significant number of planned care (elective) procedures were deferred, and fewer people presented to primary care, Accident & Medical centres, and emergency departments. This resulted in an influx of patients requiring care post COVID-19. Ensuring that we catch up and respond to our patients requiring treatment and care will be a priority over the next year.

New ways of working that developed during COVID-19 are now being embedded into business as usual. This includes greater use of telehealth and increasing the availability of specialist support and advice to primary care, working across agencies to look after our most vulnerable populations, including homeless people, and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations. For Regional Public Health, which is the lead public health agency in a pandemic response, this includes implementing national system changes to improve our capacity for contact tracking.

To help mitigate the economic fallout from COVID-19, we are now prioritising the psychosocial response to the pandemic. This includes a comprehensive programme of work delivering our 3DHB Mental Health and Addictions Strategy 2019-2015, Living Life Well 2019 - 2025, which aligns with the recommendations in He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction.

The Health Emergency Plan and the Pandemic Plans (both hospital and community) have been reviewed across the three DHBs to incorporate learnings from the COVID-19 response and ensure we are even better prepared for future events.

Our Public Health response to COVID-19

Since the first whisperings of a potential global pandemic in early January 2020, Regional Public Health (RPH) has been in full preparation and response mode. In February, RPH stood-up its Incident Management Team (IMT) to respond to the pandemic. This saw the majority of the RPH workforce of 125 staff redeployed to focus on protecting our communities from COVID-19.

As part of this response, a key tool utilised to control the spread of COVID-19 was contact tracing. Contact tracing is a concept that prior to COVID-19, many New Zealanders will not have been familiar with. However, contact tracing is bread-and-butter work for public health nurses, who carry out the same process for cases of many different communicable diseases. Contact tracing aims to establish a potential source of infection and to look for close contacts who interacted with a case while they were considered infectious. Through a phone interview, contact tracers capture details such as the history of illness, travel, any contact with a known case. Individuals who are identified as having close contact with the case during this period are then followed up.

Liz MacDonald, RPH Clinical Nurse Specialist, says “The contact tracing aspect of our work is really interesting. It sometimes feels like you’re both public health nurse and private investigator as you work to track people down, and attempt to identify links between cases. Sometimes people choose to share some entertaining anecdotes with us and we find out what interesting lives people lead, even during their illness. We prefer people to over-share with us, in the pursuit of getting the most accurate information and again, the information people share with us is treated with sensitivity and the individual’s right to privacy at front of mind”.

Another key aspect of RPH’s pandemic response was at the border. During the initial stages of the COVID-19 outbreak in New Zealand, RPH staff were present at Wellington Airport to provide health screening for returning passengers. This saw our staff collaborating with Wellington International Airport, NZ Customs and Aviation Security to ensure that returnees were aware of COVID-19, and knew what to do if they became symptomatic during the first 14 days following their return.

Similarly, the RPH health promotion workforce were involved in range of activities alongside community organisations which included providing information and resources to the community, as well as packaging and distributing food and hygiene packages. They also connected with small business owners who ran

essential services to make sure they were aware of effective hygiene practices to keep themselves and their customers safe.

Preventing COVID-19 is an all-of-community effort. Having strong connections with the community and key agency partners has played a vital part of RPH's response. These ties to the community have strengthened during the pandemic response. The Māori whakataukī, or saying, is relevant to RPH's work: Nāu te rourou, nāku te rourou, ka ora ai te iwi. With your food basket and my food basket the people will thrive. This whakataukī talks to community, to collaboration and a strengths-based approach. An approach that has been utilised by RPH, with the understanding that everybody has something to offer, a piece of the puzzle, and by working together we can all thrive.

Community Based Assessment Centres (CBACS) rising to the challenge

CBAC in Porirua

The word CBAC has quickly become part of our everyday vernacular. Although technically not accurate, CBAC refers to the community based testing centres which were established rapidly early in 2020 around the Greater Wellington Region in locations where they could best meet the needs of the local community.

Some were attached to medical centres, some in community halls or other council facilities. Tents and other temporary structures sprang up, and with them, hundreds of staff were needed to work on the frontline meeting and greeting, directing, taking details, swabbing, security, cleaning, administration. You name it, they were all there. A remarkable effort, and admirable commitment, from a huge team of people in the face of enormous uncertainty.

CBACs were commissioned by the three DHBs and are operated by the PHOs. They were primarily established to test people who had been screened and triaged as meeting the case definition for COVID-19. Over time the case definition widened increasing the workload at CBACs considerably. Surveillance testing was added for asymptomatic people who may have been exposed – frontline and essential workers including pharmacy and primary care staff, and people living and working in hostels for example. When surveillance testing was announced, our PHOs – Tu Ora Compass, Ora Toa, Te Awakairangi, and Cosine – stepped up to the challenge with less than a day's notice and swabbed more than 1000 people over a 48-hour period.

Testing remained a priority at alert level 2 where the potential risks increased as people started travelling around the country, going back to work and school. To ensure priority populations were accessing testing, many CBACs started taking walk-ins from the public and CBACs in some areas began offering enhanced services to ensure people were getting welfare and social support, mental health and wellbeing care, and general practice care if needed.

Emergency packages of care delivered to rangatahi by rangatahi

#YouthQuake members Mel and Alistair

As part of the COVID-19 response, Hutt Valley and Capital & Coast DHBs funded some emergency packages of care (EPoCs) to support Māori, Pasifika, people with disabilities, and rangatahi (youth) in need of extra support. EPoCs can include food, petrol and paying for utilities like power and gas.

The assessment and delivery of EPoCs in most of the region was managed by Youth One Stop Shops (YOSS) which offer a range of primary healthcare services in one place for young people. Because there is no YOSS in Porirua, #YouthQuake stepped in.

#YouthQuake is a group of rangatahi working with CCDHB to develop a YOSS for Porirua. #YouthQuake members, Mel Thetadig and Alistair Paiti, in partnership with Maraeroa Marae, were reaching out to Porirua rangatahi in need of additional support to offer EPoCs. So far over 200 rangatahi were identified and the team reached out to to assess and offer them an EPoC.

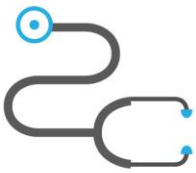
Mel and Alistair say the experience has been really satisfying.

“We are in a position to help rangatahi in a practical way, and it puts our community focused skills to great use.”

They received awesome messages of thanks and are confident the EPoCs went to those who needed them most. The support enables rangatahi to have a role in contributing to their wider whānau needs.

2019-2020

a year at CCDHB



60,961
people presented to the emergency department at Wellington Regional Hospital

3,359
babies were born in our units

148,443
outpatient appointments

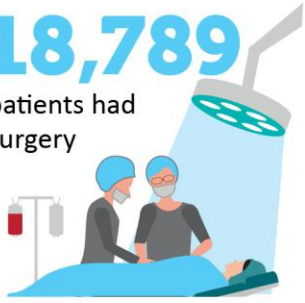
2.95million
laboratory tests were completed in the community and hospital

74,792
face to face client consultations with our specialist mental health services

665,744

29,424
children had a free dental check

18,789
patients had surgery



1,098,306
GP visits

22,260
people were offered help to quit smoking

353,083
hours of home based support services

35,680
visits were made into people's homes by community allied health workers, such as physiotherapists or social workers

2.7million
prescriptions were filled

1,516
people are in aged residential care on any given day

Figures cover July 2019 - June 2020

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 10 members who have overall responsibility for CCDHB's performance. Seven members are elected as part of the three-yearly local body elections and three 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.

Exploring our way to wellbeing

Staff joining in with wellbeing exercises in the Wellington Regional Hospital atrium

Mental Health Awareness Week joined forces with the wellbeing week to prompt staff to explore the way to wellbeing. It was lovely to see people connecting, giving, taking notice, learning and being active – the five actions in daily life that are important for wellbeing.

Over the past year, the organisation development team co-designed a framework for wellbeing with staff around the following principles. The framework was developed to ensure that we have a thoughtful and cohesive approach to wellbeing. The principles serve to highlight what is important for wellbeing for all of us, our teams and our organisation. We now have a number of activities underway to bring this framework to life and to support us to be a place where we can all thrive.

Our Wellbeing Framework

Principle 1: People who work here, can thrive here. Our goal is to proactively support and promote health and wellbeing. When harm occurs, we have resilient teams and people, with systems, processes and resources to support them.

Principle 2: We bring our whole selves to work. Incorporating Te Whare Tapa Whā (the four cornerstones of Māori health) as core to the wellbeing framework reminds us that we bring our whole selves to work – our physical, social, spiritual and psychological elements.

Principle 3: We celebrate and honour diversity. Our wellbeing framework rests on a strong foundation of values. We aim to foster inclusive work environments where identity, pride, connectedness and belonging are realities for all.

Principle 4: Health, wellbeing and safety are part of one whole. A robust and resilient workforce is more able to proactively monitor health and safety protections and make sure they are effective, reducing the risk of harm.

Principle 5: We are all responsible for creating a safe and supportive workplace. We are all part of our work community, in which we impact the wellbeing of others and are impacted by those around us. The Pacific concept of Le Va refers to the space between, the space that connects and that holds us together in unity.

Principle 6: We support better health outcomes for all. Our work community is a small version of New Zealand society, and the three segments of the framework (whole organisation, populations, individual) recognise and reflect the need to think about our whole community and groups within it.

Our People

Being a good employer

CCDHB is committed to being a good employer that provides equal employment opportunities. We support an environment where employees feel valued and respected, and where difference is celebrated and diversity encouraged.

At CCDHB we work to support a thriving culture for our people where they can be excited to come to work, able to do their best work and proud to say they work here. The heart of our health system is its people. A safe and supportive environment for our people enables delivery of high quality, compassionate and safe care to our communities.

Our values

After almost 10 years, our values have been refreshed, with new values launched in late 2019. Our values, and the behaviours that underpin them, guide the way we work together and the way we provide care to our communities.

Six months in the making, the values have been shaped by our people through team discussions, poster activities and workshops. Our executive team then worked together to identify three key values.

Manaakitanga - focuses on caring for a person's mana by showing hospitality, generosity and mutual respect. It calls for us to treat others in the way they want to be treated.

Kotahitanga - focuses on unity and collective action. We can demonstrate it through working in a fair and just way with each other and with the communities we serve.

Rangatiratanga - challenges each of us to use our personal power with integrity and to trust people and share leadership, influence and decision-making.

Following the launch of the new values, a programme of work has been completed to embed the values into our people processes (recruitment, orientation, leadership development and policies), communications (internet and intranet) and the way in which we work with each other and provide care to our community every day.

Values have been put into action to achieve a more inclusive workplace this year, to support our goal to achieve equity. Initial steps have aimed to increase the experience of manaakitanga for people first connecting with CCDHB. We have focussed on the advertising and recruitment processes, to create increased visibility of te reo Māori, throughout job advertisements, role descriptions, the CCDHB website, and in email signatures. Whānau are now more able to support candidates through the recruitment process. Our People and Capability teams have now completed Te Tohu Whakawaiora, a one-year course in which participants increase their understanding of Te Tiriti o Waitangi, cultural practices, Te Ao Māori, and health outcomes for Māori.

Celebrating Success 2019, embodied a celebration of rangatiratanga. Each year in November, we take time to formally recognise the dedication, innovation and passion of our staff, our providers and our volunteers through an awards event and a week of celebration activities.

In February, **kotahitanga** came to life in the formation of 'Out and About CCDHB', an employee-led network for LGBTQI+ and allies. The group marched in the Pride Hikoi to open Pride Week this year and the network has since had several meetings. We aim to be a welcoming, fair and just workplace that values diversity and inclusion, and we want our people to be able to bring their whole selves to work.

Workforce

Most staff employed in the 2DHBs are covered by Collective Employment Agreements. This means that their terms and conditions of employment are primarily set out in Multi-Employer Collective Agreements (MECA).

This year saw the Clinical Physiology, Medical Imaging Technologists, Psychologists, Sonographers and Senior Medical Officers Multi-Employer Collective Agreements (MECA) settled. A number of the remaining collective agreements are due to be renegotiated over coming months, including nursing, junior doctors, allied and technical workforces and single employer collective agreements for our ICT staff and the pharmacy, building services and store persons at Hutt Valley DHB.

Work continues nationwide for pay equity for our administration, clerical and nursing workforces.

The first steps toward an IEA remuneration strategy have been completed. The strategy is designed to ensure alignment across the 2DHBs with MECAs, relativity between staff and roles, recruitment and retention and affordability. The strategy's initial focus has centred on several key roles/job families. In ICT this work is supported by the SFIA (Skills Framework for the Information Age) competency system. In 2020, the strategy has also factored in the Government request for pay restraint, given the economic impact of COVID-19.

A union-DHB partnership approach to workforce concerns is supported by monthly Bi-partite Action Group meetings with the unions and the quarterly Joint Consultative Committee meeting with the Association of Salaried Medical Specialists (ASMS).

2DHB People, Culture and Capability

In November and December 2019 the HVDHB Human Resources and CCDHB People & Capability leadership teams came together to explore opportunities where the teams could collaborate and work more closely together.

While formal structural changes are currently being progressed, the arrival of COVID-19 led to a significant alignment and connection across the 2DHBs. Teams from each DHB collaborated closely to provide services to our people during COVID-19.

Welfare and wellbeing

COVID-19 has meant our people and their loved ones have experienced anxiety, navigated uncertainty and had their lives disrupted. Given the magnitude and far-reaching impacts of the pandemic, a holistic response to the welfare and wellbeing of our people was critical.

To ensure consistency, a dedicated staff welfare and wellbeing stream of work was established across our 3DHBs (CCDHB, HVDHB and Wairarapa DHB). Integral was the creation of a staff wellbeing framework which applied the principles of readiness, response and recovery to ensure our plan was phased, agile and

adaptable given the changing situation. At the core of the framework, Te Whare Tapa Whā, the Māori Health model made sure wellbeing initiatives were delivered in a holistic way.

Some of the ways we focussed on wellbeing were to:

- **Make sure our people sustained their wellbeing** through a suite of resources e.g. self-care, where to go for support, staying calm, mindfulness, resilience strategies, personal safety.
- **Support our leaders to lead through wellbeing** with a series of webinars and resources that provided tools on connecting and leading their teams, completing wellbeing check-in's, looking after their own wellbeing, flexible working tips, effective communication and psychological first aid training.
- **Strengthen and connect our teams, whānau and community** by harnessing the positivity that shone through for example supporting our values, highlighting the different ways we're working together, and celebrating successes.
- **Provide focused intervention and wellbeing support** with the introduction of the Kotahi team (defusing/debriefing team). Accessed by over 30 teams, skilled volunteers worked with managers and teams to identify useful wellbeing strategies.

COVID-19 has also been a catalyst for the DHB to continuously evolve how we work in the new normal. Several wellbeing initiatives born out of necessity during the pandemic are now being progressed into business as usual. Flexible working guidelines which align with the State Services Commission's 'flexible by default' approach are in development. A formal framework is also being shaped to improve how we provide ongoing wellbeing support at all levels to our leaders and teams.

Although COVID-19 has meant unprecedented times, we have come together as one and risen to the challenge. Our people have shown dedication, kindness and the ability to adapt to ensure colleagues, patients, whānau and our community remain safe.

OUR PEOPLE SHARE THEIR EXPERIENCES

CONNECTIONS AND COLLABORATION

"The flexibility, camaraderie and teamwork shown has been tremendous."
(Jon, physiotherapist, CCDHB)

"I've really enjoyed the passion and support my colleagues have brought to the table through this challenging time."
(Business partner, 3DB ICT)

"It's been a fantastic opportunity to make connections with colleagues and work with different people."
(Project coordinator, CCDHB)

TAUTOKO/SUPPORT

"Support from senior staff has been incredible."
(Sarah, Oral health therapist, Regional Bee Healthy Service)

"Working with a wonderful cohesive leadership team who have supported each other."
(Charge nurse manager, HVDHB)

"A kind, caring and supportive culture where there is appreciation of everyone's presence and contribution."
(Allied health clinician, CCDHB)

INNOVATION

"[There's been] development and implementation of new solutions at pace"
(Business partner, 3DHB ICT)

"Some of the new systems and processes implemented have been great and have led to staff working together effectively."
(Security orderly, CCDHB)

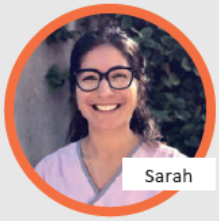
STEPPING UP

"This situation has allowed people to shine."
(Clinical nurse manager, HVDHB)

"I've been witnessing inspirational leadership."
(Tutangi, associate allied health director - Pasifika, CCDHB)

"This has been an opportunity to stretch and grow."
(Wendy, educator, MHAIDS)


Jon


Sarah


Tutangi


Wendy

Impact of COVID-19-19 on our workforce

The rapidly changing situation meant that regular, clear communications for all staff was essential and a primary focus has been on collating, translating and condensing the huge amounts of information to create regularly updated FAQs (Frequently Asked Questions), advice for people leaders and daily communications to all staff.

As part of developing our leaders to lead with confidence during COVID-19 a series of three webinars: "Leading for Wellbeing" provided information on Occupational Health and Safety through the levels, Sustaining Wellbeing, and Positive Communication to Build Great Teams.

A 2DHB COVID-19 Workforce Office was established during the early stages of the active COVID-19 response to coordinate requests for, and responses to, the need for additional workforce across the health sector i.e. use of casual or agency staff. Support was also provided to Wairarapa DHB.

The office enabled redeployment of staff for the COVID-19 response for example dental technicians working as swabbing staff in Community Based Assessment Centres. In total over 1000 hours of staff deployment time was managed through the Workforce Office, with over 70% of this being supplied by Allied, Health, Science & Technical into non-traditional roles for the staff groups involved.

A 20DHBs Emergency Response Function was established to support the coordinated workforce response for COVID-19. The structure and operating model were identified and stood up during the response. This function remains on standby, to enable rapid response for future pandemic events.

Specific joint CCDHB / HVDHB / Union meetings were introduced to ensure that the unions were fully briefed on COVID-19 and these proved to be very effective.

Continuous learning and improvement

COVID-19-19 has put significant demand on our workforce to learn and refresh their capabilities in order to meet the changing work environment. To ensure the safety of our staff, mixed media approaches were utilised to continue core learning and also quickly create COVID-19 specific learning.

- Redesign of protocols and processes to suit COVID-19 for example adapted resuscitation protocols were introduced (with a 7 day/week presence of clinical educator support at HVDHB); the design of COVID-19 specific PPE training and enhanced personal safety learning, and adapted orientation processes for new staff
- Our reporting on completion rates especially on PPE training were a core metric for maintaining a safe operational workforce
- Guidelines were provided to support educators with holding training and meetings, ensuring physical distancing and hygiene protocols were maintained
- Support was provided for employees to utilise and fully embrace Zoom as a way of communicating. Māori health and nursing leadership, have both since adopted this technology as a permanent solution for workshops and networking
- At CCDHB, innovative virtual simulation technology was used to support the delivery of training where physical distancing was required
- It was important to continue to develop our leaders - our leadership programmes were converted to small group sessions using Zoom. Meaning learning was captured in real time and new leaders were supported through the rapidly changing times.

Employee health and COVID-19 risk management

To reduce the risk of COVID-19 transmission in our workforce, while also maximising staff availability, the 2DHB Occupational Health services collaborated with a range of partners to establish a 3DHB COVID-19 Employee Response function which included:

- A Response Centre staffed by senior clinicians was established to take health enquires from employees and provide advice on testing, isolation and related matters for employees
- Dedicated COVID-19 swabbing facilities were set up for 2DHB employees, to reduce pressure on public testing facilities and minimise delays in returning employees to work
- Adoption of the 20DHB Vulnerable Worker process enabled assessment of workers against a nationally agreed framework. Workers with pre-existing health conditions were assigned a Vulnerable Worker category which determined the type and area of work appropriate to their health status
- An information management system was built to allow the identification, assessment and reporting of employee COVID-19 enquiries
- An early and aggressive iInfluenza campaign targeting employees reduced the risk of influenza during the COVID-19 crisis
- N95 Disposable Mask Fit Testing programmes have been implemented as an ongoing initiative for all frontline employees, COVID-19 stream employees and those working with airborne precautions. This was coupled with Fit Checking education to ensure consistency.

Celebrating midwives and nurses in 2020

Carolyn Coles, Director of Midwifery and Emma Hickson, Chief Nursing Officer

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

2020 is the International Year of the Nurse and Midwife. This provides an opportunity to celebrate and acknowledge all nurses and midwives, who make an enormous contribution to the health and wellbeing of the people of Aotearoa.

The year's planning included grand rounds, visiting speakers, information sessions, and opportunities to advance and develop staff nursing and midwifery practice.

The year gave us the opportunity to celebrate our wonderful nurses and midwives through our intranet and social media. There have been stories from leaders, pioneers and trailblazers, and the chance to get to know some of those right at the start of their careers, to give a flavour of the huge breadth and depth of the work carried out by these professions.

There is a national and international shortage of these crucial professionals so there was also a reflection on the reasons why, and shared information about how we're working to overcome these shortages and attract people into these professions.

There was a particular focus on ensuring greater representation of Māori and Pasifika. There was discussion about what great career choices there are, with their many opportunities for development.

New Zealand Nursing Organisation (NZNO) staff awards

NZ Award of Honour

Sipaia Kupa, senior systems development manager for Pacific Peoples, was awarded the most prestigious award from NZNO in September.

“I understood the award was special but I didn’t realise the magnitude of how significant it was. The show of support I have received from everyone has been truly humbling.”

Of Tokelau, Cook Island and Tuvalu descent, she has been in the health sector for 30 years. Much of her career was spent in clinical practice as a registered nurse, before she took up a role as a senior systems development manager with the CCDHB Pacific Directorate. She credits the teachings from her parents and family for her achievements, especially the value of showing compassion for the vulnerable and those in need. Sipaia was recognised for her enthusiasm and passion for improving health outcomes for her community, and her supportive work for the growth of Pacific nursing. She has been involved in many community-based organisations at a leadership level. She sees potential for a strengthened Māori and Pacific nursing workforce to play a key role in reducing inequities and achieving better health outcomes. Her advice for Pacific Peoples starting out in their healthcare careers is to “know thyself, be proud of who you are, your heritage and cultural identity, and that will hold you in good stead for the future”.

Services to NZNO

Theatre nurse Jenny Kendall was awarded a top honour for Services to NZNO. She has been carrying out NZNO work for much of her career, supporting her colleagues’ professional development and union needs.

“I feel very honoured to have won,” she says. “But you don’t get these awards on your own – it’s a team effort.”

A CCDHB employee for 44 years, she says the best part of her nursing work is “the variety, and the camaraderie. There are now more opportunities for education, professional groupings, and opportunities for learning at conferences.”

In recent years, she has observed nurses who are “more empowered to speak up – more vocal and more readily asking for support, rather than trying to deal with things on their own.”

Jenny’s vision is for pay equity and greater recognition for the work nurses do, and for staff to take care of themselves to avoid burnout. “We are trying to encourage people to insist on taking breaks. If you can’t look after yourself, you can’t look after others.”

Outside her professional life, Jenny volunteers her nursing services in the Pacific Islands every year. “I’ve been brought up volunteering,” she explains. “My generation was brought up giving back to the community.”

Workforce Profile

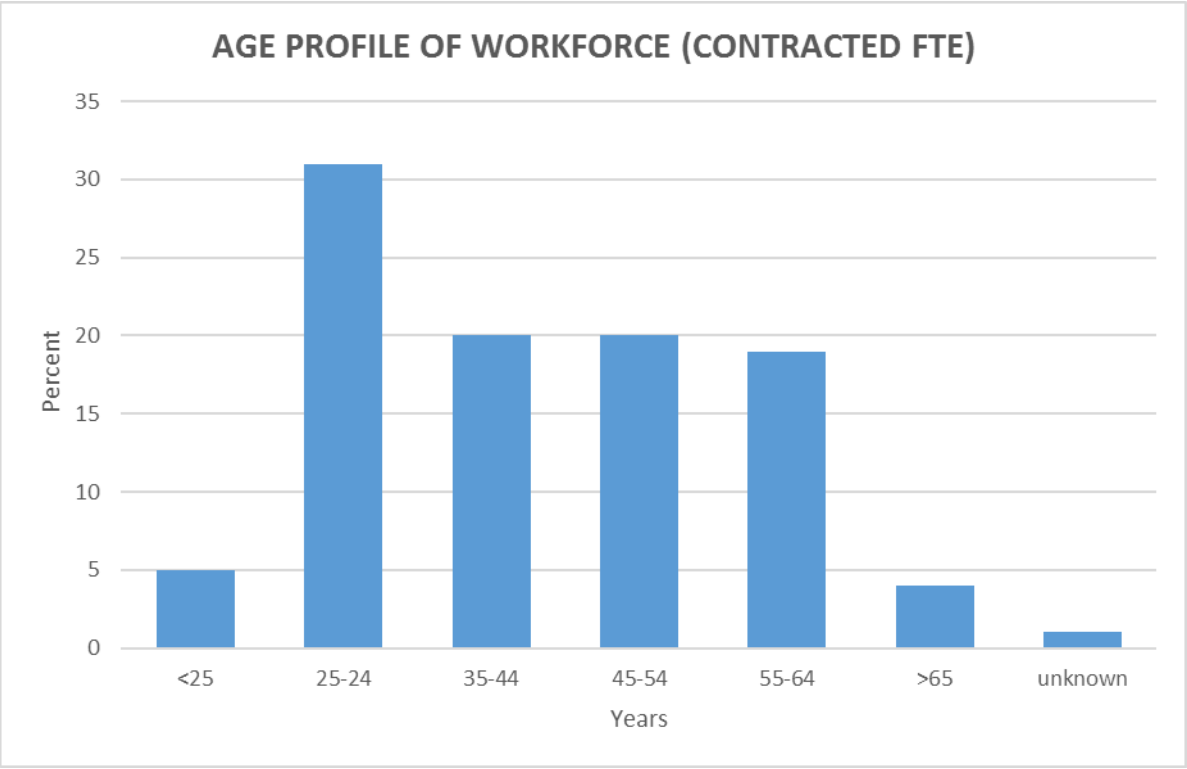
Full Time Equivalent (FTE) staff numbers

Profession	2020	2019	2018	2017	2016	2015	2014	2013
Medical	977	911	900	848	832	800	781	702
Nursing	2327	2254	2131	2043	2004	1940	1892	1907
Allied Health	753	727	724	713	707	766	774	760
Other	1052	1020	1000	950	963	997	978	1011
Total	5108	4912	4755	4554	4506	4502	4426	4379

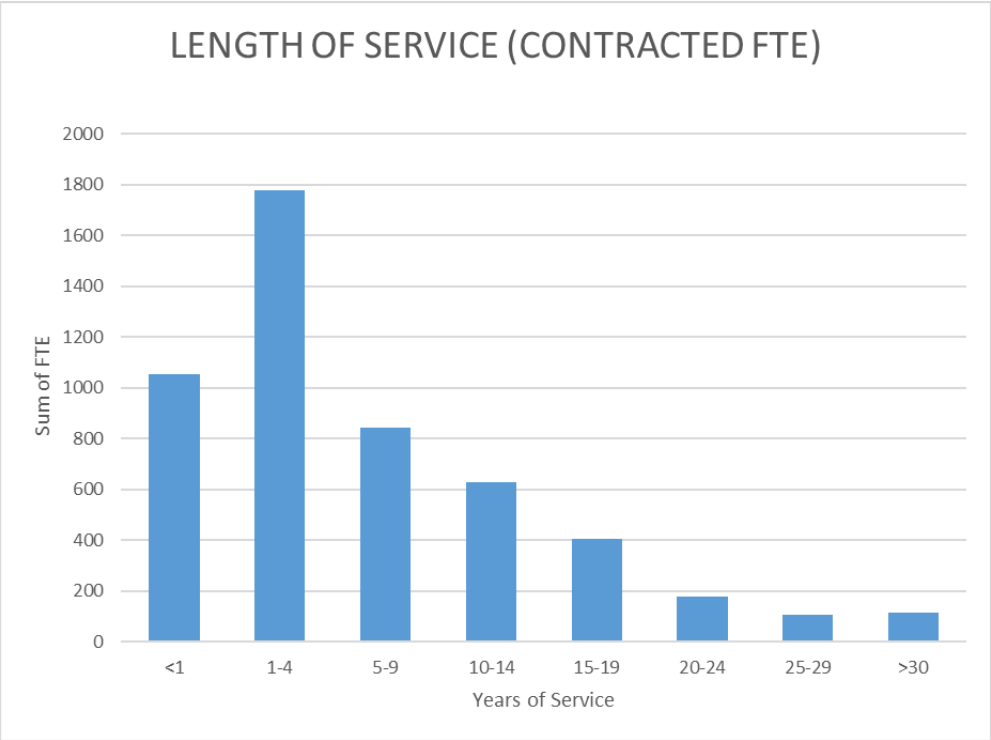
Statistics by gender (%)

Gender	2020	2019	2018	2017	2016	2015	2014	2013
Female	72%	72%	72%	72%	73%	72%	72%	72%
Male	28%	28%	28%	28%	27%	28%	28%	28%

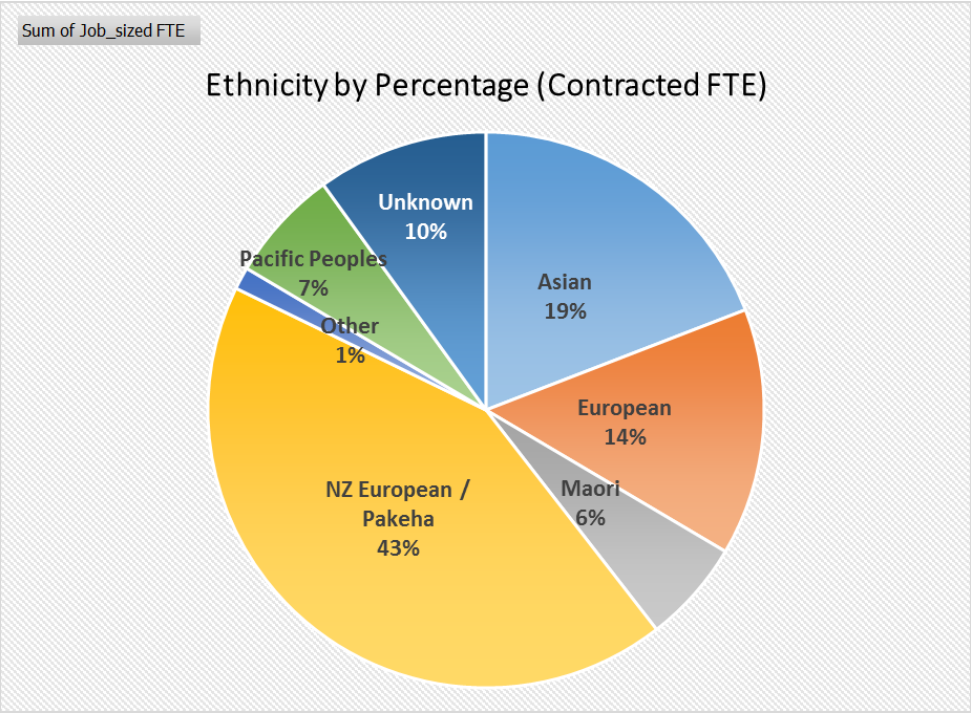
Age profile of Workforce



Length of Service (FTE)



Statistics by Ethnicity



Notes:

These numbers are based on contracted FTE at the end of the financial year not capped at 1FTE.

The numbers include those on LWOP/Parental leave, however, excludes personnel not paid through the CCDHB payroll system.

Celebrating Our Success Awards 2019

In November 2019, we held our Celebrating our Success Awards in Wellington. These awards aim to recognise and celebrate the work staff do to improve the health of our community.

The event was such a fantastic display of the dedication, innovation and passion of our staff, our providers and our volunteers.

Right: Two of the award winners with their certificates

Activities

Our progress

This section outlines what we've done under the three key strategic directions in the Health System Plan 2030.

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	○

PROMOTE HEALTH AND WELLBEING

Progress Measure	Baseline	Target 2019/20	Actual 2019/20	Trends – including equity gap	
Amenable mortality rates (rate per 100,000)	2016: Maori: 161.6 Pacific: 168.8 Other:58.2	Māori: 161.6 Pacific: 168.8	No new Mortality Data	No new Mortality Data	
Babies breastfed at 3 months	2018/19: Maori: 48% Pacific: 43% Total: 64%	≥60%	Maori: 43% Pacific: 50% Total: 62%	Māori	●
				Pacific	●
				Total	●
Children fully immunized at 2 years	2018/19: Maori: 89% Pacific: 92% Total: 92%	≥95%	Maori: 90% Pacific: 93% Total:94%	Māori	●
				Pacific	●
				Total	●
Children with no cavities at five years of age	2018: Maori 53% Pacific 76% Total 90%	69%	2019: Maori 53% Pacific 43% Total: 71%	Māori	●
				Pacific	●
				Total	●
Average number Diseased Missing and Filled Teeth (DMFT) at age 5	2018 Māori: 2.05 Pacific: 2.75 Total: 1.13	Reducing trend	2019 Māori:1.94 Pacific: 2.66 Total: 1.16	Māori	●
				Pacific	●
				Total	●
Reduced burden of tooth decay at year 8 (DMFT	2018 Māori: 0.8 Pacific: 0.92 Total: 0.52	Reducing trend	2019 Maori 0.27 Pacific 0.26 Total 0.33	Māori	●
				Pacific	●
				Total	●
Women screened for	2018/19:	>80%	Maori 65%	Māori	●

Progress Measure	Baseline	Target 2019/20	Actual 2019/20	Trends – including equity gap	
cervical cancer	Maori 63% Pacific 66% Total 76%		Pacific 64% Total : 72%	Pacific	🔴
				Other	🟠
Women screened for breast cancer	2018/19: Maori: 67% Pacific: 68% Total : 72%	>70%	Maori 67% Pacific 70% Total 72%	Māori	🟠
				Pacific	🟢
				Total	🟢
PHO enrolled patients who smoke and are offered help to quit	2018/19: Māori: 84% Pacific: 83% Total: 87%	≥90%	Māori: 83% Pacific: 85% Total: 84%	Māori	🟠
				Pacific	🟠
				Total	🟠
Hospital patients who smoke and are offered help to quit	Māori: 88% Pacific: 87% Total: 87%	≥95%	Maori 84% Pacific 90% Total 84%	Māori	🔴
				Pacific	🟠
				Total	🔴
% of babies living in Smokefree homes at 6 week check	Dec 18 Māori: 28% Pacific: 27% Total: 70%	Improved performance	Dec-19 Maori: 41% Pacific: 51% Total: 67%	Māori	🟢
				Pacific	🟢
				Total	🟠
% of eligible population having CVD risk assessment in last 5 years	Māori: 78% Pacific: 80% Total: 78%	≥90%	Māori: 78% Pacific: 78% Total: 87%	Māori	🔴
				Pacific	🔴
				Total	🟠

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. Health promotional activities and initiatives are also undertaken by contracted providers such as primary care and Māori and Pacific providers, collaborative partners and Regional Public Health. These activities raise awareness and promote healthy choices across a range of topics.

Progress Measure	Baseline	Target 2019/20	Actual 2019/20	Trend – including equity gap	
ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000)	Maori: 7880 Pacific: 11040 Total: 6611	5700	Maori: 5833 Pacific: 9577 Total: 4991	Māori	🟠
				Pacific	🔴
				Total	🟢
ASH Rates (avoidable hospitalisations) for 45-64 years	Maori: 5831 Pacific: 7853 Total: 3218	2537	Maori: 6308 Pacific: 7409 Total: 3100	Māori	🔴
				Pacific	🔴
				Total	🔴
Well managed diabetes in primary care	Māori: 54% Pacific: 49% Total: 62%	≥70%	Maori 50% Pacific 44% Total 55%	Māori	🔴
				Pacific	🔴
				Total	🔴
Acute hospital bed days per	Maori: 325	Decrease	Maori: 316	Māori	🟢

1,000	Pacific: 461 Total: 329	rate	Pacific: 419 Total: 300	Pacific Total	 
Acute readmission to hospital	Māori: 13.6% Pacific: 12.3% Total: 12.7%	Not applicable	Year to March 2020 Māori: 13.8% Pacific: 12.1% Total: 12.9%	Māori Pacific Total	  
Acute readmission to hospital Age 0-4	Māori: 14.9% Pacific: 15.8% Total: 13%	Not applicable	Year to March 2020 Māori: 12.7% Pacific: 15.3% Total: 13.7%	Māori Pacific Total	  
PHO Enrolment	Māori: 80% Pacific: 96% Total: 93%	Increased enrolment	Māori: 89% Pacific: 100% Total: 92%	Māori Pacific Total	  
Newborn PHO enrolment	June 19 94%	Increased enrolment	90.6%		
Proportion of dispensed Asthma medications that were preventer rather than reliever	2018/19 45%	Increasing trend	2019/20 54%		
Cancer Mortality	2015 370	Decreasing trend	2016 355		
Decrease in hospitalisation for cardiovascular disease	Maori: 369 Pacific: 334 Total: 3614	Decreasing trend	Māori: 352 Pacific: 310 Total: 3592	Māori Pacific Total	  
Decrease in hospitalisations for Chronic Obstructive Respiratory Disease	Maori: 118 Pacific: 79 Total: 602	Decreasing trend	Māori : 121 Pacific: 69 Total: 578	Maori Pacific Total	  

Health Care Homes

We have enhanced primary care by progressing the Health Care Home (HCH) patient-centered model of care across our district. 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, the evaluation of the model is promising and suggests that a significant proportion of acute need is being prevented or successfully dealt with out of hospital by HCH practices.1

During COVID-19, greater use of telehealth services were adopted by general practices. The HCH model includes a new triage service, where patients calling the practices first thing in the morning may talk directly to a general practitioner or nurse. Talking to a health professional means some issues may be resolved over the phone, saving people the time and hassle 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. Implementation planning is progressing with a further two practices expected to adopt the HCH model.

[1] *Health Care Home evaluation - updated analysis, April-September 2017*. Auckland: Ernst & Young, 2018.

Health Pathways

We have improved consistency of best practice care, and seamless referral between services, by making it easier for primary care clinicians to access best practice online advice, based on local clinical and service pathways. Health Pathways are localised to each DHB and provide an electronic best practice clinical pathway for primary care. Pathways for more than 502 conditions are now live. Recent pathways have been developed for COVID-19, termination of pregnancy, wound care, varicose veins and chronic venous insufficiency, snoring and sleep apnoea in children, restless legs syndrome and periodic limb movements of sleep, pre-exposure prophylaxis (PrEP), palliative care in adults, lymph node enlargement, and analgesia in adults/children with acute pain. Multiple pathways are also under development.

TIMELY EFFECTIVE CARE THAT IMPROVES HEALTH OUTCOMES

Progress Measure	Baseline	Target 2019/20	Actual 2019/20	Trend – including equity gap	
Length of inpatient stay in hospital (average days)	Acute: 2.28 Elective: 1.53	Acute: 2.3 Elective: 1.52	Acute: 2.27 Elective: 1.54	Acute	
				Elective	
Time patient is in ED (discharged or transferred with 6 hours)	80%	95%	78%		
Waiting time to access mental health / addiction services (Referred to service and seen within 3 weeks and within 8 weeks)	66%< 3 weeks 92% < 8 weeks	80% < 3 weeks 95% < 8 weeks	60% < 3 weeks 83% < 8 weeks	3 weeks	
				8 Weeks	
Readmission to Mental health services within 28 days	11.5%	<9%	10.5%		
Access to electives	100%	100%	95.4%		
Patient experience in hospital (Average patient score out of 10 across four domains)	Communication: 8.5 Coordination: 8.3 Partnership: 8.6 Physical and emotional needs: 8.6	Communication: 8.5 Coordination: 8.5 Partnership: 8.7 Physical and emotional needs: 8.8	Communication: 8.4 Coordination: 8.6 Partnership: 8.4 Physical and emotional needs: 8.8	Communication	
				Coordination	
				Partnership	
				Physical and emotional needs	
Percentage of patients receiving their first cancer treatment (or	91%	≥85%	89%		

other management) within 31 days from date of decision-to-treat.				
Age of entry into Age Residential Care	83.6	Increasing trend	83.8	

Three-Year Plan for Planned Care Services

We have completed a Three-Year Plan for Planned Care Services 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 Hutt Valley DHB 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
- improving the experience of service users and their whānau
- creating incentives to implement innovative models of care
- an increase in the volume and range of interventions to meet changing population health needs
- encouraging provision of non–surgical care alternatives in community settings
- increasing the focus on prevention and early intervention programmes to improve wellbeing and reduce the need for more complex and expensive interventions.

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.2 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.

[2] The Safe Staffing and Healthy Workplaces Unit sits within District Health Boards New Zealand and is part of a collaborative agreement between the New Zealand Nurses' Organisation and the DHBs.

We have also recently completed full detailed reviews of some of the existing pathways and updated them as needed. The pathways reviewed include: Cervical Screening, Eczema in Children, Lymphocytosis, Gout, Abdominal Aortic Aneurysm, Intermittent Claudication, and Cannabis-based Products.

Co-response pilot extended to Hutt Valley

This year the Wellington District Police/Health Co-Response pilot was extended to the Hutt Valley. The pilot provides emergency front-line support for people who ring 111 requiring an urgent mental health response. The Co-Response team deploys staff from Wellington District Police, Wellington Free Ambulance (WFA) and DHB Mental Health services to attend events requiring an urgent mental health intervention.

Prior to its extension into the Hutt Valley, the pilot had been operating successfully in the Wellington Region for six months and attended over 90 mental health events in the community. It also assisted in the coordination of around 300 other events, resulting in timely and improved outcomes for those in crisis. The team's interventions include face-to-face care, collaboration with other units and services, and providing advice over the phone. The service enables people presenting in mental health crisis to receive the most appropriate response in the right setting for their needs, and is therefore expected to reduce the number of crisis presentations to the Emergency Department.

"The pilot's success in Wellington provided us with a great opportunity to extend the initiative to the Hutt Valley, where we expect to see a very positive impact," says Nigel Fairley, general manager Mental Health Addictions and Intellectual Disability Service.

"The Co-Response Team delivers timely, coordinated and specialist care at home or in a community setting, with an experienced mental health clinician as part of the team".

This service provides another layer of crisis support for people in the Wellington and Hutt Valley regions, and complements our 24/7 mental health and addictions crisis contact centre, Te Haika, contactable on 0800 745 477."

Data and digital

We have developed a digital strategy for the sub-region, including specific plans for CCDHB. The strategy sets out the direction of travel of future ICT work across the 3DHBs, ensuring the work aligns with the digital needs of our hospitals and primary care and community providers. The strategy also balances the digital needs of clinical services and corporate services, which are both critical for meeting our strategic objectives. To help implement the digital strategy, our 3DHB ICT service has made organisational changes and aligned roles, reporting lines, and workforce development programmes with the digital strategy.

An Architectural Governance Board has been established to ensure investments in digital and data technologies are sustainable and aligned with our strategic goals. The Architecture Board provides guidance to programmes and projects to ensure that technology decisions are aligned with the overall technology direction. A Digital and Data Intelligence Governance Group (DDIGG) has also been established to prioritise and approve digital and data projects and oversee implementation of the digital strategy.

A comprehensive assessment of the ICT digital maturity across our DHBs and PHOs has been undertaken. This assessment allows us to compare our maturity with other DHBs within New Zealand and other health care organisations worldwide. The maturity assessment also allows us to determine where we are lacking in capability so these gaps can be addressed.

Over the last year, our 3DHB ICT service has completed a number of projects that directly affect Capital& Coast DHB staff. These projects include the following:

- Windows 7 to Windows 10 upgrade
- Intune mobile device management
- Exchange Online
- Care Capacity Demand Management screens
- NetScaler project to improve the performance and security of our Citrix environment.
- Supported the deployment of new clinical equipment that require connectivity to clinical systems and supporting ICT infrastructure

Our 3DHB ICT service has also initiated the following projects:

- Digital Workplace Programme
- Single 3DHB Clinical Portal
- Replacing legacy telephony systems with a modern unified communications system and contact centre platform
- Rollout of a new WAN for the 3DHBs in order to increase performance and resilience
- Ongoing cybersecurity improvements to ensure patient and DHB data is secure inclusive of leadership training.
- Initiation of a TeleHealth programme of work to support delivery of outpatient care to patients at home in response to COVID-19.
- Selected Nervecentre Software as the platform for patient observations, assessments and task management
- Initiated the upgrade of the WebPAS database from the legacy Informix system
- Replacing legacy telephony systems with a modern unified communications system

COVID-19 has had a significant impact on ICT's work programme. COVID-19 necessitated a rapid shift to work from home and the introduction of new tools to allow the DHB to cater for a predicted surge in patients and also to allow staff to continue corporate and clinical functions from home.

As a result of COVID-19, staff have continued working in a more flexible manner, based either at home or the office. Further work is continuing so that we can optimise productivity with fit for purpose devices and tools.

The show goes on! School immunisation team on track amongst COVID-19 school closures

Every year the Child Health, School-Based Immunisation team at Regional Public Health (RPH) sets about the considerable task of immunising 7,500 children in years 7 and 8 (ages 10 to 12) in 113 schools across Wellington, Hutt Valley, Porirua and Kapiti. The team deliver the Boostrix and HPV vaccines to these students.

For Maureen Stringer, Child Health Immunisations team leader, 2020 has seen her team lose eight available weeks to administer immunisations due to COVID-19.

"As soon as there were confirmed cases of COVID-19 in New Zealand, we had a number of schools contacting us saying, 'put the immunisations for our school on hold, we don't want any external visitors at the moment.' We could understand why they wanted to take every precaution to keep their tamariki safe", Maureen said.

By late March, under alert level 4 lockdown, all schools closed and the school immunisation programme went on hold. The immunisation team were redeployed within RPH as part of the pandemic response, which included completing daily monitoring of COVID-19 cases and assisting the wider team with contact tracing.

On the other side of the COVID-19 response, the team faced condensing the school immunisation programme into a much shorter timeframe. It was vital that all HPV round one immunisations were completed by the middle of the year, to allow for a minimum of 22 weeks before round two can be administered.

Maureen's "D-Day whiteboard" – the whiteboard used when planning school immunisation visits – suffered through markers and erasers going into overdrive as a number of quick revisions to schedules were made. With great working relationships already established with schools and flexibility shown from both sides, new schedules were completed. "Our team of 5.2 FTE staff wasn't going to get through the workload. Luckily we're a collaborative bunch here at RPH so we called on support from the wider team of public health nurses to help us out," said Maureen.

From there, round one of the HPV vaccine was delivered to all schools. "The team are now working hard to try to deliver HPV round two, on time, by the end of the year," said Maureen.

"The team have continued to go above and beyond, during really challenging times, to ensure that kids get immunised. I have a wonderful team and I am immensely proud how they have risen to the challenges that have been thrown our way this year," she said.

Quality Improvement and Patient Safety

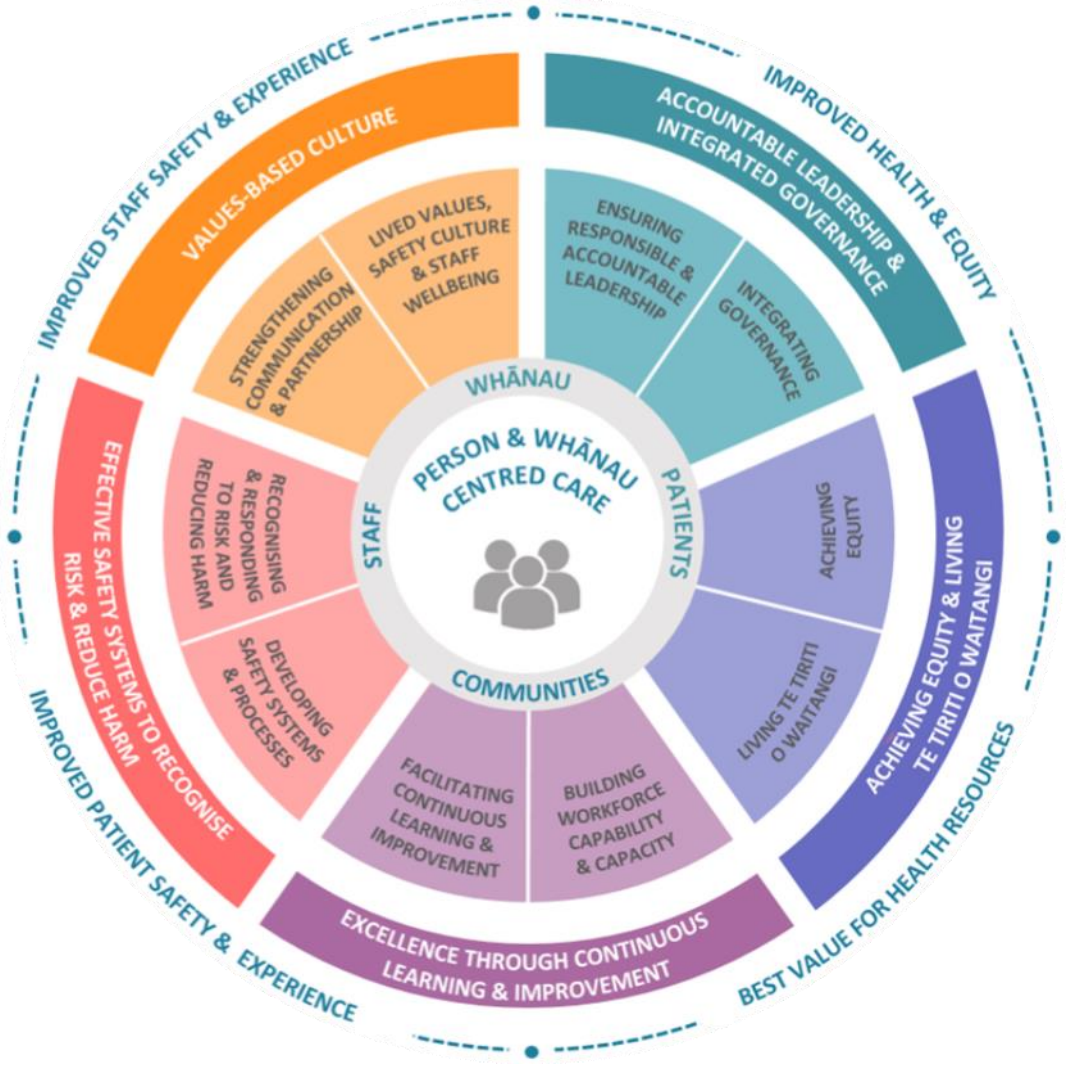
The Quality Improvement and Patient Safety Directorate leads and supports the quality improvement and patient safety work across the DHB using quantitative and qualitative measures to support evidence-based decision making and practice change, as well as streamlining systems and data reporting mechanisms.

Over the last 12 months, the clinical governance approach has matured, and 18 sub-committees that focus on areas of high harm meet regularly. Building clinical governance has further strengthened focus on the quality and safety of services, with a renewed emphasis on engaging with consumers/ whānau to reduce inequities for priority groups including Māori, Pacific people and those with a disability.

2DHB Quality and Safety Framework

In February 2020 the 2DHB Quality and Safety Framework was introduced across 2DHBs, influenced by the quadruple aim in recognition of the link between patient / whānau safety and staff safety. The framework established a clear direction for the DHBs to deliver safe services that reduce harm to staff and patients, improve the quality of care and drive clinical excellence. The framework introduced six quality and safety domains, goals and measures supported by a focus on learning and improvement, to ensure quality and safety is a top priority and is effectively embedded from ward to Board. The six domains:

- Person and whānau-centred care
- Accountable leadership and integrated governance
- Living Te Tiriti o Waitangi
- Excellence through continuous learning and improvement
- Effective safety systems to recognise risk and reduce harm
- Values-based culture



The expectation is that quality and safety initiatives, projects and programmes will align to the domains of the framework. For each domain there is a corresponding patient and staff safety measure, and progress against the measures is reported to the 2DHB Board.

Safety Walk Rounds

In 2019, it was recognised that CCDHB did not have a regular forum in which senior leaders met with front-line healthcare staff to talk about their patient safety issues.

The Safety Walk Rounds model was developed based on international models (Institute of Health & Innovation, and Health Service Executive) with the aim to better understand the frequency and nature of safety issues faced by patients. The concept is simple, creates a mechanism to promote change, build trust and establish meaningful relationships between frontline staff and executive leaders.

In May 2020, the first Safety Walk Round was conducted on a surgical ward, which involved leaders visiting the ward to talk to a team of frontline staff about any patient safety issues that had caused or may potentially have caused, harm. Concerns raised during these conversations were addressed by implementing preventative measures and establishing an action plan with clear ownership of corrective actions. Whilst some issues were easy to fix (for example granting clinician's access to the Risk Register, ordering essential equipment), others have been escalated to ELT, for example a number of surgical High Dependency Unit beds. Subsequent Safety Walk Rounds have been held on a number of different inpatient wards and units, and the model used continues to develop in alignment with the 2DHB quality and safety framework.

Patient and System Tracer Audits

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. Tracer audits compare observed and documented practice with evidence-based standards. They are the audit methodology of choice for the Ministry of Health (MoH), who monitor and measure all New Zealand healthcare facilities against the Health & Disability Sector Standards. There are two types of tracer audits: patient and system.

In October 2019, the associate director of nursing (QIPS) led CCDHB's first tracer audit in the delivery suite at Wellington Regional Hospital. The auditing team followed the experience of a sample of women, as they interacted with the health care system. The auditors spoke with staff and women who had received care, conducted an environmental check, and reviewed clinical documentation. Feedback was provided to the delivery suite's manager in real-time, so that identified safety issues and risks were acted upon quickly.

The tracer audit methodology continues to be developed, with audits conducted on 22 inpatient wards/units at Wellington and Kenepuru hospitals. The audit tools have been refined and patient-specific tracer audit tools have been developed for falls prevention, pressure injury management and medication management to capture systems and controls for patient safety outcomes. Further development is underway to support the same approach in outpatient areas and mental health services and four pilot areas have been identified and due to commence in November 2020. A tracer audit schedule has been implemented across the inpatient areas, with development of training, tools and policy to guide and support practice.

Improvement

Previous hospital certification identified the need to improve cold chain processes at CCDHB to meet the MoH National Standards for Vaccine Storage. This was identified as a significant patient safety, financial and organisational risk. There was no process to measure across the organisation how often medicines were stored at incorrect temperatures, which reduce the effectiveness of the medicines and vaccines and also has a financial impact due to those medicines and vaccines needing to be discarded.

CCDHB now has a fully implemented monitoring system with clear visibility across the organisation and clear Key Results:

- Reduced instances of when a fridge is the incorrect temperature which has improved patient safety and reduced costs (baseline spend on medicine wastage was $3,900/month; post implementation $149/month)
- Saved nursing and pharmacist time through automating a manual process
- Increased cold chain accreditation of vaccine fridges from 1 (2%) to 41 out of 44 (93%) ie meeting the MoH National Standards for Vaccines.

2DHB Risk Process

Risk management is an integral part of everything we do. Hutt Valley and Capital & Coast DHBs have developed a Risk Management Approach, which will be supported by the Risk Management policy, Risk Management procedure, and Risk Management training manual and is underpinned by the International Standard 31000:2018 Risk Management – Guidelines and Best Practice. Risk Management enables the delivery of well-informed, innovative care and provide best possible outcomes for patients.

The aim of the approach is to further embed risk management at a group/division, service and ward level, and ensure appropriate escalation of risks through the organisation to the Board. In addition, promote local

level ownership of risk, enhance clarity regarding roles and responsibilities and strengthen governance to support delivery.

The key objectives of the Risk Management approach are to:

- Embed risk management at all levels of the organisation
- Create a culture where risk management is transparent, inclusive, integrated and is responsive to change
- Provide the tools and training to support risk management
- Embed the DHB's risk appetite in decision making
- Measure the impact of implementation and the effectiveness of the system to ensure continuous improvement
- Meet best practice standards for risk management.

Serious Adverse Events

At CCDHB improving the quality and safety of care we provide to our patients and whānau is a key priority. Early detection and review of adverse events that are the result of a health care system or process failure is therefore essential. By learning from these reviews we can reduce the risk of similar adverse events recurring and causing avoidable harm to our patients.

A formal review is conducted for each adverse event to better understand what happened and why, and to establish improvements in our systems of care to prevent harm occurring again. Families have input into the reviews and are provided copies of the final report.

There has been a focus on collecting ethnicity data for complaints and adverse events. Processes have been developed to improve the partnership with the Whānau Services and patient whānau when undertaking reviews. This is complimented by an increased focus on reporting and the implementation of the Speaking Up For Safety programme. The number of serious adverse events reported at CCDHB has increased, indicating an improvement of the patient safety culture.

The time taken to complete reviews greatly exceeded the mandated 70 working day target set by the Health, Quality & Safety Commission (HQSC, 2017). This led to a rapid improvement event, where 41 serious adverse events were allocated to a group of 20 technical experts, with the aim to complete as many of the 41 reviews as possible over a three day workshop. Six consumers and members of the Whānau Services provided invaluable expertise and ideas about how best to write the reports, ensuring they were patient-centred, culturally sensitive and respectful.

More breast screening access in Wellington

L-R: Kaumatua Alex Watson; CCDHB and HVDHB joint CE Fionnagh Dougan; mammographer Yvonne Clarke; health promotion officer Te Rangi Winitana; mammographer Dawn Ruttenberg; Hayley Shatford.

July 2019 saw the launch of breast screening services at Wellington Regional Hospital. Women living in central Wellington will now be able to access screening services here for the first time in several years.

“Having a centre located in the hospital is so much more convenient for many women,” says Breast Screen Central’s clinical director Dr Madeleine Wall. “Our mobile unit is great and really helps, but for the thousands living in the southern suburbs, this is much more accessible.”

Women aged 45-69 are eligible for free two-yearly breast screens, and it’s hoped that the new service will help reduce health inequities. “It removes barriers for women who want to get screened,” explains mammographer Yvonne Clarke. “We’re expecting to screen about 42 women every Monday at our clinics. We’ll be busy!”

Early detection gives women the best chance of successful treatment. It is vital that screening services are accessible to all, in particular to wahine Māori who are around 1.7 times more at risk of dying from breast cancer than non-Māori women.

“We know from the wahine Māori diagnosed with breast cancer in screening programmes and treated, that the disparity in survival rates can be completely eliminated,” says Madeleine. “Breast screening literally saves lives. I encourage women to prioritise their health and take 15 minutes to get screened.”

The team at Wellington Regional Hospital radiology and staff from Hutt Hospital’s breast screening team worked together to bring this service to Wellington. Joint Hutt Valley and Capital & Coast DHB chief executive Fionnagh Dougan attended the launch, and emphasised how vital it is that our screening services are accessible to all.

“I am determined to address the challenges of equity for Māori and Pasifika communities,” said Fionnagh. “Collaborations like this amplify our ability to make that happen.”

New children's hospital taking shape

A small gathering with the Minister of Health David Clark and our generous benefactor Mark Dunajtschik marked the latest milestone - the steel framing going up to support our new building.

Just two years after it was announced that property developer Mark Dunajtschik would be donating $50 million to build a new children's hospital in Wellington, the building's steel-framing started to take shape in 2019.

The DHB and the Minister of Health were joined onsite by Mark, as well as members of Wellington City Council and the Māori Partnership Board, to celebrate the milestone.

"This is a truly exciting phase for the project as the three-storey building – which is expected to open in mid-2021 – starts to take shape," says CCDHB's general manager corporate services Thomas Davis.

The main hospital structure will consist of more than 950 tonnes of structural steel, and 1.2km of floor beams sized and fabricated specifically for this building. The steel columns will sit on 45 'triple pendulum friction' proprietary-designed isolator bearings. The same bearings have been installed in the new Apple Corporate Headquarters in California – one of the top 10 largest base-isolated buildings in the world.

In just under two more years, Wellington will have a purpose-built facility for children of the lower North Island and upper South Island who are in need of specialist hospital services. The new building will bring inpatient services and outpatient clinics under one roof for the first time, allowing for greater integration of services.

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. Measuring our outputs helps us to understand how we are progressing towards our impacts and outcomes set out in the Improving Outcomes section of this report. Each output class includes measures which help to evaluate our performance over time, recognising the funding received, government priorities, national decision-making and board priorities. These measures include the health targets.

Our DHB is responsible for monitoring and evaluating service delivery, including audits, for the full range of funded services. Some of the measures reflect the performance of the broader health and disability services provided to CCDHB residents, not just those provided by the DHB.

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 HVDHB, 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 Hutt Valley health system and help us to monitor that we are on track to achieve positive long term outcomes. Some of the measures that we have chosen to reflect outputs of services we fund or deliver are also Performance Measures used by the Ministry to monitor DHB performance through the quarterly reporting system.

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 2018/19 or no data available in 2017/18	-	★

Class	Class Description
Q	Quality
V	Volume
T	Timeliness
C	Coverage

Interpreting our performance

Impact of COVID-19

In 2019/20, we delivered a coordinated emergency response to the COVID-19 pandemic in partnership with Hutt Valley DHB, Wairarapa DHB, and the Wellington Regional Emergency Management Office. We followed guidance issued by the Government and the Ministry of Health. As a result, our response to COVID-19 had a significant impact on the delivery of health care services across the region and consequently performance. The COVID-19 response impacted performance in the following ways:

- Cessation of non-essential services
- Impacts of other sectors (eg education) ceasing onsite activity impacted our ability to deliver services
- Flow on effects to other parts of the health system
- Social distancing requirements reduced productivity for services which require physical interaction
- Shifts in alert levels have a disruptive effect on production
- Areas where the DHB faces significant challenges and persistent ethnic disparities were compounded
- Shifts in deployment of staff to priority areas or stand-down periods as a precautionary approach to managing COVID like symptoms
- Precautionary approaches to engaging with potentially COVID-19 positive patients.

Work is underway to ensure that residents of CCDHB, who would have received services were it not for COVID-19, are re-engaged.

For these reasons, COVID-19 has affected performance in the following areas:

Prevention Services

- % of eight- month-olds fully immunised
- % of two-year-olds fully immunised

- % of five-year-olds fully immunised
- % of children (girls and boys aged 12 years) provided HPV vaccination
- % of eligible women (25-69 years old) having cervical screening in the last three years
- % of eligible children receiving a B4 School Check
- % of four year olds identified as obese at their B4 School Check referred for family-based nutrition, activity and lifestyle intervention
- % of adolescents accessing DHB-funded dental services
- Number of new referrals to Public Health Nurses in primary/intermediate schools
- Number of environmental health investigations
- Number of premises visited for alcohol controlled purchase operations

Early Detection and Management

- % of the DHB-domiciled population that is enrolled in a PHO
- % of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol
- Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)
- Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)

Intensive Assessment and Treatment

- Number of zero-fee consultations at after-hours services by children under 13 years
- % of patients admitted, discharged or transferred from ED within six hours.
- Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals
- % of patients given a commitment to treatment but not treated within four months
- % of patients waiting longer than four months for their first specialist assessment
- % of people admitted to an acute mental health inpatient service that were seen by mental health community team: seven days following the day of discharge
- % of people admitted to an acute mental health inpatient service that were seen by mental health community team: seven days prior to day of admission
- % of patients 0-19 referred to non-urgent child and adolescent services that were seen within eight weeks: Addiction Services
- % of patients 0-19 referred to non-urgent child and adolescent services that were seen within eight weeks: Mental Health Services
- % 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
- Rate of Māori under the Mental Health Act: Section 29 community treatment orders
- Rate of surgical site infections for hip and knee operations, per 100 procedures
- Rate of rapid response escalations, per 1000 admissions
- Rates of deep vein thrombosis/pulmonary embolus

Rehabilitation and Support

- Number of older people accessing respite services
- Number of CCDHB Disability Forums
- Number of sub-regional disability forums
- Rate of ED presentations from aged residential care facilities that are not admitted per 1,000 population in aged residential care

Output Class 1: Prevention Services

Description

'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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of eight-month-olds fully vaccinated	Māori	87%	≥95%	87%	🟠
	Pacific	90%		91%	🟠
	Non-Māori, Non-Pacific	97%		96%	🟢
	Total	93%		94%	🟠
% of two-year-olds fully immunised	Māori	89%	≥95%	90%	🟠
	Pacific	92%		93%	🟠
	Non-Māori, Non-Pacific	95%		95%	🟢
	Total	92%		94%	🟠
% of five-year-olds fully immunised	Māori	86%	≥95%	91%	🟠
	Pacific	90%		87%	🟠
	Non-Māori, Non-Pacific	91%		91%	🟠
	Total	90%		91%	🟠
% of children aged 11 years provided Boostrix vaccination	Māori	73%	≥70%	73%	🟢
	Pacific	81%		67%	🟠
	Non-Māori, Non-Pacific	-		67%	🟠
	Total	69%		68%	🟠
% of children (girls and boys aged 12 years) provided HPV vaccination	Māori	59%	≥75%	62%	🔴
	Pacific	70%		61%	🔴
	Non-Māori, Non-Pacific	71%		67%	🟠
	Total	69%		66%	🟠

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of eligible children receiving a B4 School Check	Māori	76%	≥90%	60%	🔴
	Pacific	85%		54%	🔴
	Non-Māori, Non-Pacific	88%		70%	🔴
	Total	95%		62%	🔴
% of eligible women (25-69 years old) having cervical screening in the last three years	Māori	63%	≥80%	65%	🔴
	Pacific	66%		64%	🔴
	Non-Māori, Non-Pacific	78%		75%	🟠
	Total	76%		72%	🟠
% of eligible women (50-69 years old) having breast cancer screening in the last two years	Māori	67%	≥70%	67%	🟠
	Pacific	68%		70%	🟢
	Non-Māori, Non-Pacific	73%		72%	🟢
	Total	72%		72%	🟢

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of infants fully or exclusively breastfed at three months[3]	Māori	48%	≥60%	43%	
	Pacific	43%		50%	
	Non-Māori, Non-Pacific	66%		67%	
	Total	64%		62%	
% of four-year-olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention	Māori	97%	≥95%	92%	
	Pacific	97%		86%	
	Non-Māori, Non-Pacific	98%		90%	
	Total	97%		90%	
% of PHO-enrolled patients who have quit smoking in the last 12 months	Māori	9%	12%	11%	
	Pacific	10%		11%	
	Non-Māori, Non-Pacific	17%		17%	
	Total	14%		12%	

Public Health Services					
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Target Group	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Number of disease notifications investigated	Māori	100	109	175	
	Pacific	81	92	93	
	Non-Māori, Non-Pacific	1098	1090	1395	
	Total	1279	109	1663	
Number of new referrals to Public Health Nurses in primary/intermediate schools	Māori	385	756	535	
	Pacific	365	707	526	
	Non-Māori, Non-Pacific	211	424	419	
	Total	961	1887	1480	
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Total	29	20	38	

[3] Data to Q3 2019/20

Number of environmental health investigations	Total	583	727	547	●
Number of premises visited for alcohol controlled purchase operations	Total	31	70	48	●
Number of premises visited for tobacco controlled purchase operations	Total	44	17	43	●
Number of investigations related to requirements of the Drinking-Water Standards	Total	-	9	12	●

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of children under five years enrolled in DHB-funded dental services	Māori	68%	≥95%	72%	●
	Pacific	76%		84%	●
	Non-Māori, Non-Pacific	98%		104%	●
	Total	90%		95%	●
% of children caries free at five years [4]	Māori	53%	≥69% (2018)	53%	●
	Pacific	44%		43%	●
	Non-Māori, Non-Pacific	78%		78%	●
	Total	72%		71%	●
Ratio of mean decayed, missing, filled teeth (DMFT) at year eight [2]	Māori	0.8	≤0.49 (2018)	0.27	●
	Pacific	0.92		0.26	●
	Non-Māori, Non-Pacific	0.42		0.35	●
	Total	0.52		0.33	●
% of children (0-12) enrolled in DHB oral health services examined according to planned recall	Māori	13%	≤10%	8%	●
	Pacific	13%		7%	●
	Non-Māori, Non-Pacific	8%		5%	●
	Total	9%		6%	●
% of adolescents accessing DHB-funded dental services	Māori	N/A	≥85%	N/A	○
	Pacific	N/A		N/A	○
	Non-Māori, Non-Pacific	N/A		N/A	○
	Total	79%		77%	●

[4] Data to Q3 2019/20

Output Class 2: Early Detection and Management

Description

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of the DHB-domiciled population that is enrolled in a PHO	Māori	80%	≥94%	89%	●
	Pacific	96%		100%	●
	Non-Māori, Non-Pacific	94%		91%	●
	Total	92%		92%	●
% of the eligible population assessed for CVD risk in the last five (5) years	Māori	78%	≥90%	78%	●
	Pacific	80%		78%	●
	Non-Māori, Non-Pacific	79%		89%	●
	Total	78%		87%	●
% of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	53%	≥70%	50%	●
	Pacific	51%		44%	●
	Non-Māori, Non-Pacific	69%		59%	●
	Total	64%		55%	●
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Māori	7880	5,700	5833	●
	Pacific	11040		9577	●
	Non-Māori, Non-Pacific	5535		4033	●
	Total	6611		4991	●
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)	Māori	5831	2,537	6308	●
	Pacific	7853		7409	●
	Non-Māori, Non-Pacific	2649		2460	●
	Total	3218		3100	●
Primary Care Patient Experience scores[5]	Communication	8.3	8.0	N/A	○
	Partnership	7.5		N/A	○
	Physical & Emotional Needs	8.2		N/A	○
	Coordination	8.4		N/A	○

[5] Data for 2019/20 is unavailable due to a change in the national vendor and provider of the survey.

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of the DHB-domiciled population that were dispensed at least one prescription item	Māori	72%	78%	72%	●
	Pacific	81%		79%	●
	Non-Māori, Non-Pacific	77%		75%	●
	Total	78%		75%	●
% of people aged 65+ years receiving five or more long-term medications	Māori	33%	25%	32%	●
	Pacific	48%		49%	●
	Non-Māori, Non-Pacific	30%		29%	●
	Total	30%		30%	●
Number of people registered with a Long-term Conditions programme in a pharmacy	Total	6571	6,604	6956	●
Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Total	208	250	257	●

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of maternity deliveries made in Primary Birthing Units	Māori	20%	≥9%	18%	●
	Pacific	16%		18%	●
	Non-Māori, Non-Pacific	8%		7%	●
	Total	11%		10%	●

Output Class 3: Intensive Assessment and Treatment

Description

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Number of Community Acute Response packages of care provided in community settings[6]	Total	674	≥729	902	
Number of zero-fee consultations at after-hours services by children under 13-years	Māori	3019	≥2,622	2849	
	Pacific	3924	≥3,716	2837	
	Non-Māori, Non-Pacific	14486	≥12,154	10432	
	Total	21429	≥18,492	16118	
Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals	Māori	203	≤158	211	
	Pacific	247		246	
	Non-Māori, Non-Pacific	150		143	
	Total	161		156	
% of patients admitted, discharged or transferred from ED within six hours	Māori	82%	≥95%	76%	
	Pacific	81%		74%	
	Non-Māori, Non-Pacific	80%		78%	
	Total	80%		78%	
Standardised acute readmission rate within 28 days	Total	12.5%	12.4%	12.9%	

[6] Data to May 2019/20

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Number of surgical elective discharges		Total	11,207	11,205	14,373	
% of patients given a commitment to treatment but not treated within four months		Total	0.8%	<5%	22.9%	
% of "DNA" (did not attend) appointments for outpatient appointments		Māori	16.3%	14%	9.8%	
		Pacific	17.7%	16%	8.9%	
		Non-Māori, Non-Pacific	3.7%	5%	3.5%	
		Total	7.5%	7%	4.8%	
% of patients waiting longer than four months for their first specialist assessment		Total	2.5%	<0.4%	12.7%	
% 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	91%	≥90%	83%	
		Pacific	91%		57%	
		Non-Māori, Non-Pacific	89%		91%	
		Total	89%		89%	

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of population accessing community mental health services	Mental health services	Māori	1.8%	1.2%	1.5%	
		Pacific	1.1%	0.8%	1.0%	
		Non-Māori, Non-Pacific	0.5%	0.4%	0.5%	
		Total	0.7%	0.6%	0.7%	
	Addiction services	Māori	1.4%	1.9%	1.4%	
		Pacific	0.7%	1.0%	0.7%	
		Non-Māori, Non-Pacific	0.3%	0.4%	0.3%	
		Total	0.5%	0.6%	0.4%	
% of population accessing secondary:	Mental health services	Māori	7.2%	6.9%	7.1%	
		Pacific	3.6%	3.5%	3.5%	
		Non-Māori,	3.0%	3.1%	2.9%	

		Non-Pacific				
		Total	3.5%	3.5%	3.4%	🟠
	Addiction services	Māori	1.8%	1.9%	2.0%	🟢
		Pacific	0.8%	0.9%	0.9%	🟢
		Non-Māori, Non-Pacific	0.5%	0.6%	0.5%	🟠
		Total	0.7%	0.8%	0.7%	🟠
% of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks:	Mental health services	Māori	N/A	≥95%	85%	🟠
		Pacific	N/A		89%	🟠
		Non-Māori, Non-Pacific	N/A		82%	🔴
		Total	88%		83%	🔴
	Addiction services	Māori	N/A		94%	🟠
		Pacific	N/A		89%	🟠
		Non-Māori, Non-Pacific	N/A		92%	🟠
		Total	93%		92%	🟠
% 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	63%	≥75%	72%	🟠
		Pacific	55%		67%	🟠
		Non-Māori, Non-Pacific	72%		N/A	○
		Total	68%		75%	🟢
	Seven days following the day of discharge	Māori	76%	≥90%	79%	🔴
		Pacific	77%		71%	🔴
		Non-Māori, Non-Pacific	81%		82%	🟠
		Total	79%		80%	🟠
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	492	434	495	🔴
		Non- Māori	140	125	145	🔴

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Rate of In-hospital falls with fractured neck of femur, per 100,000 admissions by month[7]	Total	7.23	14	7.1	🟢
Rate of staphylococcus aureus bacteraemia, per 1,000 bed days	Total	0.24	-	0.15	-
Rate of surgical site infections for hip and knee operations, per 100 procedures[7]	Total	1.2	0.41	1.7	🔴
Rate of in-hospital cardiopulmonary	Total	1.3	1.7	1.0	🟢

[7] Data to Q3 2019/20

arrests in adult inpatient wards, per 1,000 admissions[8]					
Rate of rapid response escalations, per 1000 admissions [8]	Total	47.9	40.4	48	
Rates of deep vein thrombosis/pulmonary embolus [8]	Total	1.65	1.05	1.19	
The weighted average score in the Inpatient Experience Survey by domain [6]	Communication	8.5	8.5	8.4	
	Partnership	8.6	8.7	8.4	
	Physical & Emotional Needs	8.6	8.7	8.8	
	Coordination	8.3	8.5	8.6	

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

Description

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Number of CCDHB Disability Forums	Total	1	3	0	
Number of sub-regional Disability Forums	Total	1	1	0	
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	23%	33%	46%	
Number of people with a Disability Alert	Total	8881	9,000	9083	
% of the CCDHB domiciled population with a Disability Alert who are Māori or Pacific	Māori	10.7%	11%	11.1%	
	Pacific	5.6%	7%	5.7%	

[8] Data to Q2 2019/20 – December unavailable due to data completeness issues

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
% of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Māori	N/A	≥60%	67%	●
	Pacific	N/A		69%	●
	Non-Māori, Non-Pacific	N/A		69%	●
	Total	65%		69%	●
% of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical (interRAI) assessment and a completed care plan	Māori	98%	≥98%	97%	●
	Pacific	97%		98%	●
	Non-Māori, Non-Pacific	99%		99%	●
	Total	99%		99%	●
% of people who have had an interRAI assessment with an Advance Care Plan	Total	4.0%	≥4.2%	5.0%	●
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+	Total	2.5	≤2.5	2.1	●
Number of older people accessing respite services	Total	506	≥506	462	●

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	2018/19 Result	2019/20 Target	2019/20 Result	Achievement
Rate of ED presentations from aged residential care facilities that are not admitted per 1,000 population in aged residential care	Total	10.98	≤5.53	12.53	●
% of residential care providers meeting four year certification standards	Total	64%	≥53%	59%	●

Managed isolation facilities collaboration is key

CCDHB is leading the Wellington health response at two Managed Isolation Facilities (MIFs) – Grand Mercure and Bay Plaza – sparking up the collaborative effort between the DHB and Regional Public Health (RPH).

RPH is involved in border control, ensuring the safe transition of passengers from their arrival in New Zealand through to their arrival at their MIF hotel, and overseeing their exit and onward journey. CCDHB monitors the health of guests on a daily basis. RPH nursing staff were instrumental in the early days of standing up the MIF to ensure ongoing systems and processes were established for CCDHB nursing staff to follow.

Guests receive a number of health checks from CCDHB nursing staff, including entry and exit screening, daily health monitoring and a COVID-19 test on days three and 12 of their stay. RPH is ready to manage any guests who test positive and move to quarantine until they are recovered or require hospital level care.

Miranda Walker, MIF charge nurse manager, coordinates the nursing staff rosters. She describes her work as a logistical feat, with challenges ably met by the “amazing nursing staff” working in unfamiliar surroundings with people who are not actually patients, but guests.

Above: Children from the local school decorated stars and sent well wishes to the guests at Grand Mercure

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	2019/20 Target	2019/20 Outcome
% of buildings with a condition rating equal to or better than 2	Condition	≥59%	60.3%
M2 of buildings that are not earthquake prone or risk*	Condition	≥83%	90.9%
% occupancy rate of our buildings	Utilisation	≥97%	97.8%
M2 of buildings that meet current and foreseeable service delivery requirements (>10 years - A) *	Functionality	≥45%	40.7%
M2 of buildings that meet current service delivery requirements but may fall short in the foreseeable future (5–10 years - B) *	Functionality	≤43%	45%
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%	86%

*[1] Excludes buildings that are vacant and tagged for demolition.

ICT asset performance measures

Measure ICT asset portfolio	Indicator	2019/20 Target	2019/20 Outcome
% availability of critical systems	Functionality	≥99.9%	99.1%
% of ICT hardware at a condition level of 'Acceptable' or better (a rating of three or lower)	Condition	≥80%	73%
% usage of storage data network (SAN)	Utilisation	≥75%peak	70%

Clinical equipment asset performance measures

Measure Asset portfolio: Clinical equipment (CE)	Indicator	2019/20 Target	2019/20 Outcome
% of CE assets that have passed indicated life expectancy	Functionality	≤37%	31.6%
% of CE assets with a physical condition rating equal to or better than three (average)	Condition	≥98%	96.7%
Time MRI is in operation expressed as a % of available time*[2]	Utilisation	≥34.5%	28%

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

Financial Statements

Statement of comprehensive revenue and expense

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Revenue	1	1,218,189	1,209,199	1,161,622
Total revenue		**1,218,189**	**1,209,199**	**1,161,622**
Expenditure				
Clinical supplies		122,741	121,218	121,834
Employee benefit costs	2	542,594	538,195	505,739
Infrastructure and non-clinical expenses		69,231	57,165	63,090
Other operating expenses	3	5,944	5,648	5,012
Outsourced services		39,765	33,990	35,793
Payments to other district health boards		102,847	103,064	98,083
Payments to non-health board providers		307,256	304,138	288,681
Capital charge	4	24,407	26,281	29,805
Depreciation and amortisation expense	6,7	35,212	36,000	36,419
Total expenditure excluding Holidays Act and NOS*		**1,249,997**	**1,225,699**	**1,184,456**
Surplus / (deficit) excluding Holidays Act and NOS*		**(31,808)**	**(15,900)**	**(22,834)**
Holidays Act Provision	2,5	12,365	-	67,161
National Oracle System (NOS) impairment	7	-	-	6,379
Surplus / (deficit) for the year		**(44,173)**	**(15,900)**	**(96,374)**
Other comprehensive revenue and expense				
Revaluation reserve transfer to equity	19	(702)	-	-
Impairment losses on revalued assets	6	-	-	(5,350)
Total other comprehensive revenue and expense		**(702)**	**-**	**(5,350)**
Total comprehensive revenue and expense		**(44,875)**	**(15,900)**	**(101,724)**

*NOS = National Oracle System

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

Explanations of significant variances against budget are detailed in note 26.

Statement of changes in equity

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Balance at 1 July		424,523	424,523	515,632
Total comprehensive revenue and expense for the year		(44,875)	(15,900)	(101,724)
Transfer from revaluation reserves to retained earnings		368	-	-
Owner transactions				
Contribution from the crown		27,859	15,900	14,100
Conversion of loan to equity		-	-	-
Repayment of equity		(3,484)	(3,484)	(3,484)
Balance at 30 June	**19**	**404,391**	**421,039**	**424,523**

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

Explanations of significant variances against budget are detailed in note 26.

Statement of financial position

As at 30 June 2020

in thousands of New Zealand Dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Assets				
Current assets				
Cash and cash equivalents	12	6,553	33	-
Trade and other receivables	11	52,599	55,414	56,063
Inventories	8	8,995	9,046	9,046
Trust and special funds	13	11,683	10,754	10,754
Total current assets		**79,830**	**75,247**	**75,863**
Non-current assets				
Property, plant and equipment	6	564,080	568,982	556,089
Intangible assets	7	27,842	39,354	26,583
Investments in joint ventures	9	-	-	-
Investments in associates	10	1,150	1,150	1,150
Total Non-Current Assets		**593,072**	**609,486**	**583,822**
Total Assets		**672,902**	**684,733**	**659,685**
Equity				
Crown Equity	19	801,942	797,780	777,568
Revaluation Reserve	19	130,659	131,360	131,361
Accumulated comprehensive revenue and expenses	19	(528,210)	(508,102)	(484,406)
Total equity		**404,391**	**421,038**	**424,523**
Liabilities				
Current Liabilities				
Bank overdraft	12	-	-	2,671
Trade and other payables	17	91,584	89,661	72,900
Borrowings	14	-	55	55
Employee entitlements	15	161,006	154,783	145,638
Provisions	16	681	1,478	628
Patient and restricted funds	18	92	10,760	72
Total current liabilities		**253,363**	**256,737**	**221,964**
Non-current liabilities				
Borrowings	14	-	-	-
Employee entitlements	15	14,589	6,353	12,646
Provisions	16	559	605	552
Total non-current liabilities		**15,148**	**6,958**	**13,198**
Total liabilities		**268,511**	**263,695**	**235,162**
Total equity and liabilities		**672,902**	**684,733**	**659,685**

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

Explanations of significant variances against budget are detailed in note 26.

Statement of cash flows

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	Note	2020 Actual	2020 Budget	2019 Actual
Cash flows from operating activities				
Cash receipts from Ministry of Health and other Crown Entities		1,205,327	1,239,635	1,139,635
Other receipts		23,420	19,989	19,299
Cash paid to suppliers		(654,353)	(662,964)	(616,299)
Cash paid to employees		(530,469)	(545,758)	(501,958)
Cash generated from operations		**43,925**	**50,902**	**40,677**
Goods & services tax, other taxes (net) (a)		(1,595)	(2,244)	(2,244)
Capital charge paid		(12,297)	(29,805)	(29,805)
Net cash flows from operating activities		**30,033**	**18,853**	**8,628**
Cash flows from investing activities				
Interest received		762	1,248	1,204
Dividend received		138	-	-
Acquisition of property, plant and equipment		(41,230)	(40,040)	(35,271)
Acquisition of intangible assets		(3,871)	(6,961)	(4,142)
Investment in joint venture		-	-	-
Appropriation from trust & special funds (b)		-	-	-
Net cash flows from investing activities		**(44,201)**	**(45,753)**	**(38,209)**
Cash flows from financing activities				
Contribution from the Crown		27,859	15,900	14,100
Repayment of borrowing		(55)	-	(247)
Repayment of equity		(3,484)	(3,484)	(3,484)
Repayment of finance leases		-	-	-
Interest Paid		-	-	-
Net cash flows from financing activities		**24,320**	**12,416**	**10,369**
Net increase/(decrease) in cash and cash equivalents		10,152	(14,484)	(19,212)
Cash and cash equivalents at beginning of year		8,084	8,084	27,296
Cash and cash equivalents at end of year		**18,236**	**(6,400)**	**8,084**
Represented by				
Cash and cash equivalents/ (Bank overdraft)	12	**6,553**		**(2,671)**
Trust and special funds	13	**11,683**		**10,754**

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

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

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

Explanations of significant variances against budget are detailed in note 26.

Reconciliation of surplus with net cash flows from operating activities

For the year ended 30 June 2020

in thousands of New Zealand Dollars

	2020 Actual	2019 Actual
Surplus/(deficit) for the year	(44,173)	(96,374)
Add back non-cash items:		
Depreciation & amortisation	35,212	36,419
Impairment on Intangibles	-	6,379
Add back items classified as investing activity:		
Net loss/(gain) on disposal of property, plant and equipment	2	14
Interest revenue on financial assets	(655)	(1,263)
Donated assets	-	-
Add back items classified as financing activity:		
Interest expense on financial liabilities	-	-
Movements in working capital:		
(Increase)/decrease in trade and other receivables	3,464	(3,912)
(Increase)/decrease in trust funds	-	-
(Increase)/decrease in inventories	50	(979)
Increase/(decrease) in trade and other payables	17,998	398
Increase/(decrease) in employee benefits	17,310	70,448
Increase/(decrease) in provisions	825	(2,502)
Net movement in working capital	39,647	63,453
Net cash inflow/(outflow) from operating activities	**30,033**	**8,628**

Statement of contingent liabilities and contingent assets

as at 30 June 2020

in thousands of New Zealand Dollars

This statement discloses situation that existed at 30 June 2020, the ultimate outcome of which is uncertain and will be confirmed only on the occurrence of one or more future events after the date of approval of the financial statements.

Contingent liabilities

The only ongoing matter is the pharmacists ERA proceedings. The applicants, who are PSA members, are seeking overtime payments for work done while on call, which is currently unpaid. The DHB is defending the claim. However, the DHB could be liable for the arrears of payment if the Authority finds in the applicants' favour.

Contingent assets

	Note	2020 Actual	2019 Actual
Legal proceedings against the DHB		800	100
		800	**100**

The DHB has been notified of a potential claim as at 30 June 2020 (2019: 1) relating to an appeal following a win by the DHB in the High Court.

The Wellington regional hospital domestic hot water systems are failing due to corrosion in the copper pipes causing leaks throughout the building. The durability of the pipes has been compromised by the corrosion that has occurred, and the damage caused by the corrosion is not reversible. The current and projected performance of the copper pipes does not meet the standards expected under the building code. A concept plan to most efficiently replace the failing systems while minimising disruption to the hospital is being developed by external consulting engineers and a business case for funding for that project is being prepared. Since the issues are currently being investigated an unquantified contingent liability has been disclosed. Legal proceedings have been commenced to recover the cost of replacing the hot water pipes from the head contractor which constructed the building, the copper pipe manufacturer, the installer and the designer. A full hearing is scheduled by the High Court for late 2020. Since the amount cannot be quantified, an unquantified contingent asset has been disclosed.

Notes to the Financial Statements

In thousands of New Zealand dollars

Statement of Accounting Policies

Reporting entity

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

The primary objective of the DHB is to provide goods or services for the community or social benefit rather than making a financial return. Accordingly, the DHB has designated itself as a public benefit entity (PBE) for financial reporting purposes. The DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

Statement of compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes a requirement of compliance with New Zealand Generally Accepted Accounting Practice (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Changes in accounting policies

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

Standards early adopted

Financial instruments

In line with the Financial Statements of the Government, the DHB has elected to early adopt PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Information about the adoption of PBE IFRS 9 is provided in Note 21.

Impairment of revalued assets

In April 2017, the XRB issued Impairment of Revalued Assets, which now clearly scopes revalued property, plant, and equipment into the impairment accounting standards. Previously, only property, plant, and equipment measured at cost were scoped into the impairment accounting standards.

Under the amendment, a revalued asset can be impaired without having to revalue the entire class of asset to which the asset belongs. This amendment is effective for financial periods beginning on or after 1 January 2019, with early adoption permitted. The DHB has elected to early adopt this amendment.

Standards issued that are not yet effective and not early adopted

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 annual periods beginning on or after 1 January 2021, with early application permitted. The DHB does not intend to early adopt the amendment.

PBE FRS 41 Finance Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. 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.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after1 January 2021. The DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

Basis of preparation

The financial statements for the year ended 30 June 2020 were approved by the Board on 3 December 2020. The financial statements have been prepared for the period 1 July 2019 to 30 June 2020. Comparative figures and balances relate to the period 1 July 2018 to 30 June 2019. The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except where modified by the revaluation of certain items of land, buildings and the measurement of equity instruments and derivative financial instruments at fair value. The accounting policies set out below have been applied consistently to all periods presented in the financial statements.

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

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

Statement of Going Concern

The going concern principle has been adopted in the preparation of these financial statements. The Board, after making enquiries, has a reasonable expectation that the DHB has adequate resources to continue operations for the foreseeable future based on current trading terms and legislative requirements. The Board has reached this conclusion having regard to circumstances which it considers likely to affect the DHB during the period of one year from the date of signing the 2019/20 financial statements, and to circumstances which it knows will occur after that date which could affect the validity of the going concern assumption (as set out in its current Statement of Intent). The key considerations are set out below.

Letter of Comfort

The Board has received a letter of comfort, dated 29 September 2020 from the Ministers of Health and Finance which states that the Crown acknowledges that equity support may be required and that the Crown will provide such support where necessary to maintain viability.

Operating and cash flow forecasts

Taking the Letter of Comfort into consideration, the Board has considered forecast information relating to operational viability and is satisfied that there will be sufficient cash flows available to meet the operating and financing cash flow requirements of the DHB as set out in its current Statement of Intent and based on current trading terms and legislative requirements.

Borrowing covenants and forecast borrowing requirements

The forecast for the next year prepared by the DHB shows that the peak borrowing requirement will not exceed the available borrowing facilities. Furthermore, the forecast borrowing requirements can be met without breaching covenants or other borrowing restrictions, with the assumption the DHB's approved facilities will be available taking into account the needs of the rest of the health sector. While the Board is confident in the ability of the DHB to continue as a going concern, if the forecast information relating to operational viability and cash flow requirements is not achieved there would be significant uncertainty as to whether the DHB would be able to continue as a going concern based on current trading terms and legislative requirements. If the DHB was unable to continue as a going concern, adjustments may have to be made to reflect the situation that assets may have to be realised and liabilities extinguished other than in the normal course of business and at amounts which could differ significantly from the amounts at which they are currently reported in the statement of financial position.

Joint ventures

Joint ventures are those entities over whose activities the DHB has joint control, established by contractual agreement. The DHB has a 16.67% shareholding in a joint venture, Central Region Technical Advisory Services Limited (CRTAS) and participates in its commercial and financial policy decisions. CRTAS is a joint venture company incorporated on 6 June 2001 and owned by the six DHBs within the central region. The results of the joint venture company have not been included in the financial statements as they are not considered significant.

Associates

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

Foreign currency

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

Budget figures

The budget figures are those approved by the DHB in its Annual Plan and included in the Statement of Intent tabled in Parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with 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.

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Addition to property, plant and equipment

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

Disposal of property, plant and equipment

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

In thousands of New Zealand dollars

Leased assets

Finance Leases

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

Operating Lease

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

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

Subsequent costs

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

Depreciation

Depreciation is charged to the statement of comprehensive revenue and expense using the straight line method. Land is not depreciated. Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life
• freehold buildings	1 to 60 years (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 of assets is reassessed annually. Leasehold improvements are depreciated over their lease term. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Research and development

Expenditure on research activities, undertaken with the prospect of gaining new scientific or technical knowledge and understanding, is recognised in the statement of comprehensive 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.

Other intangibles

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

Subsequent expenditure

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

Amortisation

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

Type of asset	Estimated life
Software	3 – 10 years (10% to 33%)
Licences	3 – 10 years (10% to 33%)

Financial instruments

Non-derivative financial instruments

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

Trade and other receivables

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.

Inventories

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

Cash and cash equivalents

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

Impairment

The DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return. 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 the present value of an asset's remaining service potential. It 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 against 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 credited to 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. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted. Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

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

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount. An impairment loss on items of property, plant and equipment carried at fair value is reversed through the revaluation reserve. All other impairment losses are reversed through the statement of comprehensive revenue and expense. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Employee entitlements

Short term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the year 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 expenses, and sick leave.

Long term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the year in which the employee renders the related service, such as sabbatical leave, long service leave, retirement gratuities, sick leave, continuing medical education leave and expenses, have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff 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 and expenses, 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.

Defined contribution plans

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

Defined benefit plan

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

Annual leave

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

Provisions

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

Trade and other payables

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

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.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense. Commitments and contingencies are disclosed exclusive of GST. The net amount of GST recoverable from, or payable to, the Inland Revenue Department is included as part of receivables or payables in the statement of financial position. The net GST paid to, or received from the IRD, including the GST related to investing and financing activities, is classified as an operating cash flow in the statement of cash flows.

Capital charge

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

Impact of COVID-19

On 11 March 2020 the World Health Organisation declared a global pandemic as a result of the outbreak and spread of COVID-19. Following this, on Wednesday 25 March 2020 the New Zealand Government realised its Alert Level to 4, full lockdown of non-essential services, for an initial four week period.

Due to the lockdown, CCDHB's operations were affected. Access to the hospital was limited; and patients' treatment, diagnoses, and elective surgeries were put on hold during the lockdown period.

The progress of the new Children hospital project was also impacted.

Note 26 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.

Revenue

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

Crown funding

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

Expenses

Operating lease payments

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

Finance lease payments

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

Cost of service (statement of performance)

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 and charged to output categories. Indirect costs are charged to output categories based on production cost drivers and related activity/usage information. The DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Accounting estimates and judgements

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.

Key sources of estimated uncertainty

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

Property, plant and equipment

Estimating useful lives and residual values of property, plant, and equipment

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

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

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

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

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 2018. The valuation conforms to international valuation standards. Land revaluation was determined by reference to its highest and best use. The revaluation of buildings was based on depreciated replacement cost methodology. Specialised buildings are valued using depreciated replacement cost because no reliable market data is available for such buildings. Refer to note 6 for additional details.

Retirement, long service leave, sick leave and continuing education

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

Critical accounting judgements in applying the DHB's accounting policies

Leases classification

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

Finance and operating leases

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

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

NOTES TO THE FINANCIAL STATEMENTS

In thousands of New Zealand dollars

1 REVENUE

	2020 Actual	2019 Actual
Ministry of Health contract funding	934,493	882,565
Other government	12,944	15,780
Inter district flows (other DHBs)	247,096	237,983
Non government & crown agency sourced	22,956	23,821
Reversal of impairment previously recognised	-	-
Interest revenue	655	1,263
Revenue from donations	45	210
	1,218,189	1,161,622

2 EMPLOYEE BENEFIT COSTS

	2020 Actual	2019 Actual
Direct staff costs (excluding increases in employee benefit provisions)	518,031	537,668
Indirect staff costs (excluding contributions to defined contribution plans and increases in employee benefit provisions)	12,413	18,743
Contributions to defined contribution plans [1]	16,735	15,634
Increase/(decrease) in employee benefit provisions	7,780	854
	554,959[2]	572,899

[1] Employer contributions to defined contribution plans include contributions to Kiwisaver, State Sector Retirement Savings Scheme and the Defined Benefit Plan Contributors Scheme.

[2] Includes Holidays Act Provision of $12,365k

3 OTHER OPERATING EXPENSES

	Note	2020 Actual	2019 Actual
Increase/(decrease) in provision of trade receivables (doubtful debts)	11	1,047	428
(Gain)/loss on disposal of property, plant and equipment		2	14
Audit fees for financial statements audit		246	236
Fees for other assurance services		136	136
Board member fees	22	288	323
Operating lease expense		2,747	2,572
Other operating expense		1,478	1,303
Total other operating expenses		5,944	5,012

In thousands of New Zealand dollars

4 CAPITAL CHARGE

	2020 Actual	2019 Actual
The DHB pays a monthly capital charge to the Crown based on the greater of its actual or budgeted closing equity balance. The capital charge rate for the period ended 30 June 2020 was 6 % (2019: 6 %)	24,407	29,805

5 HOLIDAYS ACT PROVISION

	2020 Actual	2019 Actual
Holidays Act Provision	12,365	67,161

Holidays Act 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 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 (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-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 will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, as at 30 June 2020, in preparing these financial statements, Capital & Coast District Health Board recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This 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 indicative liability amount 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.

The estimates and assumptions may differ to the subsequent actual results as further work is completed and result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT

	Freehold land	Freehold buildings	Leasehold Improvements	Plant & equipment	Furniture & fittings	Total
Cost						
Balance at 1 July 2018	41,165	473,390	1,191	99,422	28,442	643,610
Additions	-	3,741	-	15,408	3,871	23,020
Disposals	-	-	-	(474)	(91)	(565)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2019	41,165	477,131	1,191	114,356	32,222	666,065
Balance at 1 July 2019	41,165	477,131	1,191	114,356	32,222	666,065
Additions	-	5,899	-	8,406	295	14,600
Disposals	(813)	(955)	-	(757)	(1)	(2,526)
Impairment losses	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Transfer to fixed assets	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2020	40,352	482,075	1,191	122,005	32,516	678,139
Depreciation and impairment losses						
Balance at 1 July 2018	-	35	(503)	(72,037)	(25,293)	(97,798)
Depreciation charge for the year	-	(24,801)	(65)	(6,230)	(2,628)	(33,724)
Impairment losses	-	(5,350)	-	-	-	(5,350)
Disposals	-	-	-	461	90	551
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2019	-	(30,116)	(568)	(77,806)	(27,831)	(136,321)

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Depreciation and impairment losses						
Balance at 1 July 2019	-	(30,116)	(568)	(77,806)	(27,831)	(136,321)
Depreciation charge for the year	-	(23,403)	(64)	(8,025)	(732)	(32,224)
Impairment losses	-	-	-	-	-	-
Disposals	-	377	-	53	1	431
Revaluations	-	-	-	-	-	-
Restatement plant & equipment, furniture & fittings	-	-	-	-	-	-
Transfer between categories	-	-	-	-	-	-
Balance at 30 June 2020	-	(53,142)	(632)	(85,778)	(28,562)	(168,114)
Carrying amounts						
At 1 July 2018	41,165	473,425	688	27,385	3,149	545,812
At 30 June 2019	41,165	447,015	623	36,550	4,391	529,744
At 1 July 2019	41,165	447,015	623	36,550	4,391	529,744
At 30 June 2020	40,352	428,933	559	36,227	3,954	510,025

	Freehold land	Freehold buildings	Leasehold improvements	Plant & equipment	Furniture & fittings	Total
Work in progress						
Balance at 1 July 2018	-	14,692	-	150	2,897	17,739
Additions	-	7,959	-	20,080	3,589	31,628
Transfer from WIP	-	(3,742)	-	(15,409)	(3,871)	(23,022)
Balance at 30 June 2019	-	18,909	-	4,821	2,615	26,345
Balance at 1 July 2019	-	18,909	-	4,821	2,615	26,345
Additions	-	22,157	-	18,875	1,278	42,310
Transfer from WIP	-	(5,899)	-	(8,406)	(295)	(14,600)
Balance at 30 June 2020	-	35,167	-	15,290	3,598	54,055

In thousands of New Zealand dollars

6 PROPERTY, PLANT AND EQUIPMENT (CONTINUED)

	2020 Actual	2019 Actual
Capital commitments		
Buildings	-	828
Plant & equipment	6,325	-
Intangible assets	16	938
Capital Commitments	**6,341**	**1,766**

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

Fair value assessment

Current Crown accounting policies require all crown entities to revalue land and buildings in accordance with PBE IPSAS 17, Property, Plant and Equipment. Current valuation standards and guidance notes have been developed in association with the treasury for the valuation of hospitals and tertiary institutions.

The fair value assessment of land and buildings was carried out at 30 June 2020 by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand Limited. 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".

The DHB has assessed and determined that the carrying value of land and building as at 30 June 2020 does not materially differ to its fair value at that date.

Borrowing costs

The total amount of borrowing costs capitalised during the year ended 30 June 2020 was $nil (2019: $nil).

Restrictions

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

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS

	Software	NOS shared services rights	Licenses	Total
Cost				
Balance at 1 July 2018	28,667	7,005	3,042	38,714
Additions	3,136	394	951	4,481
Disposals	-	-	-	-
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2019	31,803	7,399	3,993	43,195
Balance at 1 July 2019	31,803	7,399	3,993	43,195
Additions	4,394	-	734	5,128
Disposals	-	(7,399)	-	(7,399)
Transfer to fixed assets	-	-	-	-
Impairment losses	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2020	36,197	-	4,727	40,924
Amortisation and impairment losses				
Balance at 1 July 2018	(19,469)	(1,020)	(2,817)	(23,307)
Amortisation charge for the year	(2,479)	-	(217)	(2,696)
Impairment losses	-	(6,379)	-	(6,379)
Disposals	-	-	-	-
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2019	(21,948)	(7,399)	(3,034)	(32,382)
Balance at 1 July 2019	(21,948)	(7,399)	(3,034)	(32,382)
Amortisation charge for the year	(2,668)	-	(320)	(2,988)
Impairment losses	-	-	-	-
Disposals	-	7,399	-	7,399
PP&E restatement	-	-	-	-
Transfer between categories	-	-	-	-
Balance at 30 June 2020	**(24,616)**	**-**	**(3,354)**	(27,970)
Carrying amounts				
At 1 July 2018	9,198	5,985	225	15,407
At 30 June 2019	9,855	-	959	10,813
At 1 July 2019	9,855	-	959	10,813
At 30 June 2020	11,581	-	1,373	12,954

In thousands of New Zealand dollars

7 INTANGIBLE ASSETS (CONTINUED)

	Software	Licenses	CRTAS	Total
Work in progress				
Balance at 1 July 2018	707	20	11,626	12,353
Additions	4,790	931	1,783	7,504
Transfer from WIP	(3,136)	(951)	-	(4,087)
Balance at 30 June 2019	2,361	-	13,409	15,770
Balance at 1 July 2019	2,361	-	13,409	15,770
Additions	2,124	734	1,388	4,246
Transfer from WIP	(4,394)	(734)	-	(5,128)
Balance at 30 June 2020	91	-	14,797	14,888

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

New Zealand Health Partnerships

Health Benefits Limited (HBL) was established in July 2010 to undertake a range of shared services for DHBs. This included National Oracle Solution (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 (NZHP). Following advice from New Zealand Health Partnerships 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.

Regional Health Informatics Programme (RHIP)

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 Central Region Technical Advisory Services Limited (CRTAS) would create the RHIP assets and provide services in relation to those assets to the DHBs. Each DHB would provide funding to CRTAS and in return for the funding relating to capital items the DHBs would be provided with Class B Redeemable Shares in CRTAS. 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 2020, CCDHB had contributed $14,796m 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. However at this stage on the information available no impairment is required at this point.

In thousands of New Zealand dollars

8 INVENTORIES

	2020 Actual	2019 Actual
Pharmaceuticals	3,271	3,161
Surgical & medical supplies	5,378	5,546
Other supplies	346	339
	8,995	9,046

The amount of inventories recognised as an expense during the year ended 30 June 2020 was $103m (2019: $125m). All inventories are distributed to operating areas in the normal course of business. The write-down of inventories held for distribution amounted to $nil (2019: $nil). There have been no reversals of write-downs. No inventories are pledged as security for liabilities, but some inventories are subject to retention of title clauses (Romalpa clauses). The value of stocks subject to such clauses cannot be quantified due to the inherent difficulties in identifying the specific inventories affected at year-end.

9 INVESTMENTS IN JOINT VENTURES

	2020 Actual	2019 Actual
Carrying amount of investments in joint ventures		
Uncalled ordinary share capital	-	-
	-	-

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

Summary of the DHB's interests in Central TAS joint venture (16.67%)	2020 Actual	2019 Actual
Revenue	6,629	6,678
Expense	6,652	6,623
Non-current assets	293	313
Current assets	3,006	2,708
Non-current liabilities	119	119
Current liabilities	2,370	2,068
Equity	810	834
Contingent liabilities	-	-
Commitment	995	1,084

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

In thousands of New Zealand dollars

10 INVESTMENTS IN ASSOCIATES

	2020 Actual	2019 Actual
Carrying amount of investments in associates		
Investment in Allied Laundry Services Ltd. (ALSL)	1,150	1,150
	1,150	1,150

ALSL has a total ordinary share capital of 6,900,000 of which the DHB's share is 1,150,000. The shares have been fully paid.

Summary of the DHB's interest in Allied Laundry Services Ltd. (16.67%)	2020 Actual	2019 Actual
Revenue	1,960	1,821
Expense	1,834	1,726
Non-current assets	1,725	1,428
Current assets	259	225
Non-current liabilities	359	28
Current liabilities	402	411
Equity	1,223	1,214
Contingent liabilities	-	-
Commitment	-	-

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

11 TRADE AND OTHER RECEIVABLES

	2020 Actual	2019 Actual
Trade receivables from non-related parties	5,948	6,966
Ministry of Health receivables	9,609	19,313
Other DHB receivables	12,358	9,547
	27,915	35,826
Accrued revenue	18,427	16,040
Prepayments	6,257	4,197
Total receivables	52,599	56,063
Total receivables comprises:		
Receivable from the sale of goods and services (exchange transactions)	42,990	36,750
Receivable from Ministry funding (non-exchange transactions)	9,609	19,313
	52,599	56,063

Trade receivables are shown net of a provision for doubtful debts amounting to $2.2m (2019: $1.5m).

The carrying value of receivables approximates their fair value.

In thousands of New Zealand dollars

As at 30 June 2020, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

Past due days	Amount	Estimats of losses	Impaired credit loss	Expected credit loss
Current	7,534	0.0%	-	-
< 6 months	4,944	16.8%	-	830
6 months – 1 year	1,160	31.9%	-	370
1 – 2 years	3,065	10.6%	-	324
> 2 years	1,180	59.7%	-	704
Identified bad debts	342	100.0%	342	-
Total	18,225		342	2,228

Trade receivables are reported at their face value, less an allowance for expected losses. 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.

Movements in the provision for impairment of receivables are as follows:	2020 Actual	2019 Actual
Balance at 1 July 2019	1,522	1,504
Additional provisions made during the year	1,047	428
Receivables written-off during period	(342)	(410)
Balance at 30 June 2020	2,227	1,522

12 CASH AND CASH EQUIVALENT

	2020 Actual	2019 Actual
Petty cash	13	13
Bank accounts	10	(10)
NZHP call deposits	6,530	(2,674)
Cash and cash equivalent / (Bank overdraft)	6,553	(2,671)

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 (NZHP) and the participating DHBs. This Agreement enables NZHP to "sweep" DHB bank accounts daily and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with NZHP, which will incur interest at on-call interest rate received by NZHP plus an administrative margin. The maximum working capital facility limit for the DHB is $67.5m. (2019:$ 61.4m). The highest overdrawn bank balance during financial year 2019/20 was $20.6m. (2019: $14.2m).

While cash and cash equivalents at 30 June 2019 are subject to the expected credit loss requirements of PBE IFRS9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

In thousands of New Zealand dollars

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.

	2020 Actual	2019 Actual
Non patient funds		
Balance at 1 July 2019	10,687	9,644
Monies received	4,365	3,594
Interest received	282	320
Payments made	(3,743)	(2,871)
Balance at 30 June 2020	11,591	10,687
Patient funds		
Balance at 1 July 2019	67	49
Monies received	178	207
Interest received	-	-
Payments made	(153)	(188)
Balance at 30 June 2020	92	67
Total trust and special funds	11,683	10,754

14 INTEREST BEARING LOANS AND BORROWINGS

	2020 Actual	2019 Actual
Current		
Unsecured EECA loans	-	55
	-	55
Non-current		
Unsecured EECA loans	-	-
	-	-

In thousands of New Zealand dollars

Unsecured loans

Interest rate summary	**2020 Actual**	**2019 Actual**
Energy Efficiency and Conservation Authority (EECA)	0%	0%

Loan repayable as follows:	**2020 Actual**	**2019 Actual**
Within one year	-	55
One to two years	-	-
Two to five years	-	-
Later than five years	-	-
Loan repayable as follows:	-	55

Term loan facility limits	**2020 Actual**	**2019 Actual**
Energy Efficiency and Conservation Authority (EECA)	-	55

15 EMPLOYEE ENTITLEMENTS

	2020 Actual	**2019 Actual**
Current liabilities		
Liability for long service leave	3,340	3,270
Liability for sabbatical leave	400	400
Liability for retirement gratuities	950	1,010
Liability for annual leave	53,455	46,664
Liability for sick leave	615	405
Liability for continuing medical education leave and expenses	2,843	2,337
Salary and wages accrual	99,403	91,553
	161,006	145,638

Non-current liabilities		
Liability for long service leave	4,888	4,616
Liability for sabbatical leave	528	510
Liability for retirement gratuities	1,149	1,227
Liability for sick leave	2,336	1,620
Liability for continuing medical education leave and expenses	5,688	4,673
	14,589	12,646

In thousands of New Zealand dollars

Defined benefit plans

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

Other employee entitlement liabilities

Liability for 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%, (2019: 2.5%) and a discount rate ranging from 0.22% to 1.60% (2019: 1.35% to 2.42%) from 1-10+ years.

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

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

16 PROVISION

	2020 Actual	2019 Actual
Current provisions		
ACC Partnership Programme	681	628
Non current provisions		
ACC Partnership Programme	559	552
	1,240	1,180
ACC Partnership Programme		
Undiscounted amount of claims at balance date	975	958
Discount	2	20
Central estimate of present value of future payments	1,111	1,057
Risk margin	129	123

The movement in provisions is represented by:	**ACC Partnership Programme**
2019	
Balance at 1 July 2018	1,442
Additional provisions during the year for the risks borne in current period	600
Additional provisions relating to a reassessment of risks in a previous period	73
Subtotal	2,115
Amounts used during the year	(935)
Total liability	1,180
(Decrease) / increase in provision	(262)

In thousands of New Zealand dollars

2020	
Balance 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
Subtotal	2,034
Amounts used during the year	(794)
Total liability	1,240
(Decrease) / increase in provision	60

ACC Partnership Programme

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

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

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

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

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

An external independent actuarial valuer, Mr 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 1.62% for the year ended 30 June 2020. A discount rate of 0.38% has been used for the year ended 30 June 2020. The value of the liability is not material for the DHB's financial statements, therefore any changes in assumptions will not have a material impact on the financial statements.

In thousands of New Zealand dollars

17 TRADE AND OTHER PAYABLES

	2020 Actual	2019 Actual
Payables under exchange transactions		
Trade payables	3,067	8,730
Capital charge due to the Crown	12,110	-
Other non-trade payables and accrued expenses	52,359	47,723
Total payables under exchange transactions	67,536	56,453
Payables under non-exchange transactions		
Revenue in advance	1,277	177
GST and other taxes payables	22,771	16,270
Total payables under non-exchange transactions	24,048	16,447
Total Payables	91,584	72,900

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.

18 PATIENT AND RESTRICTED FUNDS

	2020 Actual	2019 Actual
Patient funds		
Balance at 1 July 2019	67	48
Monies received	178	207
Interest received	-	-
Payments made	(153)	(188)
Balance at 30 June 2020	92	67

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 2019 are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as at 30 June 2020, both as an asset and a liability.

	2020 Actual	2019 Actual
Holiday homes funds		
Balance at 1 July 2019	20	8
Monies received	8	22
Interest received	-	-
Payments made	(10)	(10)
Balance at 30 June 2020	18	20
Hutt Valley DHB Portion ¼ of holiday homes total	-	5
Total patient and restricted funds	92	72

In thousands of New Zealand dollars

19 EQUITY

	2020 Actual	2019 Actual
Contributed capital		
Balance at 1 July	777,567	766,951
Capital contribution	27,859	14,100
Conversion of loans to equity		
Repayment of capital	(3,484)	(3,484)
Balance at 30 June	801,942	777,567
Property revaluation reserves		
Balance at 1 July	131,361	136,711
Disposals	(702)	-
Impairment losses on revalued assets	-	(5,350)
Balance at 30 June	130,659	131,361
Accumulated surplus / (deficit)		
Balance at 1 July	(484,405)	(388,031)
Surplus / (deficit) for the year	(44,173)	(96,374)
Transfer from revaluation reserves to retained earnings	368	-
Balance at 30 June	(528,210)	(484,405)
Total equity	404,391	424,523

Capital Management

The DHB's capital is its equity, which is comprised of equity contribution, accumulated funds and other reserves. Equity is represented by net assets. The DHB is subject to financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives. The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

20 OPERATING LEASES

Leases as lessee

Non-cancellable operating lease rentals are payable as follows:

	2020 Actual	2019 Actual
Less than one year	3,808	3,257
Between one and five years	5,725	6,766
More than five years	1,012	221
	10,545	10,244

During the year ended 30 June 2020, $2.7m was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases (2019: $2.6m)

In thousands of New Zealand dollars

The DHB:

- leases a number of buildings, vehicles and items of medical equipment under operating leases.
- leases are on normal commercial terms and include restrictions on sub-leasing. For leased buildings some leases have ratchet clauses, and most have rights of renewal.
- leases include no contingent rentals.
- operating lease payments are recognised as an expense on a straight line basis over the term of the lease.
- leased properties are not subleased by the DHB.

Leases as lessor

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

	2020 Actual	2019 Actual
Less than one year	3,539	4,030
Between one and five years	8,929	7,717
More than five years	1,997	2,053
	14,465	13,800

The DHB has:

- a long term agreement with the University of Otago for the provision of medical consultancy services and facilities from which they operate these services.
- long term ground leases in operation where the lessee owns all the improvements.
- a mix of short and medium term leases to both clinical and commercial tenants.

21 FINANCIAL INSTRUMENTS

Exposure to credit, interest rate and currency risks arise in the normal course of the DHB's operations.

Adoption of PBE IFRS 9 Financial Instruments

In accordance with the transitional provisions of PBE IFRS 9, the DHB has elected not to restate the information for previous years to comply with PBE IFRS 9.Under PBE IFRS 9, impairment of short-term receivables is determined by applying an expected credit loss model. The DHB's impairment of receivables in previous years was consistent with this model. Accounting policies have been updated to comply with PBE IFRS 9. The main updates are:

Credit risk

Financial instruments, which potentially subject the DHB to concentrations of risk, consist principally of cash, short-term deposits and accounts receivable.

The DHB places its cash and short term deposits with high quality financial institutions and the DHB has a policy that limits the amount of credit exposure to any one financial institution.

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 21.22% in 2020 (2019: 53.91%). It is assessed to be a low risk and high quality entity due to its nature as the government funded purchaser of health and disability support services.

At the balance sheet date there were no significant other concentrations of credit risk.

Interest rate risk

Cash flow interest rate risk is the risk that cash flows from a financial instrument will fluctuate because of changes in market interest rates. Investments and borrowings issued at variable rates expose the DHB to cash flow interest rate risk.

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 $0.37m in 2020 (2019: $0.47m).

In managing interest rate and currency risks the DHB aims to reduce the impact of short-term fluctuations on the DHB's earnings. Over the longer-term, however, permanent changes in foreign exchange and interest rates would have an impact on consolidated earnings.

21 FINANCIAL INSTRUMENTS (CONTINUED)

Effective interest rates and repricing analysis

In respect of interest-bearing financial liabilities, the following table indicates their effective interest rates at balance sheet date and the periods in which they reprice.

	2020 Actual							2019 Actual						
	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs	Effective interest rate %	Total	6 mths or less	6-12 mths	1-2 yrs	2-5 yrs	More than 5 yrs
Loans:														
NZD unsecured loan	0	-	-	-	-	-	-	0	55	55	-	-	-	-

In thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Contractual maturity analysis of financial liabilities

The table below analyses the DHB's financial liabilities into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date. The amounts disclosed are the contractual undiscounted cash flows and include all interest payments.

	Carrying amount	Contractual cash flows	Less than 1 year	1-2 years	2-5 years	More than 5 years
2020						
Creditors and other payables	91,584	91,584	91,584	-	-	-
Secured loans	-	-	-	-	-	-
Unsecured loans	-	-	-	-	-	-
Patient and restricted funds	92	92	92	-	-	-
Total	91,676	91,676	91,676	-	-	-
2019						
Creditors and other payables	72,900	72,900	72,900	-	-	-
Secured loans	-	-	-	-	-	-
Unsecured loans	55	55	55	-	-	-
Patient and restricted funds	73	73	73	-	-	-
Total	73,028	73,028	73,028	-	-	-

Contractual maturity analysis of financial assets

The table below analyses the DHB's financial assets into relevant maturity groupings based on the remaining period at the balance date to the contractual maturity date.

	Carrying amount	Contractual cash flows	Less than 1 year	1- 2 years	2-5 years	More than 5 years
2020						
Cash and cash equivalents	6,553	6,553	6,553	-	-	-
Debtors and other receivables	52,599	52,599	52,599	-	-	-
Trust and special funds - bank	656	656	656	-	-	-
Trust and special funds - term deposit	10,400	10,507	10,507	-	-	-
Trust and special funds - debtors	517	517	517	-	-	-
Total	70,725	70,725	70,725	-	-	-
2019						
Cash and cash equivalents	(2,671)	(2,671)	(2,671)	-	-	-
Debtors and other receivables	56,063	56,063	56,063	-	-	-
Trust and special funds - bank	582	582	582	-	-	-
Trust and special funds - term deposit	9,600	9,832	9,832	-	-	-
Trust and special funds - debtors	452	452	452			
Total	64,027	64,259	64,259	-	-	-

In thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (CONTINUED)

Maximum exposure to credit risk

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

	2020 Actual	2019 Actual
Cash and cash equivalents	6,553	-
Debtors and other receivables	52,599	56,063
Trust and special funds – bank	656	582
Trust and special funds – term deposit	10,400	9,600
Trust and special funds – debtors	517	452
	70,725	66,697

	2020 Actual	2019 Actual
Counterparties with credit ratings		
Cash at bank and term deposits	17,609	10,182
AA- (Standard & Poor's)	17,609	10,182

Debtors and other receivables mainly arise from the DHB's statutory functions, therefore there are no procedures in place to monitor or report the credit quality of debtors and other receivables to internal or external credit ratings.

Foreign currency risk

The DHB is exposed to foreign currency risk on purchases that are denominated in a currency other than NZD. The currencies giving rise to this risk are primarily US Dollars and AUD Dollars.

The DHB hedges large transactions denominated in a foreign currency. The DHB uses forward exchange contracts to hedge its foreign currency risk. The DHB has no forward exchange contracts as at the balance sheet date.

Forecasted transactions

The DHB classifies its forward exchange contracts hedging forecasted transactions as cash flow hedges and states them at fair value. The net fair value of forward exchange contracts used as hedges of forecasted transactions at 30 June 2020 was $nil (2019: $nil), comprising assets of $nil (2019: $nil) and liabilities of $nil (2019: $nil) that were recognised in fair value derivatives.

Recognised assets and liabilities

Changes in the fair value of forward exchange contracts that economically hedge monetary assets and liabilities in foreign currencies and for which no hedge accounting is applied are recognised in the statement of comprehensive revenue and expense. Both the changes in fair value of the forward contracts and the foreign exchange gains and losses relating to the monetary items are recognised as part of "Net loss on derivative classified as fair value through statement of comprehensive revenue and expense". The fair value of forward exchange contracts used as economic hedges of monetary assets and liabilities in foreign currencies at 30 June 2020 was $nil (2019: $nil) recognised in fair value derivatives.

In thousands of New Zealand Dollars

21 FINANCIAL INSTRUMENTS (continued)

Fair values

The fair values together with the carrying amounts shown in the statement of financial position are as follows:

	Note	Carrying amount 2020 Actual	Fair value 2020 Actual	Carrying amount 2019 Actual	Fair value 2019 Actual
Trade and other receivables	11	52,599	52,599	56,063	56,063
Cash and cash equivalents	12	6,553	6,553	-	-
Secured loans	14	-	-	-	-
Unsecured loans	14	-	-	(55)	(55)
Trade and other payables	17	(91,584)	(91,584)	(72,900)	(72,900)
		(32,432)	(32,432)	(16,892)	(16,892)
Unrecognised (losses)/gains			-		-

Estimation of fair value analysis

The following summarises the major methods and assumptions used in estimating the fair values of financial instruments reflected in the table.

Derivatives

Forward exchange contracts are either marked to market using listed market prices or by discounting the contractual forward price and deducting the current spot rate. Where discounted cash flow techniques are used, estimated future cash flows are based on management's best estimates and the discount rate is a market related rate for a similar instrument at the balance sheet date. Where other pricing models are used, inputs are based on market related data at the balance sheet date.

Interest bearing loans and borrowings

Fair value is calculated based on discounted expected future principal and interest cash flows.

Finance lease liabilities

The fair value is estimated as the present value of future cash flows, discounted at market interest rates for homogeneous lease agreements. The estimated fair values reflect change in interest rates.

Trade and other receivables and payables

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

In thousands of New Zealand Dollars

22 RELATED PARTIES TRANSACTIONS

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.

Remuneration

Key management personnel remuneration is as follows:

	2020 Actual	2019 Actual
Board Members		
Remuneration	$288	$323
Full-time equivalent members	0.9	1.3
Leadership Team		
Remuneration	$4,536	$4,404
Less: Amount paid by Hutt Valley DHB	($475)	-
Less: Amount paid by Wairarapa DHB	($23)	-
Amount paid by Capital & Coast DHB	$4,038	$4,404
Full-time equivalent members	13	17
Total key management personnel remuneration	$4,326	$4,727
Total members and full time equivalent personnel	13.9	18.3

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

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

In thousands of New Zealand Dollars

22 RELATED PARTIES TRANSACTIONS (CONTINUED)

The Board has taken insurance cover for Board members, Board Committee members, and employees for personal loss caused by wrongful acts in the course of their duties where indemnity is not available from the organisation. The Board has also taken insurance cover covering personal accident and travel risk for Board members, Board Committee members and employees where injury or loss occurs whilst on DHB business.

Current board members as at 30 June 2020		**Board fees ($)**		**Committee fees ($)**	
		2020	**2019**	**2020**	**2019**
Mr David Smol, Chair	Appointed	24.6	-	-	-
Dr Ayesha Verrall, Deputy Chair	Elected	16.4	-	-	-
Ms Kathryn Adams	Elected	24.3	25.5	1.5	2.0
Mr Roger Blakeley	Elected	24.3	25.5	3.0	4.0
Mr Hamiora Bowkett	Appointed	13.0	-	-	-
Ms ‘Ana Coffey	Elected	24.3	25.5	1.4	1.8
Dr Tristram Ingham	Appointed	13.0	-	-	-
Mr Chris Kalderimis	Elected	13.0	-	-	-
Ms Sue Kedgley	Elected	24.3	25.5	1.2	2.3
Ms Vanessa Simpson	Elected	13.0	-	-	-
Board member who left during 2019/20					
Mr Andrew Blair	Appointed	26.4	61.0	1.8	2.3
Ms Eileen Brown	Elected	11.0	25.5	1.7	2.5
Mrs Sue Driver	Elected	11.0	25.5	0.8	2.5
Ms Kim Ngarimu	Appointed	11.0	25.5	2.1	2.1
Mr Darrin Sykes	Appointed	2.1	25.5	0.9	2.2
Dame Fran Wilde	Elected	13.8	31.9	2.3	4.6
Mr Kim von Lanthen	Appointed	5.3	-	-	-
		270.8	296.9	16.7	26.2

Committee members (other than Board members and employees)	**DSAC fees ($)**		**HSC fees ($)**	
	2020	**2019**	**2020**	**2019**
Dr Tristram Ingham	0.4	0.7	0.5	1.4
Mr Bob Francis	-	0.9	-	-
Mr Fa’amatuainu Tino Pereira	-	-	0.2	1.4
Ms Suzanne Jane Emirali	0.4	-	0.9	0.2
Dr Margaret Southwick	-	-	-	0.2
	0.8	1.6	1.6	3.2

23 BOARD MEETING ATTENDANCE

Key:
DSAC Disability Services Advisory Committee
FRAC Finance, Risk, Audit Committee
HSC Health Systems Committee
\- Not a member

Attendance from 1 July 2019 to 30 November 2019

Board member	Board	DSAC	FRAC	HSC
Andrew Blair	5/5	0/2	4/5	-
Fran Wilde	5/5	2/2	2/5	5/5
Darrin Sykes [1]	1/5	-	1/5	-
Kimbal von Lanthen	4/5	-	4/5	-
Kim Ngarimu	5/5	-	5/5	-
Eileen Brown	4/5	2/2	-	5/5
Sue Driver	4/5	-	-	5/5
Roger Blakeley	5/5	-	5/5	5/5
Sue Kedgely	5/5	2/2	-	5/5
Kathryn Adams	5/5	-	4/5	-
'Ana Coffey	4/5	2/2	-	5/5

[1] Resigned August 2019

Attendance from 1 December 2019 to 30 June 2020

Board member	Board	DSAC	FRAC	HSC
David Smol	5/5	N/A	3/5	-
Ayesha Varrel	5/5	N/A	-	1/1
Kimbal von Lanthen	1/5	N/A	-	-
'Ana Coffey	5/5	N/A	-	0/1
Chris Kalderimis	4/5	N/A	-	0/1
Hamiora Bowkett	4/5	N/A	4/5	-
Kathryn Adams	5/5	N/A	5/5	-
Roger Blakeley	5/5	N/A	5/5	1/1
Sue Kedgely	5/5	N/A	-	1/1

In thousands of New Zealand Dollars

Tristram Ingham	5/5	N/A	3/5	-
Vanessa Simpson	5/5	N/A	-	0/1

24 EMPLOYEE REMUNERATION

The number of employees or former employees who received remuneration and other benefits of $100,000 or more per annum during 2019/20 within specified $10,000 bands were as follows:

Salary band	*Number of Employees 2020*	*Number of Employees 2019*	*Salary band*	*Number of Employees 2020*	*Number of Employees 2019*
100 – 110	*410*	*306*	*360 – 370*	*4*	*8*
110 – 120	*233*	*157*	*370 – 380*	*8*	*2*
120 – 130	*140*	*120*	*380 – 390*	*8*	*2*
130 – 140	*124*	*73*	*390 – 400*	*6*	*4*
140 – 150	*62*	*61*	*400 – 410*	*7*	*2*
150 – 160	*52*	*42*	*410 – 420*	*4*	*2*
160 – 170	*54*	*38*	*420 – 430*	*3*	*3*
170 – 180	*38*	*31*	*430 – 440*	*5*	*-*
180 – 190	*32*	*16*	*440 – 450*	*3*	*2*
190 – 200	*25*	*19*	*450 – 460*	*1*	*4*
200 – 210	*21*	*24*	*460 – 470*	*-*	*2*
210 – 220	*28*	*10*	*470 - 480*	*1*	*3*
220 – 230	*11*	*18*	*480 – 490*	*2*	*-*
230 – 240	*21*	*18*	*490 – 500*	*3*	*2*
240 – 250	*25*	*21*	*500 – 510*	*3*	*-*
250 – 260	*13*	*17*	*510 – 520*	*-*	*1*
260 – 270	*19*	*25*	*520 – 530*	*2*	*-*
270 – 280	*21*	*13*	*530 – 540*	*1*	*1*
280 – 290	*14*	*17*	*550 – 560*	*1*	*-*
290 – 300	*17*	*11*	*590 – 600*	*2*	*-*
300 – 310	*9*	*10*	*600 – 610*	*1*	*-*
310 – 320	*11*	*6*	*620 – 630*	*-*	*1*
320 – 330	*6*	*9*	*630 – 640*	*2*	*1*
330 – 340	*12*	*10*	*650 – 660*	*-*	*1*
340 – 350	*8*	*13*		*1,477*	*1,135*
350 – 360	*4*	*9*			

Of the 1,477 employees shown above, 632 are or were medical or dental employees and 845 were neither medical nor dental employees. This represents an increase of 342 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 2,197 compared with the actual total number of 1,477.

25 CESSATION PAYMENTS

During the year ended 30 June 2020, 13 employees (2019: 17) received compensation and other benefits in relation to cessation totalling $0.2m (2019: $0.3m).

No Board members (2020: $nil) received compensation or other benefits in relation to cessation (2019: $nil).

26 EXPLANATIONS TO FINANCIAL VARIANCES FROM BUDGET

Section 154(3)(c) of the Crown Entities Act requires the Annual Financial Statements to include the forecast financial statements (Budget numbers) prepared at the start of the financial year for comparison with the actual financial statements. The Budget numbers are obtained from the Statement of Performance Expectation Budget approved by the DHB Board and tabled in Parliament.

Statement of comprehensive revenue and expense

The DHB recorded a deficit of $44.9m compared with a budgeted deficit of $15.9m.

Revenue was higher than budget in most categories, including Funder Arm new contracts, other DHB and other government revenues. Additional revenue was received from Ministry of Health to support MECA increases implemented during 2019-20 and funding support for increased capital charge. Additional funding of $8m was received from the Ministry of Health as part of the COVID-19 response. Most of this funding was passed through the DHB to non-health board providers.

Expenditure was over budget for the following reasons:

- Clinical supplies costs were higher than budget due to increased Pharmaceuticals related to new Cancer Treatments offset by lower activity in the hospital during the COVID-19 response period
- A $12.3m provision was made for the remediation of Holidays Act compliance. Employee benefit costs (excluding the Holidays Act provision) were higher than budget due to COVID-19 response cost and unmet savings targets
- Infrastructure & Non Clinical expenses were over budget due to unmet savings targets and integrated services contract renewals
- Outsourced Services were over budget due to additional outsourcing during COVID-19 response period from April to June 2020
- Payments to non-health board providers were higher than budget, due to funds related to COVID-19 response from April to June 2020. Offsetting revenue was received

Statement of changes in Equity

The variance in equity movement for the year was due to an additional injection of $14.6 m from the Crown for building the new Children's Hospital, and a total comprehensive revenue and expense deficit of $44.9m.

Statement of financial position

Employee entitlements has further increased due to a Holidays Act remediation provision of $80m.

Statement of cash flows

The net cash flow from operating activities was lower than budget mainly due to higher cash paid to employees and increased capital charge.

The net cash flow from investment activities was higher than budget due to increased capital spend.

The net cash flow from financing activities was less than budget due to a lower than forecast equity injection from the Crown.

27 EVENTS AFTER BALANCE DATE

There were no significant events after the balance date.

28 SUMMARY REVENUE AND EXPENSES BY OUTPUT CLASS

	Prevention services		Early detection and management		Intensive assessment and treatment		Rehabilitation and support		Total DHB	
	2020 Actual	**2019 Actual**	**2020 Actual**	**2019 Actual**	**2020 Actual**	**2019 Actual**	**2020 Actual**	**2019 Actual**	**2020 Actual**	**2019 Actual**
Revenue										
Crown	11,404	12,144	198,521	234,054	850,923	782,997	135,436	114,292	1,196,284	1,143,486
Other	-	-	-	-	21,905	18,136	-	-	21,905	18,136
Total revenue	**11,404**	**12,144**	**198,521**	**234,054**	**872,828**	**801,133**	**135,436**	**114,292**	**1,218,189**	**1,161,622**
Expenditure										
Personnel	144	159	2,722	3,009	538,271	500,962	1,457	1,610	542,594	505,739
Depreciation	-	-	-	-	35,212	36,419	-	-	35,212	36,419
Capital charge	-	-	-	-	24,407	29,805	-	-	24,407	29,805
Provider payments	10,190	10,546	175,300	207,975	104,716	67,835	119,897	100,408	410,103	386,764
Other	660	670	12,299	13,962	215,900	204,350	8,822	6,747	237,681	225,729
Total expenditure	**10,994**	**11,375**	**190,321**	**224,945**	**918,506**	**839,370**	**130,176**	**108,765**	**1,249,997**	**1,184,456**
Net surplus/(deficit)	**410**	**768**	**8,199**	**9,108**	**(45,678)**	**(38,238)**	**5,260**	**5,527**	**(31,808)**	**(22,834)**
Extraordinary adjustments										
Holidays Act provision	-	-	-	-	(12,365)	(67,161)	-	-	(12,365)	(67,161)
NOS Impairment	-	-	-	-	-	(6,379)	-	-	-	(6,379)
Impairment losses on revalued assets	-	-	-	-		(5,350)	-	-		(5,350)
Revaluation reserves transfer to equity	-	-	-	-	(702)	-	-	-	(702)	-
Net surplus/deficit	**410**	**768**	**8,199**	**9,108**	**(58,745)**	**(117,128)**	**5,260**	**5,527**	(44,875)	**(101,724)**

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.

Reconciliation to retained earnings

	Provider			Governance			Funder			Consolidated		
	2020 Actual	**2020 Budget**	**2019 Actual**	**2020 Actual**	**2020 Budget**	**2019 Actual**	**2020 Actual**	**2020 Budget**	**2019 Actual**	**2020 Actual**	**2020 Budget**	**2019 Actual**
Opening balance	(552,495)	(552,497)	(431,079)	(14,241)	(14,241)	(14,765)	69,185	69,185	50,016	(497,552)	(497,553)	(395,828)
Surplus/(deficit)	(56,926)	(15,900)	(121,416)	1,080	-	524	10,971	-	19,169	(44,875)	(15,900)	(101,724)
Closing balance	**(609,422)**	(568,397)	**(552,495)**	**(13,161)**	**(14,241)**	**(14,241)**	**80,156**	**69,185**	**69,185**	**(542,427)**	**(513,453)**	**(497,552)**

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 2020.

Signed on behalf of the Board

David Smol – Board Chair

Fionnagh Dougan – Chief Executive

Rosalie Percival - Chief Financial Officer

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 2020

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 106, that comprise the statement of financial position as at 30 June 2020, 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 33 to 38, 49 to 62 and 107.

In our opinion:

- the financial statements of the Health Board on pages 65 to 106:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2020; 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 33 to 38, 49 to 62 and 107:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2020, 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 appropriations; 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 of the financial statements and the performance information was completed on 18 December 2020. This is the date at which our qualified opinion is expressed.

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 in the financial statements.

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

Note 5 on page 81, 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 made progress during the 30 June 2020 year, and estimated a provision of $80 million, as at 30 June 2020 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

Page 72 summarises the Board's use of the going concern assumption in preparing the financial statements. The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether the Health Board will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with the Health Board over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Impact of Covid-19

Page 77 of the financial statements and page 50 and 51 of the performance information outlines the impact of Covid-19 on the Health Board.

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 responsible on behalf of the Health Board for assessing the Health Board's ability to continue as a going concern. The Board also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Health Board or there is no realistic alternative but to do so.

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 going concern basis of accounting by the Board and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast a significant doubt on the Health Board's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements and the performance information or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Health Board to cease to continue as a going concern.

- 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 responsible for the other information. The other information comprises the information included on pages 3 to 109, 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: 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

Board Members as at 30 June 2020

The Board has eleven members. Six are elected. Four are appointed by the Minister of Health (including the Chair and Deputy Chair). As per 30 June 2020 the Board has one position vacant following the resignation of one of the appointed members in February 2020.

David Smol, Joint Chair Hutt Valley and Capital Coast DHBs	**Chris Kaldermis**
Ayesha Verrall, Deputy Chair	**Hamiora Bowkett**
'Ana Coffey	**Kathryn Adams**
Vanessa Simpson	**Roger Blakely**
Tristram Ingham	**Sue Kedgely**

Executive Leadership Team for Capital and Coast DHB as at 30 June 2020

Fionnagh Dougan	Chief Executive Officer Hutt Valley and Capital Coast DHBs	**Michael McCarthy**	Chief Financial Officer
Joy Farley	Director Provider Services Hutt Valley and Capital Coast DHBs	**Sandy Blake**	General Manager – Quality, Service Improvement and Innovation
Emma Hickson	Director of Nursing	**Arawhetu Gray**	Director of Māori Health
John Tait	Chief Medical Officer	**Tofa Suafole Gush**	Director of Pacific Peoples Health Hutt Valley and Wairarapa DHBs
Christine King	Director of Allied Health, Scientific & Technical	**Rachel Haggerty**	Director Strategy Planning and Performance Hutt Valley and Capital Coast DHBs
Declan Walsh	Director People, Culture and Capability Hutt Valley and Capital Coast DHBs	**Tracy Voice**	Chief Digital Officer, 3DHB

Nigel Fairley	General Manager, Mental Health, Addictions and Intellectual Disabilities, 3DHB	**Nicola Holden**	Director of the Office of the Chief Executive
Debbie Barber	Interim Director of Communications Hutt Valley and Capital Coast DHBs		
3DHB Disability Support Advisory Committee as at 30 June 2020			
'Ana Coffey (Chair)	Capital & Coast	**Yvette Grace**	Hutt Valley
Sue Kedgley	Capital & Coast	**John Ryall**	Hutt Valley
Tristram Ingham	Capital & Coast	**Naomi Shaw**	Hutt Valley
Vanessa Simpson	Capital & Coast	**Ryan Soriano**	Wairarapa
Jill Pettis	Wairarapa	**Jill Stringer**	Wairarapa
Sue Emirali	Chair, Sub-regional Disability Advisory Group	**Jack Rikihana**	Māori Partnership Board Representative, Capital & Coast
Bernadette Jones	Chair, Sub-regional Disability Advisory Group	**To be nominated**	Iwi Relationship Board, Hutt Valley
Marama Tuuta	Chair of Kaunihera Whaikaha, Wairarapa	**To be nominated**	Sub-regional Pacific Strategic Health Group
To be nominated	Community Māori Representative, Hutt Valley		
Combined Health System Committee as at 30 June 2020			
Sue Kedgley (Chair), Capital & Coast		**Ken Laban** (Deputy), Hutt Valley	
Josh Briggs, Hutt Valley		**Keri Brown,** Hutt Valley	
'Ana Coffey, Capital & Coast		**Chris Kalderimis,** Capital & Coast	
Vanessa Simpson, Capital & Coast		**Richard Stein,** Hutt Valley	
Ayesha Verrall, Capital & Coast		**Roger Blakeley,** Capital & Coast	
Paula King, Māori Partnership Board Representative, Capital & Coast		**Fa'amatuainu Tino Pereira,** Chair, Sub-regional Pacific Strategic Health Group	
Sue Emirali, Chair, Sub-regional Disability Advisory Group		**Bernadette Jones**, Chair, Sub-regional Disability Advisory Group	
Kuini Puketapu, Chair, Iwi Relationship Board, Hutt Valley		**Teresea Olsen,** Community Māori Representative, Hutt Valley	

Finance Risk and Audit Committee as at 30 June 2020	
Roger Blakely (Co-Chair)	
Hamiora Bowkett	**David Smol,** Hutt Valley and Capital & Coast
Kathryn Adams	**Tristram Ingham**