
Capital & Coast District Health Board

# Annual Report 2021–2022

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 – Hutt 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, Addiction and Intellectual Disability Service

**Cover photo:** Three local women who have shared their journeys of getting tested to keep themselves and their whānau safe. Read about Cervical and Breast screening at: https://www.timetoscreen.nz/.

# Chair and Chief Executive's Foreword

I am pleased to present Capital & Coast District Health Board's Annual Report for 2021-2022. This report outlines the progress we have made over the past 12 months towards putting patients, their whānau and the wider communities we serve at the heart the healthcare we provide.

Together with Hutt Valley District Health Board as 2DHB, and from 1 July as Te Whatu Ora – Health New Zealand, we have been working hard to further embed our partnership approach across the district, with a shared focus on safe, high-quality services and equitable health outcomes for all those in our care.

There has been considerable change over the past 12 months, with the formal disestablishment of 20 District Health Boards across the motu, including our own, and the establishment of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority. Throughout, our hospitals have continued to manage winter illnesses, further COVID-19 peaks, disruptions to planned care and high occupancy levels, and demand for services. Our kaimahi have maintained the same high level of professionalism and dedication in providing care to communities in the face of all these pressures.

I would also like to acknowledge the work of our Board and thank members for their service. Their commitment to ensuring a sustainable financial position and the optimisation of resources has once again had a huge impact on our ability to deliver care over the past 12 months and has set us up well to make the transition to Te Whatu Ora and Te Aka Whai Ora.

The COVID-19 pandemic continued to disrupt our activities and brought unprecedented pressure onto all health care providers across the district. Throughout the 12 months, we went through two large peaks of infection that meant we had to care for more patients with COVID-19 with fewer staff, as many of our people also caught it. Our successful vaccination and Care in the Community programmes, achieved in partnership with primary care providers, community organisations and health sector partners, meant the impact was lessened in our hospitals and the community. This success built on the partnerships that had been established in the previous year between the 2DHBs and other health and community providers and groups.

With our change over to Te Whatu Ora and Te Aka Whai Ora, our vision and strategic direction has changed to reflect a regional and national view of our health system and the changes that need to happen to bring the Pae Ora (Healthy Futures) Act 2022 to life. In October 2022, Te Whatu Ora released Te Pae Tata – the Interim New Zealand Health Plan, which sets out the next two years of action to transform healthcare in Aotearoa New Zealand. This plan ensures the health system continues to provide care to New Zealanders, while we start to implement improvements in the way services are delivered and work towards the first full New Zealand Health Plan for 2024-2027.

In closing, I would like to extend a huge thanks to all our kaimahi for their incredible contribution over the past 12 months. Ehara taku toa i te toa takitahi, engari he toa takitini.

**John Tait,**
Interim District Director

# Introduction

This final annual report of the Capital & Coast District Health Board outlines progress towards meeting its priorities and intentions under its Health System Plan 2030 and the New Zealand Health Strategy, while preparing to hand over its roles and responsibilities to Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - Māori Health Authority.

Although the DHB's disestablishment and the formal establishment of the new entities did not occur until the end of this reporting year, the 12 months were a period of transition towards the new entities. We continued to integrate our services across the 2DHBs and three hospitals, along with the Kāpiti Health Centre and Rātonga-Rua-O-Porirua mental health campus through unified leadership teams and clinical collaboration. We believe this approach sets us up well for future integration of services at district and regional levels under the health reforms.

Our pro-equity approach continues to underpin the implementation of many of our services by deliberately commissioning activities and services that disrupt inequities. Distributing resources to community NGOs and services targeted at improving equity supports plans for integrated locality-based networks in primary and community care that operate to keep people well in their community. This is allowing us to prepare for the creation of localities as a fundamental part of the health system.

Maternity and neonatal care continue as a focus and saw the adoption of the 2DHB Maternity and Neonatal Health System Plan to improving these services across the region, with a central feature being the redevelopment of maternity facilities at Hutt Hospital over 2022–2023. This is ongoing and will be a significant improvement to maternity and neonatal services in the region.

This year we made progress on a work programme to implement the Life Lived Well mental health and addiction strategy to support the complete range of care from primary and community care through to intensive inpatient services. This has the potential to be transformational in how we support the people in our care, and we are committed working with our partners to co-design this new approach. We finished the year preparing to open our new Manawai Mental Health, Addiction and Intellectual Disability Services facility where we will support clients with an intellectual disability or mental health condition and offending needs, who require a specialised individual living environment.

Our COVID-19 Community Response expanded this year to include boosters and tamariki 5–11-year-old vaccinations, Rapid Antigen Testing (RAT) and our Care in the Community programme. We established our Care in the Community programme in January 2022 to look after people in isolation and deliver care packages as needed. As COVID-19 cases rose, our teams distributed nearly three million RATs to community providers (1 March and 30 June 2022). With an equity approach, we continue to support our providers including outreach, mobile vaccinations, in home vaccinations, school pop-up clinics and tailored events for our Māori, Pacific, Disability and ethnic communities.

The community COVID-19 outbreaks put our hospital system under considerable pressure, particularly during the peaks in March and mid-2022. There were increasing numbers of COVID-positive patients in our hospitals, which reduced our ability to provide planned care and eventually led to the temporary suspension of most of it as a result of limited capacity in our wards. At the same time, many of our clinical and non-clinical staff were absent from work after catching COVID-19 or having to isolate as close household contacts. Our staff responded magnificently, and many people worked outside their normal areas to ensure our critical clinical services continued to provide patients with the care they needed.

We have been creating detailed plans to ensure we deliver equitable and contemporary models of care in modern spaces, in a clinically and financially sustainable way. We are addressing issues of inequitable access and health outcomes, an ageing population, and increasing complexity and demand for healthcare. These issues are compounded by capacity constraints and ageing infrastructure. We are taking a whole-of-system approach that involves collaboration with partners across both Capital & Coast and Hutt Valley DHBs, to support the development of a Hospital Network that brings together systems and services. Progress in our Hospital Network programme meant we released the Front of Whare and ICU expansion proposals to staff. The Hospital Network programme is the masterplan, with the Front of Whare project identified as one of our immediate priorities. Through the Front of Whare project, we are redesigning spaces and models of care for people presenting with acute needs. This will improve the flow and capacity within the Emergency Department, our acute assessment spaces and Intensive Care Unit.

We were very pleased to announce the opening of Te Wao Nui in October 2022. Te Wao Nui is our new integrated Child Health Service based in Wellington's new children's hospital. It has modern facilities and equipment and is designed to place tamariki, rangatahi and whānau at the centre of the service. The opening of Te Wao Nui has freed up space to move other services as part of the Hospital Network programme.

The staff in the organisation, and our community and other partners, remain committed to providing the best healthcare possible. There are numerous challenges, but the dedication and commitment of our people mean we remain in a good position to respond to the changes resulting from the establishment of Te Whatu Ora — Health New Zealand and Te Aka Whai Ora — Māori Health Authority.

# Our Vision and Strategic Direction

*Note – this covers the period 1 July 2021 – 30 June 2022.*

During this year, CCDHB's focus was 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 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 act 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 provide 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.

## Strategic framework

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

## Health Equity

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

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

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

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

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

## Te Tiriti o Waitangi

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

system as a whole. CCDHB values Te Tiriti and applies these the principles to our work across the health and disability system:

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity:** Being committed to achieving equitable health outcomes for Māori.
- **Active protection:** Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

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

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

## Te Upoko O Te Ika Māori Council

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

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

## Māori Health

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

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

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

Taurite Ora 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 seeks to achieve two key outcomes:

1) A stronger and more responsive CCDHB health system achieved by focusing on three strategic priorities:
   (a) becoming a pro-equity health organisation
   (b) growing and empowering our workforce, and
   (c) strengthening our commissioning services.
2) 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.

# About Capital & Coast DHB

*Note – this covers the period 1 July 2021 – 30 June 2022 - before formal disestablishment of 20 District Health Boards across the motu, and the establishment of Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority.*

CCDHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000) to fund and provide health services. CCDHB funds and provides services to residents living in the Kāpiti Coast District, Porirua City and Wellington City.

## Who we are

The CCDHB region is diverse and our communities reflect many cultures, ethnicities and abilities as well as geographic setting. In 2021/22 an estimated 327,540 people called the region home. This is projected to grow by 17,160 people by 2030/31; a 5% increase.

In 2021/22, 103,990 people under 25 years of age made up 32% of the region's population. Most people (58%) were aged 25-69 years (191,650). 10% were people over 70 years; 31,900 people.

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

The region is ethnically diverse. In 2021/22, 39,340 people identified as Māori (12% of the population), 23,760 people identified as Pacific peoples (7%) and 264,440 people identified as non-Māori and non-Pacific (i.e. 'Other' ethnicities); 80% of the population.

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

Māori and Pacific populations tend to be younger, with 27% of the region's Māori (10,440) and 24% of the region's Pacific people (5,750) aged under 15 years in 2021/22.

There are 72,000 people estimated to live with a disability in the CCDHB region. This is expected to increase by 2030/31 and 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 15% or 5,950 people. The Asian population is predicted to grow by 24% or 12,720 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 much older ages.

## The health of our population

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

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

## What we do

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

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

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

## Local services

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

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

We employ over 5,000 FTE and have an annual budget of $1.4 billion.

## Sub-Regional services

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

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

An estimated 161,610 people live in HVDHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. HVDHB's population is predicted to grow by 6% or 8,880 people by 2030/31.

A further 49,140 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 2,015 people (4%) by 2030/31.

## Tertiary services

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

The Central Region has an estimated population of 975,160 people. This represents 19% of the total New Zealand population and is projected to grow by 5% by 2030/31 to just over one million people (1,023,315).

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

## Response to COVID-19

Our COVID-19 Community Response expanded this year to include boosters and tamariki 5-11 year old vaccinations, Rapid Antigen Testing (RAT) and our Care in the Community programme.

In January 2022, CCDHB became the first DHB in the country to report 90 percent of eligible Māori having had their second dose. For the 2DHB region, 97 percent of eligible people had received their second dose, including 90 percent of Māori, and 93 percent of Pacific people.

In mid-February 2022, we reached our goal of 90 percent of eligible Māori in the Hutt Valley DHB who have had their second dose. This is a testament to the hard work from Primary Health Providers, Māori Providers, Pacific Providers, Aged Residential Care (ARC) and pharmacies along with many vaccinating general practices.

We established our Care in the Community programme in January 2022, working closely with providers, local government and the Ministry for Social Development to look after people in isolation and to deliver care packages as needed.

As COVID-19 cases rose, our testing programme ramped up with the change to RAT testing (also continuing some PCR testing). Between 1 March and 30 June 2022 we distributed nearly 3 million RAT tests to community providers including RAT distribution sites, Māori Health providers, Marae, Pacific Providers, NGO's, Pharmacies, Community Hubs, Libraries and businesses.

With an equity approach, we continued to support our providers including outreach, mobile vaccination vans, in home vaccinations, school pop-up clinics and specific events for our Māori, Pacific, Disability and ethnic communities.

Māori-led clinics continued to operate effectively, providing a Kaupapa Māori approach to vaccinating, testing and care in the community, incorporating an all-of-whānau approach. Tailored events made vaccinations as accessible as possible, including the drive-through event at SKY stadium in August 2021. Over 42 accessible, low sensory events were held across 2DHB for disabled people and those with impairments or long-term conditions. These events offered more space, with fewer people and NZSL interpreters.

Our district is diverse with people from across the MELAA (Middle East, Latin American, and Africa) and Asian communities. We worked closely with the Ministry for Ethnic Communities and established ongoing relationships with community groups and organisations to deliver vaccinations, RATs and masks to the community including former refugees with the help of organisations like Red Cross, Kiwi Class and ChangeMakers.

Vaccination remains an important tool to protect our people from getting very sick with COVID-19. At 6 June 2022, we reached over 79 percent for boosters across the Capital & Coast DHB and 74 percent for the Hutt Valley DHB. While 68 percent of tamariki 5-11 year olds in Capital & Coast DHB had their first dose and 64

percent in the Hutt Valley. 51 percent of Māori and 51 percent of pacific children had their first dose in Capital & Coast DHB, with 46 percent Māori and 54 percent pacific people in the Hutt Valley DHB.


*A pop-up clinic at St Bernadette's School in Naenae, by Kōkiri Marae Health Services proved popular with parents. Jo Buckley, Principal, said, "Our school community looks after each other, and the school wanted to offer additional vaccination opportunities this winter."*

**Vaccination and testing data is available on page 45.**

**Read the latest updates on www.VaccinateGreaterWellington.nz**

# Governance of Capital & Coast DHB

## Role of the Board

The Capital & Coast DHB was responsible for the governance of the organisation and was accountable to the Minister of Health until it was disestablished on 30 June 2022. It has been replaced by Te Whatu Ora Health New Zealand, which has taken over the planning and commissioning of services and the functions of the 20 former District Health Boards.

The DHB's governance structure was set out in the New Zealand Public Health and Disability Act 2000.

The board comprised 11 members who had overall responsibility for CCDHB's performance. Six members were elected as part of the three-yearly local body elections and five were appointed by the Minister of Health.

## Role of the Chief Executive

The Board delegated to the chief executive on such terms and conditions as were 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 endorsed 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 took a whole-of-health-system approach, including integrating clinical and support services where this provided benefits across the health system. Each board provided governance of local services and all three Boards provided 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 to progress service design.

# Our People

Against the backdrop of COVID-19, the Government Mandates and the Health Sector reforms our focus and priorities were on operational excellence, staff wellbeing and developing our Māori cultural competence and confidence.

## Operational excellence

This included continuing to align our systems and processes across Hutt Valley and Capital & Coast districts, many of which are significantly disparate; transitioning our training and learning programmes from predominantly face to face delivery to an e-learning and online environment; streamlining staff access to our Learning Management systems and improving their user experience; and redeveloping and realigning our Orientation programmes across both site to reflect a more consistent experience, a clear focus on Equity, cultural safety and ensuring our strategic, organisational and legislative training and learning obligations are fulfilled.

## Staff wellbeing

A significant focus has been on supporting the wellbeing of our staff including development of policies and procedures that provide for more flexible working conditions and staff safety (such as Family Violence and de-escalation training). We have also increased our accessibility to our Employee Assistance Programme (EAP) and as part of our commitment to improve options, care, experience and outcomes for Māori and Pasifica staff we are in the early stages of piloting Mirimiri wellbeing services which is complementary to our EAP service (see photo below). Mirimiri is culturally grounded care that weaves a te ao Māori approach through all aspects of the service.

In addition, during 2022 we established a six month pilot programme of influential Wellbeing whakaihuwaka (champions) whose primary role is to effectively drive holistic staff wellbeing and assist staff to manage COVID-19 psychosocial fatigue.

## Cultural Competence and Confidence

Early in 2022 all Executive Leadership Team (ELT) and senior staff were invited to attend the "Wall Walk"– a unique Māori Cultural workshop designed to raise collective awareness of key events in the history of New Zealand's bi-cultural relations. We also conducted our first Cultural Capability and Confidence survey underpinned by the Te Arawhiti Cultural Capability Framework.

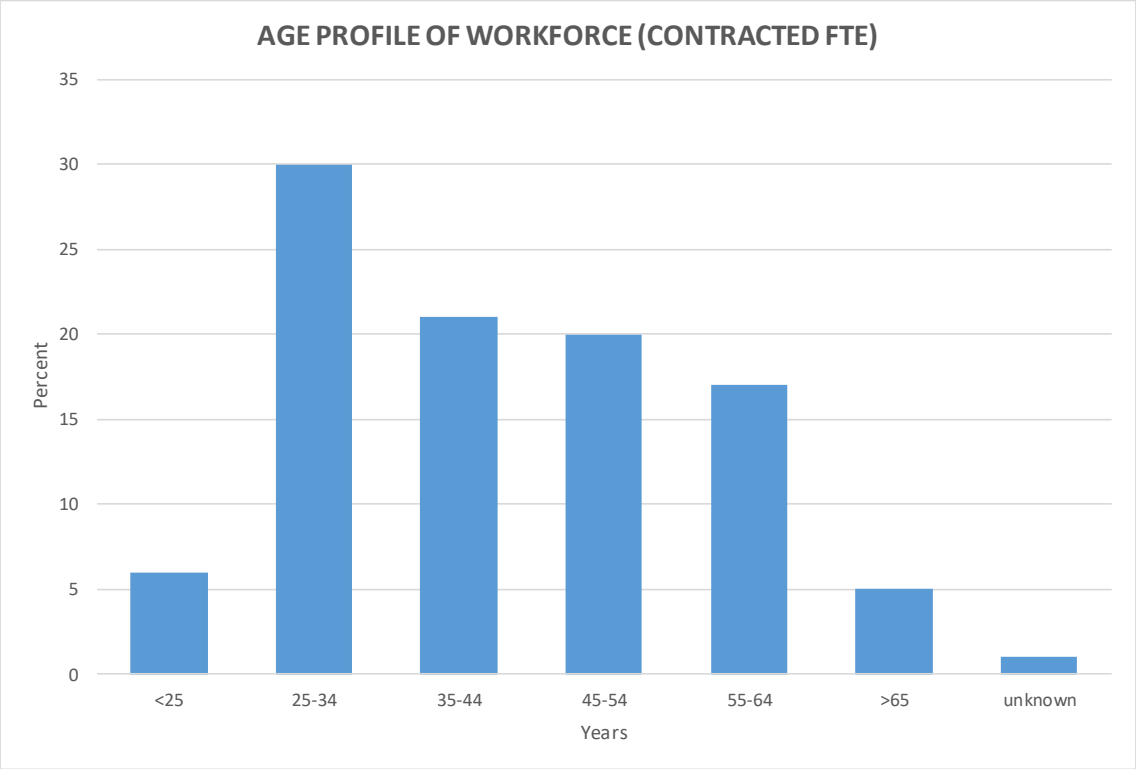
Results will be used to inform our District cultural capability and development programme for the 2022/23 financial year.

## Workforce profile

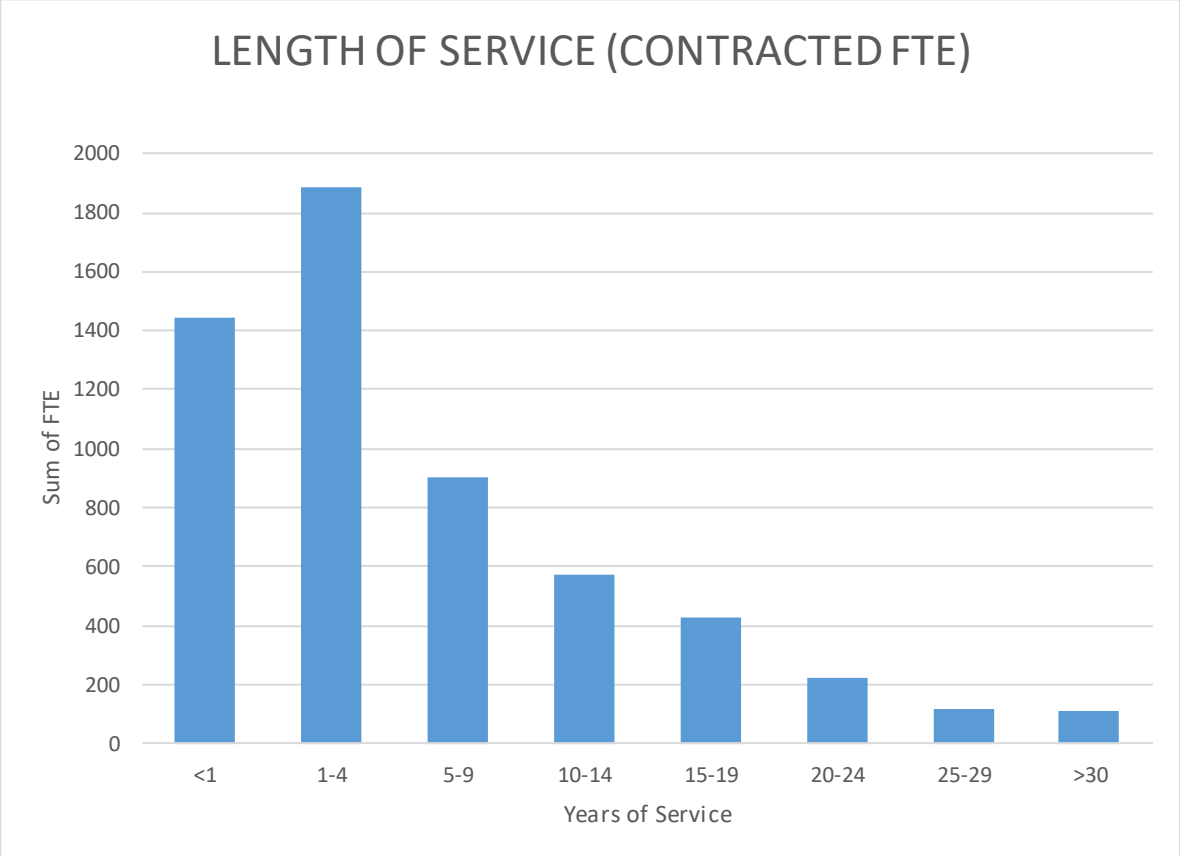
### Full Time Equivalent (FTE) staff numbers

| Profession | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 |
|---|---|---|---|---|---|---|---|---|---|
| Medical | 1021 | 1002 | 977 | 911 | 900 | 848 | 832 | 800 | 781 |
| Nursing | 2587 | 2493 | 2327 | 2254 | 2131 | 2043 | 2004 | 1940 | 1892 |
| Allied Health | 831 | 828 | 753 | 727 | 724 | 713 | 707 | 766 | 774 |
| Other | 1245 | 1170 | 1052 | 1020 | 1000 | 950 | 963 | 997 | 978 |
| Total | 5684 | 5493 | 5108 | 4912 | 4755 | 4554 | 4506 | 4502 | 4426 |

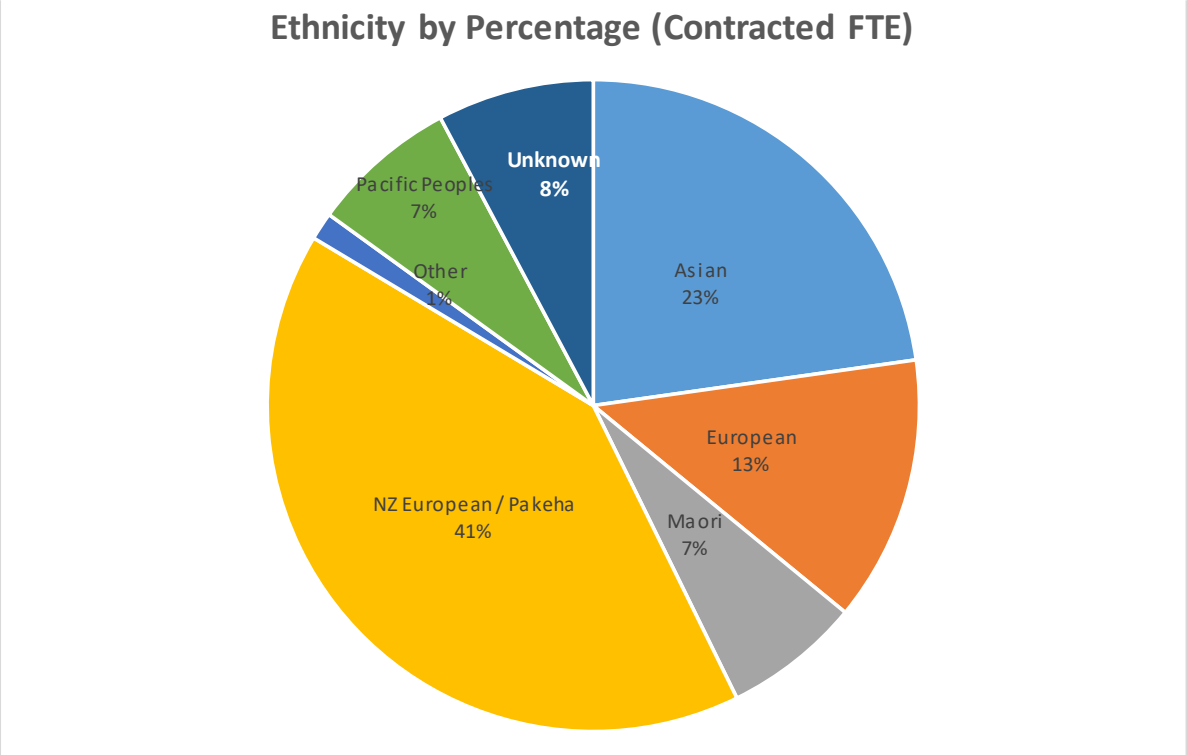
### Age profile of Workforce



## Length of Service (FTE)




## Statistics by Ethnicity



**Statistics by gender**

| Gender | 2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 |
|---|---|---|---|---|---|---|---|---|---|
| Female | 71% | 71% | 72% | 72% | 72% | 72% | 73% | 72% | 72% |
| Male | 29% | 29% | 28% | 28% | 28% | 28% | 27% | 28% | 28% |

## Being a Good Employer

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

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

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

# Our Progress

This section outlines our activities and progress under the three key strategic directions in our Health System Plan[1]: Promote Health and Wellbeing

## Promote Health and Wellbeing

### Promoting health and wellbeing means:

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

### Māori Health Strategy – Taurite Ora

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

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

Work to date on implementing Taurite Ora is outlined below.

### Increasing our Māori Workforce

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

[1] Our Health System Plan is located on the DHB website. https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-health-system-plan-2030.pdf

## Pro-Equity Commissioning

We have developed and begun to implement a Pro-Equity People Based Commissioning Policy, which is focussed on commissioning activities and services to disrupt inequities. The policy includes a focus on achieving equitable access and outcomes for Māori, Pacific, and disabled populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we intensify resources and support for those who need us the most, and simplify for those who need us the least. In line with this approach, we have begun to redistribute resources to community NGOs and services targeted at improving equity. Implementing the Pro-Equity Commissioning across both DHBs has helped us provide plans for integrated locality-based networks in primary and community care.

## Agreement recognising Te Tiriti o Waitangi

We work closely with Māori to achieve jointly agreed goals and we value partnership with Iwi. Te Upoko O Te Ika Māori Council has represented Hauora Māori and contributed to planning and developing our services across HVDHB and CCDHB. Last year an agreement was signed between Te Rūnanganui o Āti Awa ki te Upoko o te Ika a Maui Inc, Te Rūnanga o Ngāti Toa Rangatira, and the two DHBs. This agreement recognises the two parties to Te Tiriti o Waitangi – iwi/hapū Māori, in this case represented by mana whenua, and the Crown as represented by the two DHBs. Te Whanganui a Tara Mana Whenua Health Working Group is established under the partnership agreement and has helped us implement initiatives and projects to reduce the health inequities that exist between Māori and non-Māori within the rohe of Ngāti Toa and Āti Awa ki te Upoko o Te Ika a Māui.

## Mothers, babies, children and young people

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

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

We recognise the need to lift our childhood immunisation rates, particularly for tamariki Māori. In 2021, we commissioned a review of the 2DHB immunisation service delivery model, which has provided recommendations to deliver a more integrated, whānau-centred immunisation delivery model across all immunisation programmes. The recommendation will be implemented over the next year.

## Maternity and Neonatal Health

Our 2DHB[2] Maternity and Neonatal Health System Plan was endorsed by the 2DHB Board in December 2021. The System Plan will deliver a whole-of-system approach to improving maternal and neonatal care for all families in our region, with a pro-equity focus on actions to improve outcomes for Māori and Pacific whānau and families, and disabled women and babies with impairments.

We have contributed to the establishment of the Hapū Whānau maternity hub in Porirua being led by Ngāti Toa to deliver community-based maternal care for Hapū whānau. In addition, we contracted a provider to

[2] 2DHB refers to the two District Health Boards, Capital & Coast District Health Board and Hutt Valley District Health Board.

develop a 3DHB web-based resource on the Pēpē Ora website that provides information on DHB and community maternity and neonatal services, to improve access to these services and enable families to make informed decisions about their care.

## Bowel, breast, and cervical screening

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

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

## Mental Health and Addictions Strategy

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

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

## Improving sustainability and reducing carbon emissions

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

## Oral health services to children

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

## 3DHB[3] Sub-regional Pacific Strategic Advisory Group

Pacific Health directorate works with our Pacific communities to improve health outcomes and reduce inequalities experienced by Pacific peoples. We have a 3DHB Sub-regional Pacific Strategic Advisory Group that provides strategic support, advice and advocacy regarding Pacific people's health outcomes. Through extensive consultation with our Pacific communities, in 2020 we developed a Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 to 2025, which has guided the development of pro-equity actions to improve Pacific health and wellbeing. We have directed additional resources to embed learnings from the Pacific COVID-19 response and enhance our community services to Pacific peoples. New services being commissioned include a Pacific community nursing service in Wellington, health promotion and service information targeted to Pacific communities, affordable after hour's health care for Pacific people, a culturally responsive Stroke prevention and treatment service, and additional Pacific disability support service capacity.

## 3DHB Disability working group

Our 3DHB disability working group is highly regarded amongst the local disability community. The group helps us to apply a disability perspective "lens" into the development and delivery of health services for equitable outcomes. We are working with healthcare providers to rethink what 'access' means for disabled people. Commissioned services are now reporting on their actions to improve access for disabled people in their services. This mechanism has encouraged collaboration with providers to make our services more accessible for disabled people in the community.

## Progress Measures to Promote Health and Wellbeing

| Criteria Description | Rating | Rating System |
|---|---|---|
| Achieved | At or above target | |
| Not Achieved, but progress made | ≤10% of target | |
| Not Achieved | ≥ 10.1% of target | |
| Demand-drive measure | No rating applied | |

| Progress Measure | Baseline | Target 2021/22 | Actual 2021/22 | Trends – including equity gap | |
|---|---|---|---|---|---|
| Amenable mortality rates (rate per 100,000) | 2017:<br>Māori: 120.6<br>Pacific: *<br>Total: 68.0 | 2018:<br>Māori: 98.9<br>Pacific: 158.7 | 2018:<br>Māori: 132.9<br>Pacific: 166.3<br>Total: 68.0 | Māori | |
| | | | | Pacific | |
| Babies breastfed at 3 months | 2020/21<br>Māori: 56%<br>Pacific: 40%<br>Total: 62% | ≥70% | Māori:53%<br>Pacific:46%<br>Total:63% | Māori | |
| | | | | Pacific | |
| | | | | Total | |
| Children fully immunized at 2 years | 2020/21<br>Māori: 81%<br>Pacific: 90%<br>Total: 91% | ≥95% | Māori:73%<br>Pacific:84%<br>Total:88% | Māori | |
| | | | | Pacific | |
| | | | | Total | |
| Children with no cavities at 5 years of age | 2020:<br>Māori: 53%<br>Pacific: 47%<br>Total: 71% | ≥71% | 2021<br>Māori:50%<br>Pacific:41%<br>Total:70% | Māori | |
| | | | | Pacific | |
| | | | | Total | |

[3] 3DHB refers to three District Health Boards; Capital and Coast DHB, Hutt Valley DHB, and Wairarapa DHB.

| | | | | | |
|---|---|---|---|---|---|
| Average number Diseased, Missing and Filled Teeth (DMFT) at age 5 | 2020:<br>Māori: 2.00<br>Pacific: 2.30<br>Total: 1.15 | Reducing Trend | 2021<br>Māori: 2.23<br>Pacific: 2.98<br>Total: 1.23 | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🟠 |
| Reduced burden of tooth decay at year 8 (DMFT) | 2020:<br>Māori: 0.73<br>Pacific: 0.90<br>Total: 0.51 | Reducing Trend | 2021<br>Māori: 0.73<br>Pacific: 0.91<br>Total: 0.50 | Māori | 🟠 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🟢 |
| Women screened for cervical cancer | 2020/21<br>Māori 66%<br>Pacific 62%<br>Total : 74% | ≥80% | Māori:60%<br>Pacific:58%<br>Total:71% | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🟠 |
| Women screened for breast cancer | 2020/21<br>Māori 66%<br>Pacific 65%<br>Total : 71% | ≥70% | Māori:65%<br>Pacific:63%<br>Total:72% | Māori | 🟠 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🟢 |
| PHO enrolled patients who smoke and are offered help to quit | 2020/21<br>Māori 64%<br>Pacific 70%<br>Total : 66% | ≥90% | Māori: 41%<br>Pacific: 40%<br>Total: 41% | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🔴 |
| Hospital patients who smoke and are offered help to quit | 2020/21<br>Māori 81%<br>Pacific 84%<br>Total : 80% | ≥95% | Māori: 76%<br>Pacific: 80%<br>Total: 74% | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🔴 |
| % of babies living in Smokefree homes at 6 week check | 2020<br>Māori 43%<br>Pacific 56%<br>Total : 60% | Improved performance | Māori:35%<br>Pacific:37%<br>Total:57% | Māori | 🟠 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🟠 |
| % of eligible population having cardiovascular disease (CVD) risk assessment in last 5 years | 2020/21<br>Māori: 73%<br>Pacific: 74%<br>Total: 72% | ≥90% | Māori:71%<br>Pacific:73%<br>Total:70% | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🔴 |

*Suppressed due to actual volume being below 30

# People-Focused Services in the Community

### People-focussed services in the community means:

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

## Three Year Plan for Planned Care Services

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

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

## Health Care Homes

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

Although implementation of the HCH model is in its infancy in New Zealand, evaluation of the model is promising and suggests that acute need is being prevented or successfully dealt with out of hospital by HCH practices.

One of the key aims behind the Health Care Home is to support practices to create more capacity to better manage growing patient demand, and to more proactively manage those patients with complex needs alongside community services teams, who may also be high users of acute hospital services. The HCH model includes a telephone triage service, where patients calling the practices may talk directly to a registered health professional, typically a general practitioner. Talking to a health professional means some issues may

be resolved over the phone, saving people the time and effort of going to the practice. The HCH practices also offer extended opening hours, increasing the opportunity for patients to see their doctor outside normal working hours. They also use patient portals, so patients can go online to order repeat prescriptions, book appointments, check results and message their GP or nurse directly. HCH practices also offer telehealth options as alternatives to face-to-face appointments where appropriate, making healthcare more affordable and accessible.

### Kāpiti

The Kāpiti Community Health Network (CHN) is a network of health providers who are supported to coordinate and organise health service delivery to achieve equity and better meet the needs of the Kāpiti population. In partnership with Te Ātiawa Ki Whakarongotai and Tū Ora Compass Health, the Kāpiti Community Health Network has continued to develop and strengthen relationships. The Kāpiti Network has a well-developed work programme and this is progressing to plan. The initiatives supported include a coordinated care and outreach clinic for people with complex care needs, the Kāpiti Ambulance Diversion initiative (making urgent and after hours primary health care more accessible, support for a new musculoskeletal clinic in Kāpiti, coordinating a networked community pharmacy initiative for patients with complex needs, and Enabling Good Lives workshops to build actions for change for the disabled community in Kāpiti. A key development in the last six months has been the work undertaken to develop a local outcomes framework for Kāpiti recognising the importance of using shared outcomes to inform priorities and monitor progress.

We are partnering with Te Ātiawa on the next stage of this work, transitioning the Kāpiti Community Health network into a Locality, developing a locality plan underpinned by strong locality partnerships, as well as continuing to strengthen the provider network(s).

### Providing better support for people experiencing family violence

We commissioned ThinkPlace to help us design better support for health professionals and people with lived experience of family violence, post-disclosure in our hospitals. The design team included Equity Leads for Hauora Māori, Pacific Health and Disability.

A report has been completed with recommendations to improve support to victim/survivors. Recommendations include extending availability of social work after hours at Wellington Regional Hospital and Hutt Hospital, and establishing a new District-wide Family Violence specialist social worker role to lead improvements in consistent, culturally responsive, helpful responses to disclosures.

We have also worked with the People and Culture team to develop a new staff policy for employees who are experiencing family violence. The policy will be released with a suite of education and messaging to support the new policy.

## Progress Measures to People-Focused Services in the Community

| Criteria Description | Rating | Rating System |
|---|---|---|
| Achieved | At or above target | ● |
| Not Achieved, but progress made | ≤10% of target | ● |
| Not Achieved | ≥ 10.1% of target | ● |
| Demand-drive measure | No rating applied | ● |

| Progress Measure | Baseline | Target 2021/22 | Actual 2021/22 | Trends – including equity gap | |
|---|---|---|---|---|---|
| ASH Rates (avoidable hospitalisations) for 0-4 years (rate per 100,000) | Māori: 5437<br>Pacific: 7179<br>Total: 4957 | Māori: 4916<br>Pacific: 7162 | Māori: 6657<br>Pacific: 9000<br>Total: 5484 | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🔴 |
| ASH Rates (avoidable hospitalisations) for 45-64 years | Māori: 5671<br>Pacific: 6887<br>Total: 2966 | ≤2655 | Māori: 5456<br>Pacific: 6460<br>Total: 3119 | Māori | 🔴 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🔴 |
| Well-managed diabetes in primary care | Māori: 51%<br>Pacific: 49%<br>Total: 61% | ≥60% | Māori: 55%<br>Pacific: 51%<br>Total: 66% | Māori | 🟠 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🟢 |
| Acute hospital bed days per 1,000 | Māori: 545<br>Pacific: 594<br>Total: 350 | Reducing Trend | Māori:444<br>Pacific:568<br>Total:321 | Māori | 🟢 |
| | | | | Pacific | 🟢 |
| | | | | Total | 🟢 |
| Acute readmissions to hospital | Māori: 14%<br>Pacific: 13%<br>Total: 13% | Reducing Trend | Māori: 14%<br>Pacific: 12%<br>Total: 13% | Māori | 🟠 |
| | | | | Pacific | 🟢 |
| | | | | Total | 🟠 |
| Acute readmissions to hospital age 0-4 | Māori: 11.0%<br>Pacific: 11.8%<br>Total: 11.0% | Reducing Trend | Māori: 14%<br>Pacific: 12%<br>Total: 14% | Māori | 🔴 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🔴 |
| PHO enrolment | Māori: 93%<br>Pacific: 103%<br>Total: 97% | 95% | Māori: 84%<br>Pacific: 94%<br>Total: 92% | Māori | 🔴 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🟠 |
| Newborn PHO enrolment | 91% | Increasing Trend | 91% | Total | 🟠 |
| Proportion of dispensed asthma medications that were a preventer rather than reliever | 65% | Increasing Trend | 66% | Total | 🟢 |
| Cancer mortality | 2017<br>483 | Decreasing Trend | 2018:<br>509 | Total | 🔴 |
| Decrease in avoidable hospitalisation for cardiovascular disease | Māori 464<br>Pacific 446<br>Total : 4409 | Decreasing Trend | Māori: 500<br>Pacific: 483<br>Total: 4869 | Māori | 🟠 |
| | | | | Pacific | 🟠 |
| | | | | Total | 🔴 |
| Decrease in avoidable hospitalization for Chronic Obstructive Respiratory Disease | Māori: 97<br>Pacific: 55<br>Total: 507 | Decreasing Trend | Māori: 93<br>Pacific: 76<br>Total: 489 | Māori | 🟢 |
| | | | | Pacific | 🔴 |
| | | | | Total | 🟢 |

# Timely Effective Care that Improves Health Outcomes

**Timely effective care that improves health outcomes means:**

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

## 2DHB Work Programme

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

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

## Five Communities, One Vision

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

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

## Making the most of a limited resource

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

## Planning together

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

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

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

## Te Wao Nui - Child Health Service

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

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

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

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

## New procedure suite to increase surgical capacity

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

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

## Care Capacity Demand Management

We have advanced the Care Capacity Demand Management (CCDM) programme in partnership with the New Zealand Nurses Organisation, the Public Service Association and the Safe Staffing Healthy Workplaces Unit. The CCDM programme helps the DHB match the capacity to care with patient demand, and supports staff to provide high-quality and safe care to our patients, while improving the work environment and organisational

efficiency. CCDM enables the DHB to invest effectively by getting an accurate forecast of patient demand, removing as much variability as possible from the system, and matching the required resources as closely as possible (in staff numbers and skill mix).

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

### Community Mental Health and Addiction Project

This project will implement a new integrated and collaborative way of working to meet the needs of local communities. Five key changes, which will be underpinned by a pro-equity approach to commissioning:

1. Establishment of locality focussed mental health and wellbeing hubs
2. Transforming community mental health teams into integrated locality mental health and wellbeing teams
3. Transforming the pathways between primary care and the secondary mental health and addiction system
4. Building peer support capability into service delivery
5. Creating mental health and addiction locality network leadership.

Once the consultation process is completed, an implementation plan outlining the change programme for the next 12 months will be finalised. These recommendations and the implementation plan will feed into work to implement the Porirua locality prototype, which is part of the Community & Commissioning work stream.

### Progress Measures to Timely Effective Care that Improves Health Outcomes

| Criteria Description | Rating | Rating System |
|---|---|---|
| Achieved | At or above target | ● |
| Not Achieved, but progress made | ≤10% of target | ● |
| Not Achieved | ≥ 10.1% of target | ● |
| Demand-drive measure | No rating applied | ● |

| Progress Measure | Baseline 2020/21 | Target 2021/22 | Actual 2021/22 | Trends – including equity gap | |
|---|---|---|---|---|---|
| Length of inpatient stay in hospital (average days) | Acute: 2.7<br>Elective: 1.09 | Acute: ≤2.4<br>Elective: ≤1.5 | Acute: 2.4<br>Elective: 1.5 | Acute | ● |
| | | | | Elective | ● |
| Time patient is in ED (6 hour discharge or transfer) | 66% | 95% | 56% | ● | |
| | 3 Weeks: 73% | 3 weeks: 80% | 3 weeks: 89% | 3 weeks | ● |

| | | | | | |
|---|---|---|---|---|---|
| Waiting time to access Mental Health/ Addiction Services.<br>(Referred and seen within 3 and 8 weeks) | 8 Weeks: 92% | 8 Weeks: 95% | 8 weeks: 94% | 8 weeks |  |
| Readmission to Mental Health services within 28 days | 10.6% | <9% | 12.6% |  | |
| Access to electives | 106.4% | 100% | 100% |  | |
| Percentage of patients receiving their first cancer treatment within 31 days of decision to treat | 90% | ≥85% | 86% |  | |
| Age of entry into age Residential Care | 84 | Increasing Trend | 85 |  | |

# Statement of Performance

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

We have a particular focus on improving health outcomes and improving health equity for Māori and Pacific peoples. Therefore, a range of measures are used to monitor progress in improving the health and wellbeing of 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 Māori and Pacific populations.

## Output Classes contributing to desired outcomes

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

The four Output Classes and their related services are:

***Prevention Services***
- Health protection and monitoring services
- Health promotion services
- Immunisation services
- Smoking cessation services
- Screening services

***Early Detection and Management services***
- Primary care (GP) services
- Oral health services
- Pharmacy services

***Intensive Treatment and Assessment Services***
- Medical and surgical services
- Cancer services
- Mental Health and Addiction services

***Rehabilitation and Support services***
- Disability services
- Health of older people services

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

## Interpreting our performance

### Types of measures

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

| Criteria Description | Rating | Rating System |
|---|---|---|
| Achieved | At or above target | ● |
| Not Achieved, but progress made | ≤10% of target | ● |
| Not Achieved | ≥ 10.1% of target | ● |
| Demand-drive measure | No rating applied | ● |
| No data available | No rating applied | ○ |

### Standardisation, targets and estimates

In some cases the results are standardized for population characteristics, such as age, to allow meaningful comparison between different populations, for example, to compare between two or more districts that may have different age group profiles. Some measures reflect our pursuit of a target, such as aiming to screen 70% or more eligible women for breast cancer in the last two years. Other measures are more simply an estimate of the volume of a service rather than a target and are included to provide an indication of the extent of services funded or undertaken by the DHB, such as the number of prescription items filled in one year. We report on these measures by commenting if the volume is in line with our estimate, lower or higher than estimated.

## Output Class 1: Prevention Services

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

| Immunisation | | | | | |
|---|---|---|---|---|---|
| These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of eight month olds fully vaccinated | Māori | 82% | ≥95% | 78% | ● |
| | Pacific | 90% | | 76% | ● |
| | Non-Māori, Non-Pacific | 94% | | 95% | ● |
| | Total | 92% | | 90% | ● |
| % of two year olds fully immunised | Māori | 81% | ≥95% | 73% | ● |
| | Pacific | 90% | | 84% | ● |
| | Non-Māori, Non-Pacific | 94% | | 93% | ● |
| | Total | 91% | | 88% | ● |
| % of five year olds fully immunised | Māori | 84% | ≥95% | 77% | ● |
| | Pacific | 83% | | 80% | ● |
| | Non-Māori, Non-Pacific | 89% | | 90% | ● |
| | Total | 87% | | 87% | ● |
| | Māori | 73% | ≥70% | 70% | ● |

| | | | | | |
|---|---|---|---|---|---|
| % of children aged 11 years provided Boostrix vaccination | Pacific | 57% | | 70% | ● |
| | Non-Māori, Non-Pacific | 73% | | 77% | ● |
| | Total | 71% | | 75% | ● |
| % of children (girls and boys aged 12 years) provided HPV vaccination (*one dose) | Māori | 74% | ≥75% | 73% | ● |
| | Pacific | 75% | | 72% | ● |
| | Non-Māori, Non-Pacific | 79% | | 78% | ● |
| | Total | 77% | | 76% | ● |
| % of population aged 65 years and over immunised against influenza *2022 result | Māori | 59% | ≥75% | 71% | ● |
| | Pacific | 75% | | 69% | ● |
| | Non-Māori, Non-Pacific | 64% | | 74% | ● |
| | Total | 64% | | 74% | ● |

| **Health Promotion Services** | | | | | |
|---|---|---|---|---|---|
| These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of infants fully or exclusively breastfed at 3 months | Māori | 56% | ≥70% | 53% | ● |
| | Pacific | 40% | | 46% | ● |
| | Non-Māori, Non-Pacific | 66% | | 66% | ● |
| | Total | 62% | | 63% | ● |
| % of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention | Māori | 86% | ≥95% | 88% | ● |
| | Pacific | 91% | | 91% | ● |
| | Non-Māori, Non-Pacific | 84% | | 87% | ● |
| | Total | 87% | | 88% | ● |
| % of PHO-enrolled patients who have quit smoking in the last 12 months | Māori | 8% | | Data no longer reported | ○ |
| | Pacific | 9% | | | ○ |
| | Non-Māori, Non-Pacific | 13% | | | ○ |
| | Total | 11% | | | ○ |
| % of PHO-enrolled patients who smoke and have been offered help to quit by a health practitioner in the last 15 months | Māori | 64% | ≥90% | 41% | ● |
| | Pacific | 70% | | 40% | ● |
| | Non-Māori, Non-Pacific | 65% | | 41% | ● |
| | Total | 66% | | 41% | ● |
| % of hospitalised smokers offered advice to help quit | Māori | 81% | ≥95% | 76% | ● |
| | Pacific | 84% | | 80% | ● |
| | Non-Māori, Non-Pacific | 78% | | 72% | ● |
| | Total | 80% | | 74% | ● |

| | | | | | |
|---|---|---|---|---|---|
| % of pregnant women who identify as smokers upon registration with a DHB midwife or Lead Maternity Carer offered advice to quit | Māori | 100% | ≥90% | 89% | ● |
| | Total | 100% | | 87% | ● |

| Population-based Screening Services | | | | | |
|---|---|---|---|---|---|
| These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment.<br>Success is reflected by engagement in programmes and high coverage rates across the population. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of eligible children receiving a B4 School Check | Māori | 69% | ≥90% | 43% | ● |
| | Pacific | 78% | | 49% | ● |
| | Non-Māori, Non-Pacific | 95% | | 55% | ● |
| | Total | 88% | | 52% | ● |
| % of eligible women (25-69 years old) having cervical screening in the last 3 years | Māori | 66% | ≥80% | 60% | ● |
| | Pacific | 62% | | 58% | ● |
| | Non-Māori, Non-Pacific | 76% | | 72% | ● |
| | Total | 74% | | 71% | ● |
| % of eligible women (50-69 years old) having breast cancer screening in the last 2 years | Māori | 66% | ≥70% | 65% | ● |
| | Pacific | 65% | | 63% | ● |
| | Non-Māori, Non-Pacific | 72% | | 73% | ● |
| | Total | 71% | | 72% | ● |

| Oral Health Services | | | | | |
|---|---|---|---|---|---|
| These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of children under 5 years enrolled in DHB-funded dental services | Māori | 70% | ≥95% | 71% | ● |
| | Pacific | 78% | | 88% | ● |
| | Non-Māori, Non-Pacific | 98% | | 96% | ● |
| | Total | 90% | | 90% | ● |
| % of children caries free at 5 years | Māori | 53% | ≥71% | 50% | ● |
| | Pacific | 47% | | 41% | ● |
| | Non-Māori, Non-Pacific | 78% | | 77% | ● |
| | Total | 71% | | 70% | ● |
| Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 | Māori | 0.73 | ≤0.43 | 0.73 | ● |
| | Pacific | 0.90 | | 0.91 | ● |
| | Non-Māori, Non-Pacific | 0.41 | | 0.39 | ● |
| | Total | 0.51 | | 0.50 | ● |
| % of children (0-12) enrolled in DHB oral health services overdue for their scheduled examinations | Māori | 24% | ≤10% | 38% | ● |
| | Pacific | 19% | | 33% | ● |
| | Non-Māori, Non-Pacific | 24% | | 32% | ● |
| | Total | 24% | | 33% | ● |
| % of adolescents accessing DHB-funded dental services | Māori | 58% | ≥85% | 69% | ● |
| | Pacific | 66% | | 74% | ● |
| | Non-Māori, Non-Pacific | 69% | | 83% | ● |
| | Total | 66% | | 79% | ● |

## Output Class 2: Early Detection and Management

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

| Primary Care Services | | | | | |
|---|---|---|---|---|---|
| These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of newborn enrolment with general practice by three months of age | Māori | 72% | ≥85% | 59% | ● |
| | Pacific | 81% | | 102% | ● |
| | Non-Māori, Non-Pacific | 98% | | 98% | ● |
| | Total | 91% | | 91% | ● |
| % of the DHB-domiciled population that is enrolled in a PHO | Māori | 93% | ≥95% | 84% | ● |
| | Pacific | 103% | | 94% | ● |
| | Non-Māori, Non-Pacific | 98% | | 93% | ● |
| | Total | 97% | | 92% | ● |
| % 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 | 51% | ≥65% | 55% | ● |
| | Pacific | 49% | | 51% | ● |
| | Non-Māori, Non-Pacific | 65% | | 73% | ● |
| | Total | 61% | | 66% | ● |
| Avoidable hospital admission rate for children aged 0-4 (per 100,000 people) | Māori | 5,437 | 4,916 | 6,657 | ● |
| | Pacific | 7,179 | 7,162 | 9,000 | ● |
| | Non-Māori, Non-Pacific | 4,455 | 3,394 | 4,613 | ● |
| | Total | 4,957 | 4,859 | 5,484 | ● |
| Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people) | Māori | 5,671 | ≤2,655 | 5,456 | ● |
| | Pacific | 6,887 | | 6,460 | ● |
| | Non-Māori, Non-Pacific | 2,395 | | 2,602 | ● |
| | Total | 2,966 | | 3,119 | ● |
| Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years age | Māori | 7.6 | ≤7.2 | 12.2 | ● |
| | Pacific | 7.0 | | 11.6 | ● |
| | Non-Māori, Non-Pacific | 3.7 | | 4.7 | ● |
| | Total | 4.8 | | 6.9 | ● |
| Primary Care Patient Experience scores | | | | | No Longer Reported* |

*The Primary Care Patient Experience survey was redesigned in 2021/22. The questions used for this indicator are no longer published. Performance for 2021/22 cannot be assessed.

| Pharmacy Services | | | | | |
|---|---|---|---|---|---|
| These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| Age-standardised rate of initial prescription items dispensed per 1,000 population | Māori | 7,795 | Demand Driven | 7,764 | ● |
| | Pacific | 8,232 | | 8,532 | ● |
| | Non-Māori, Non-Pacific | 6,746 | | 6,827 | ● |
| | Total | 8,417 | | 8,551 | ● |
| Patients registered with CPAMS per 1,000 people dispensed warfarin | Māori | 282 | ≥159 | 311 | ● |
| | Pacific | 244 | | 271 | ● |
| | Non-Māori, Non-Pacific | 233 | | 295 | ● |
| | Total | 240 | | 294 | ● |
| LTC registrations per 1,000 people | Māori | 19 | ≥21 | 21 | ● |
| | Pacific | 30 | | 35 | ● |
| | Non-Māori, Non-Pacific | 25 | | 25 | ● |
| | Total | 24 | | 25 | ● |

| Maternity Services | | | | | |
|---|---|---|---|---|---|
| These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of maternity deliveries made in Primary Birthing Units | Māori | 18% | ≥10% | Data no longer collected | ○ |
| | Pacific | 17% | | | ○ |
| | Non-Māori, Non-Pacific | 6% | | | ○ |
| | Total | 9% | | | ○ |

## Output Class 3: Intensive Assessment and Treatment

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

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

| Acute and Urgent Services | | | | | |
|---|---|---|---|---|---|
| These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| Number of POACs delivered in community settings across 2DHB | Total | 529 | ≥1,111 | 1,659 | ● |
| Number of Community Acute Response Packages provided in CCDHB | Total | 1,319 | ≥279 | 355 | ● |
| Number of zero-fee consultations at after-hours services by children under 14 years | Māori | 2,510 | ≥2,849 | 2,913 | ● |
| | Pacific | 2,446 | ≥2,837 | 2,974 | ● |
| | Non-Māori, Non-Pacific | 8,761 | ≥10,432 | 11,173 | ● |
| | Total | 13,717 | ≥16,118 | 17,060 | ● |
| Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals | Māori | 206 | ≤143 | 165 | ● |
| | Pacific | 220 | | 184 | ● |
| | Non-Māori, Non-Pacific | 149 | | 123 | ● |
| | Total | 158 | | 131 | ● |
| % of patients admitted, discharged or transferred from ED within 6 hours | Māori | 67% | ≥95% | 63% | ● |
| | Pacific | 64% | | 60% | ● |
| | Non-Māori, Non-Pacific | 66% | | 62% | ● |
| | Total | 66% | | 62% | ● |
| Standardised acute readmission rate within 28 days | Total | 12.8% | 12.8% | 12.9% | ● |

| Elective and Arranged Services | | | | | |
|---|---|---|---|---|---|
| These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| Number of planned care interventions – inpatient surgical discharges | Total | 16,563 | 10,718 | 8,751 | ● |
| Number of planned care interventions – minor procedures | Total | New Measure | 4,865 | 6,521 | ● |
| % of patients given a commitment to treatment but not treated within four months | Total | 12.6% | 0% | 26% | ● |
| % of "DNA" (did not attend) appointments for FSA (first specialist appointments) | Māori | 13.8% | Planned Care Funding Schedule 2021/22 | 14.7% | ● |
| | Pacific | 13.8% | | 15.3% | ● |
| | Non-Māori, Non-Pacific | 3.9% | | 4.2% | ● |
| | Total | 6.0% | | 6.5% | ● |
| % of patients waiting longer than four months for their first specialist assessment | Total | 3.3% | 0% | 17% | ● |
| % 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 | Total | 87% | ≥90% | 84% | ● |
| % of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat | Total | 90% | ≥85% | 86% | ● |

| Mental Health, addictions and wellbeing services | | | | | | |
|---|---|---|---|---|---|---|
| These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service. | | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| Mental Health Access Rates | | Māori | New Measure | ≥3% | 6.7% | ● |
| | | Pacific | New Measure | | 3.7% | ● |
| | | Non-Māori, Non-Pacific | New Measure | | 3.0% | ● |
| | | Total | New Measure | | 3.5% | ● |
| % of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks: | Mental Health Services | Māori | 81% | ≥95% | 92% | ● |
| | | Pacific | 90% | | 89% | ● |
| | | Non-Māori, Non-Pacific | 73% | | 77% | ● |
| | | Total | 76% | | 82% | ● |
| | Addiction Services | Māori | 98% | | 95% | ● |
| | | Pacific | 97% | | 100% | ● |
| | | Non-Māori, Non-Pacific | 97% | | 100% | ● |
| | | Total | 97% | | 97% | ● |
| % of people admitted to an acute mental health inpatient service that were seen by mental health community team: | 7 days prior to the day of admission | Māori | 72% | ≥75% | 57% | ● |
| | | Pacific | 73% | | 61% | ● |
| | | Non-Māori, Non-Pacific | 78% | | 73% | ● |
| | | Total | 75% | | 66% | ● |
| | 7 days following the day of discharge | Māori | 82% | ≥90% | 68% | ● |
| | | Pacific | 83% | | 73% | ● |
| | | Non-Māori, Non-Pacific | 82% | | 75% | ● |
| | | Total | 82% | | 73% | ● |
| % of clients with a transition (discharge) plan | | Community | New Measure | ≥95% | 58% | ● |
| | | Inpatient | New Measure | | 77% | ● |
| % of clients with a wellness plan | | Community | 47% | ≥95% | 50% | ● |
| Rate of Māori under the Mental Health Act: Section 29 community treatment orders | | Māori | 582 | Reduce by 10% | 658 | ● |

| Quality, safety, and patient experience | | | | | |
|---|---|---|---|---|---|
| These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| Rate of in-hospital falls with fractured neck of femur, per 100,000 admissions | Total | 6.6 | ≤5 | 7.2 | ● |
| Rate of staphylococcus aureus bacteraemia, per 1,000 bed days | Total | 0.18 | ≤0.1 | 0.23 | ● |
| Rate of surgical site infections for hip and knee operations, per 100 procedures | Total | 1.2 | 0 | 1.5 | ● |
| Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, per 1,000 admissions | Total | 1.1 | ≤1.2 | 0.9 | ● |
| Rate of rapid response escalations, per 1000 admissions | Total | 68 | ≤47 | 52 | ● |
| Rates of deep vein thrombosis/pulmonary embolus | Total | 58 | ≤48 | 24 | ● |
| The weighted average score in the Inpatient Experience Survey by domain | | | | | No Longer Reported* |

*The Inpatient Experience survey was redesigned and the data used for this indicator is no longer published. Performance for 2021/22 cannot be assessed.

## Output Class 4: Rehabilitation and Support

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

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

| Disability Support Services | | | | | |
|---|---|---|---|---|---|
| These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of hospital staff that have completed the Disability Responsiveness eLearning Module | Total | 30% | ≥80% | 27% | 🔴 |

| Home-based and Community Support Services | | | | | |
|---|---|---|---|---|---|
| These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event. | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of people 75+ living in their own home | Māori | 91% | ≥94% | 94% | 🟢 |
| | Pacific | 93% | | 94% | 🟢 |
| | Non-Māori, Non-Pacific | 91% | | 92% | 🟠 |
| | Total | 91% | | 92% | 🟠 |
| Acute bed day rate per 1000 for people 75+ | Māori | 1,850 | ≤1,670 | 1,715 | 🟠 |
| | Pacific | 2,096 | | 2,573 | 🔴 |
| | Non-Māori, Non-Pacific | 1,750 | | 1,600 | 🟢 |
| | Total | 1,764 | | 1,637 | 🟢 |
| | Māori | 10.4% | ≤12.3 | 13.5% | 🟠 |

| | | | | | |
|---|---|---|---|---|---|
| Standardised acute readmission rate for people 75+ | Pacific | 11.1% | | 13.1% | ● |
| | Non-Māori, Non-Pacific | 11.5% | | 11.6% | ● |
| | Total | 11.4% | | 11.8% | ● |
| Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+ | Māori | * | ≤2.6 | * | ○ |
| | Pacific | * | | * | ○ |
| | Non-Māori, Non-Pacific | * | | * | ○ |
| | Total | 1.98 | | 2.0 | ● |

* Data is not reported by ethnicity. Performance for 2021/22 cannot be assessed.

| Aged Residential Care Services | | | | | |
|---|---|---|---|---|---|
| With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care | Target Group | CCDHB Baseline 2020/21 | CCDHB Target 2021/22 | CCDHB 2021/22 Result | Achievement |
| % of residential care providers meeting four year certification standards | Total | 97% | ≥95% | 60% | ● |

## 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 assets have been excluded for reporting due to their lesser significance (criticality) to delivering our core services.

| Property asset performance measures | | | |
|---|---|---|---|
| **Measure Portfolio: Property** | **Indicator** | **2021/22 Target?** | **2021/22 Outcome** |
| % of buildings with a condition rating equal to or better than 2 | Condition | ≥60% | 42% |
| M2 of buildings that are not earthquake prone or risk*[2] | Condition | ≥90% | 87.2% |
| % occupancy rate of our buildings | Utilisation | ≥97% | 97.8% |
| M2 of buildings that meet current and foreseeable service delivery requirements (>10 years - A) *[1] | Functionality | ≥41% | 39.9 % |
| M2 of buildings that meet current service delivery requirements but may fall short in the foreseeable future (5–10 years - B) *[1] | Functionality | ≥45% | 45.6% |

| | | | |
|---|---|---|---|
| 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% | 85.5% |

*[1] Excludes buildings that are vacant and tagged for demolition.
*[2] New earthquake assessments (DSA) for several buildings have impacted this indicator

### Clinical equipment Asset Performance Measures

| Clinical equipment asset performance measures | | | |
|---|---|---|---|
| **Measure Asset portfolio: Clinical equipment (CE)** | **Indicator** | **2021/22 Target** | **2021/22 Outcome** |
| Average of Financial Year – Statutory Compliance<br>Is the asset compliant to AS/NZS 3551 | Functionality | 93% | 85.8% |
| % of CE assets that have passed indicated life expectancy *[1] | Condition | ≥37% | 32% |
| % of CE assets with a physical condition rating equal to or better than three (average) *[2] | Condition | 96% | 97% |
| Time MRI is in operation expressed as a % of available time*[3] | Utilisation | ≥34.5% | 29% |

***1** Over 3400 new assets purchased in the past 18 months primarily due to Covid-19, increasing the overall numbers and reducing the % difference of assets past their life expectancy. The significant increase in assets directly affected Statutory Compliance which is being addressed by increasing FTE.
*[2] 410 Assets have a physical condition that is "poor or very poor" 407 of these assets are Beds, Plinths, Trollies and Stretchers and this has been identified to the capital committee
*[3] Lower outcome impacted by COVID-19 and MIT strikes.

## ICT 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 assets have been excluded for reporting due to their lesser significance (criticality) to delivering our core services.

| ICT asset performance measures | | | |
|---|---|---|---|
| **Measure ICT Asset portfolio** | **Indicator** | **CCDHB Target 2021/22** | **CCDHB 2021/22 Result** |
| % availability of critical systems | Functionality | ≥99.9% | 95.1% |
| % of ICT hardware at a condition level of 'Acceptable' or better (a rating of three or lower) | Condition | ≥80% | 50% |
| % usage of storage data network (SAN) | Utilisation | ≥75% peak | 68% |

# COVID-19 Vaccine Data at 30 June 2022

## Additional performance information: COVID-19 vaccinations and mortality

To determine the vaccination rates of the eligible population and deaths that are attributed to COVID-19 in Aotearoa, we have included additional information for the performance measures pertaining to Implementing the COVID-19 Vaccine Strategy.

## COVID-19 vaccinations

The Ministry of Health uses health service user (HSU) data as the denominator to determine the COVID-19 vaccination coverage. This section describes the percentage of the eligible population who have received the vaccination. Individuals are included in the HSU if they were enrolled with a primary health organisation, or if they received health services in a given calendar year (shown in the box, below).

As of 8 August 2022, there are two versions of the HSU available for determining COVID-19 vaccination coverage:

**HSU 2021**

People are included if they were:

- alive on 31 December 2021
- enrolled with a primary health organisation or received health services in the 2021 calendar year.

**HSU 2020**

People are included if they were:

- alive on 1 July 2020,
- enrolled with a primary health organisation or received health services in the 2020 calendar year.

During 2021/22, the Ministry reported the COVID-19 vaccination coverage using HSU 2020. This information was routinely referenced publicly, as well as in published reports and updates.

On 8 August 2022, the HSU 2020 version was officially superseded by HSU 2021. While the HSU 2021 was not used to report COVID-19 vaccination coverage during 2021/22, it is the preferred version to use in this report as the data is more up to date and relevant.

Any persons who have moved DHB since 30th June 2022 are counted in their current DHB as at 23:59 13/12/2022.

More information on the HSU data, including a comparison against Stats NZ population data, is available in 'Further notes on the HSU datasets', at the end of this section.

## Percentage of the eligible population who have completed their primary COVID-19 vaccination course: Comparing HSU 2021 and HSU 2020

To determine the coverage of the COVID-19 vaccine across the population of Capital and Coast, we have used the HSU 2021 data as the denominator (the figure which the total eligible population vaccinated is divided by). The suitability of the HSU for this purpose was reviewed by Stats NZ, with their findings and recommendations published on 4 August 2022.[4]

Percentages over 100% occur where there are more vaccinated persons than was expected in the HSU 2021 data. This is mostly seen in small populations. As the HSU is a point in time denominator, any movement of persons into or out of an area are not captured and percentages above 100% can occur.

[4] https://www.stats.govt.nz/reports/review-of-health-service-user-population-methodology

**Percentage of the eligible population who have completed their primary COVID-19 vaccination course[5] (HSU 2021 vs HSU 2020)**

| Year[6] | HSU 2021<br>Percentage of the eligible population who have completed their primary course | HSU 2020<br>Percentage of the eligible population who have completed their primary course |
|---|---|---|
| 2020/2021 | 8.41% | 8.82% |
| 2021/2022 | 85.26% | 89.35% |
| **Total** | **93.68%** | **98.17%** |

Using HSU 2021 to determine the percentage of the eligible population who have completed their primary course, the coverage is calculated to be 94%, compared with 98% using HSU 2020 as at 30 June 2022.

The difference in the percentage of the eligible population vaccinated using HSU 2021, compared with using HSU 2020, reflects an increase in the number of individuals

interacting with the health system during the 2021 calendar year compared with 2020. This is partly due to the COVID-19 vaccination programme successfully vaccinating individuals who had not engaged with the health system during 2020 and as such, were not captured in HSU 2020. Additionally, it reflects the demographic changes between 1 July 2020 and 31 December 2021. This includes births, deaths and people ageing into the eligible population and migration.

## COVID-19 vaccine doses administered by dose type and year

The counts in the table below measure the number of COVID-19 vaccination doses administered in Capital and Coast during 2021/22 and the prior financial year (2020/21). This information was obtained from the COVID-19 Vaccination and Immunisation Programme (CVIP) database.

**COVID-19 vaccine doses administered by dose type and year (HSU 2020)**

| Year[7] | Primary course | | | | |
|---|---|---|---|---|---|
| | Dose 1 | Dose 2 | Booster 1 | Booster 2 | Total[8] |
| 2020/21 | 29,785 | 22,638 | 0 | 0 | 52,423 |
| 2021/22 | 251,999 | 250,413 | 198,841 | 1,405 | 702,658 |
| **Total** | 281,784 | 273,051 | 198,841 | 1,405 | 755,081 |

By 30 June 2022, a total of 755,081 COVID-19 vaccinations had been administered, of which 93% were administered in 2021/22.

There are two similar but distinct metrics used within the following tables: Doses administered and People vaccinated. Doses administered focuses on vaccination program activities while people vaccinated uses people's vaccination status as the primary measurement. People vaccinated includes vaccinations received overseas and recorded in CIR. Furthermore deceased persons are removed from the people vaccinated counts. Doses administered includes deceased and doesn't include overseas vaccinations. This causes some variation between the two measures and exact comparisons are not feasible.

[5] Individuals who have received dose 1 and dose 2 of the COVID-19 vaccine are considered to have completed their primary course. This definition supersedes the term 'fully vaccinated' reported in our 2020/21 annual report.
[6] Data as at 30 June 2021 for 2020/21 and 30 June 2022 for 2021/22.
[7] Data as at 30 June for each financial year, and respectively covers all vaccination doses administered between 1July-30 June.
[8] Excludes third primary doses administered and any subsequent boosters a person may have received after the second booster vaccination.

## COVID-19 vaccine doses administered by age group

The counts in the table below measure the number of COVID-19 vaccination doses administered by the age group of the individual who received the dose. This information was obtained from the CVIP database.

**COVID-19 vaccine doses administered by age group[9]**

| Age group | Primary course | | | | |
|---|---|---|---|---|---|
| (years)[10] | Dose 1 | Dose 2 | Booster 1 | Booster 2 | Total[11] |
| 0 to 11 | 18,560 | 11,279 | 0 | 0 | 29,839 |
| 12 to 15 | 16,041 | 15,657 | 10 | 0 | 31,708 |
| 16 to 19 | 15,595 | 15,547 | 7,286 | 4 | 38,432 |
| 20 to 24 | 22,943 | 23,147 | 16,638 | 3 | 62,731 |
| 25 to 29 | 22,767 | 23,042 | 18,184 | 9 | 64,002 |
| 30 to 34 | 20,777 | 21,063 | 17,713 | 29 | 59,582 |
| 35 to 39 | 18,620 | 18,807 | 16,173 | 16 | 53,616 |
| 40 to 44 | 18,032 | 18,205 | 16,097 | 38 | 52,372 |
| 45 to 49 | 18,432 | 18,614 | 17,347 | 46 | 54,439 |
| 50 to 54 | 17,644 | 18,070 | 17,679 | 82 | 53,475 |
| 55 to 59 | 15,885 | 16,639 | 16,906 | 109 | 49,539 |
| 60 to 64 | 13,282 | 14,011 | 14,684 | 135 | 42,112 |
| 65 to 69 | 10,484 | 11,310 | 11,929 | 162 | 33,885 |
| 70 to 74 | 8,843 | 9,840 | 10,470 | 234 | 29,387 |
| 75 to 79 | 6,372 | 6,865 | 7,763 | 225 | 21,225 |
| 80 to 84 | 4,316 | 4,658 | 5,267 | 146 | 14,387 |
| 85 to 89 | 2,329 | 2,474 | 2,944 | 91 | 7,838 |
| 90+ | 1,077 | 1,185 | 1,751 | 76 | 4,089 |
| **Total** | 251,999 | 250,413 | 198,841 | 1,405 | 702,658 |

Note 1: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

## COVID-19 people vaccinated by age group

The counts and the percentages in the table below measure the number of people who received COVID-19 vaccination doses during 2021/22. This data was obtained from the CVIP database (broken down by age group), and the percentages calculated using HSU 2021 as the denominator.

Please note, as this table refers to people vaccinated (and the respective percentage of a given demographic per row), it is not comparable to the table above (COVID-19 doses administered by age group).

[9] Data as at 30 June 2022 and covers all vaccination doses administered between 1 July 2021-30 June 2022.
[10] Age groupings in this table reflect the age of the person at the time of the vaccination being administered.
[11] Excludes third primary doses administered to individuals and any subsequent boosters which may have been administered after the second booster vaccination.

**COVID-19 people vaccinated by age group during 2021/22[12]**

| Age group[13] (years) | Partial [14] | | Primary course [15] | | | Booster course | | |
|---|---|---|---|---|---|---|---|---|
| | Partially vaccinated | Partially vaccinated (% eligible) | Completed primary course | Completed primary course (% eligible) | Received first booster (18+) | First booster (% eligible) (18+) | Received second booster (50+) | Received second booster % eligible (50+) |
| 0 to 11 | 15,904 | 38% | 9,834 | 23% | 0 | 0% | 0 | 0% |
| 12 to 15 | 14,103 | 89% | 12,913 | 82% | 0 | 0% | 0 | 0% |
| 16 to 19 | 15,022 | 95% | 14,980 | 95% | 3,983 | 62% | 0 | 0% |
| 20 to 24 | 22,353 | 87% | 22,614 | 88% | 15,757 | 66% | 0 | 0% |
| 25 to 29 | 23,080 | 81% | 23,486 | 82% | 18,255 | 71% | 0 | 0% |
| 30 to 34 | 21,920 | 80% | 22,434 | 82% | 18,081 | 73% | 0 | 0% |
| 35 to 39 | 19,089 | 82% | 19,392 | 83% | 16,299 | 76% | 0 | 0% |
| 40 to 44 | 18,346 | 85% | 18,658 | 86% | 16,269 | 80% | 0 | 0% |
| 45 to 49 | 17,968 | 82% | 18,279 | 83% | 16,860 | 84% | 0 | 0% |
| 50 to 54 | 18,242 | 84% | 18,617 | 86% | 17,892 | 87% | 81 | 5% |
| 55 to 59 | 16,293 | 81% | 16,979 | 84% | 16,941 | 89% | 99 | 6% |
| 60 to 64 | 14,089 | 82% | 14,844 | 86% | 15,260 | 91% | 132 | 8% |
| 65 to 69 | 11,000 | 80% | 11,768 | 85% | 12,326 | 93% | 157 | 12% |
| 70 to 74 | 9,062 | 78% | 10,049 | 86% | 10,624 | 95% | 241 | 21% |
| 75 to 79 | 7,217 | 85% | 7,822 | 92% | 8,435 | 97% | 222 | 24% |
| 80 to 84 | 4,823 | 84% | 5,173 | 90% | 5,634 | 98% | 161 | 25% |
| 85 to 89 | 2,582 | 82% | 2,756 | 87% | 3,116 | 101% | 84 | 19% |
| 90+ | 1,425 | 75% | 1,530 | 81% | 1,977 | 107% | 88 | 19% |
| **Total** | 252,518 | 77% | 252,128 | 77% | 197,709 | 81% | 1,265 | 13% |

[12] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021– 30 June 2022.
[13] Age groupings in this table reflect age of the persons at end of financial year.
[14] Partial vaccination refers to individuals who had received a single one dose of the COVID-19 vaccination (as at 30 June 2022).
[15] Primary course refers to the first two doses of the COVID-19 vaccine (dose 1 and dose 2).

## COVID-19 vaccine doses administered by ethnicity

The counts in the table below measure the number of COVID-19 vaccine doses administered by the ethnicity of the individual who received the dose. This information was obtained from the COVID-19 Vaccination Immunisation Programme database.

**COVID-19 vaccine doses[16] administered by ethnicity[17] (1 July 2021 – 30 June 2022)**

| Ethnicity (Note 1, 2) | Primary course | | | | |
|---|---|---|---|---|---|
| | Dose 1 | Dose 2 | Booster 1 | Booster 2 | Total |
| Asian | 37,606 | 36,698 | 29,496 | 87 | 103,887 |
| European/other | 169,889 | 169,618 | 141,688 | 1,199 | 482,394 |
| Māori | 25,165 | 24,858 | 14,806 | 75 | 64,904 |
| Pacific peoples | 16,979 | 16,870 | 10,612 | 32 | 44,493 |
| Unknown | 2,360 | 2,369 | 2,239 | 12 | 6,980 |
| **Total** | 251,999 | 250,413 | 198,841 | 1,405 | 702,658 |

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2: Some demographic breakdowns appear to show more doses administered for Dose 2 compared to Dose 1. This is due to COVID-19 vaccination doses being administered in the previous financial year (2020/21).

## COVID-19 people vaccinated by ethnicity

The counts in the table below measure the number of people receiving doses (obtained from the COVID-19 Vaccination and Immunisation Programme database).

**COVID-19 people vaccinated by ethnicity during 2021/22[18]**

| Ethnicity (Note 1) | Partially vaccinated (12+) | Partially vaccinated (12+) (% eligible) | Completed Primary Course (12+) | Completed primary course (12+) (%) | Received First Booster (18+) | Received first booster (18+) (% eligible) | Received second booster, 50+ | Received second booster (% eligible, 50+) |
|---|---|---|---|---|---|---|---|---|
| Asian | 34,572 | 84% | 35,068 | 85% | 29,427 | 82% | 64 | 7% |
| Māori | 23,126 | 82% | 23,912 | 84% | 14,708 | 66% | 62 | 8% |
| European /other | 160,676 | 84% | 164,133 | 86% | 140,740 | 85% | 1,102 | 15% |
| Pacific peoples | 15,774 | 78% | 16,504 | 82% | 10,564 | 66% | 26 | 4% |
| Unknown | 2,466 | 78% | 2,677 | 85% | 2,270 | 75% | 11 | 9% |
| **Total** | 236,614 | 83% | 242,294 | 85% | 197,709 | 81% | 1,265 | 13% |

Note 1: Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are

[16] This excludes third primary doses administered and any subsequent boosters a person may have received after a second booster.
[17] Data as at 30 June 2022 and includes all vaccination doses being administered between 1 July 2021 – 30 June 2022.
[18] Data as at 30 June 2022 and includes all people who received COVID-19 vaccinations between 1 July 2021 – 30 June 2022.

prioritised as: Māori, Pacific peoples, Asian, European/other,Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

**COVID-19 people vaccinated by ethnicity from 1 July 2020 to 30 June 2022**

| Ethnicity (Note 1, 2) | Partially Vaccinated 12+ | Partially Vaccinated 12+ % of HSU2021 | Completed Primary Course 12+ | Completed Primary Course 12+ % of HSU2021 | Received First Booster 18+ | Received First Booster 18+ % of Eligible | Received Second Booster 50+ | Received Second Booster % of Eligible (50+) |
|---|---|---|---|---|---|---|---|---|
| Asian | 39,352 | 96% | 39,042 | 95% | 29,430 | 82% | 64 | 7% |
| Māori | 26,424 | 93% | 25,777 | 91% | 14,708 | 66% | 62 | 8% |
| European /other | 181,339 | 95% | 180,077 | 94% | 140,743 | 85% | 1,102 | 15% |
| Pacific peoples | 18,514 | 92% | 18,129 | 90% | 10,564 | 66% | 26 | 4% |
| Unknown | 3,227 | 102% | 3,175 | 101% | 2,270 | 75% | 11 | 9% |
| **Total** | 268,856 | 95% | 266,200 | 94% | 197,715 | 81% | 1,265 | 13% |

Note 1 Ethnicity is based on the prioritised ethnicity classification system. This allocates each individual to a single ethnic group, based on the ethnic group (or groups) they identify with. Where people identify with more than one ethnic group, they are prioritised as: Māori, Pacific peoples, Asian, European/other, Unknown. For example, if a person identifies as being Māori and New Zealand European, the person is counted as Māori in this dataset. 'Unknown' is where a person has not disclosed any ethnicity.

Note 2 Partially Vaccinated counted for 12+ years old (age as at 30-Jun-2022)

Completed Primary Course counted for 12+ years old (age as at 30-Jun-2022)

Rec'd First Booster counted for 18+ years old (age as at 30-Jun-2022)

Rec'd Second Booster counted for 18+ years old (age as at 30-Jun-2022)

50+ age determined as at 30-Jun-2022

Basis of population is HSU2021 for 12+ years old

All counts exclude those who died prior to 30-Jun-2022

## Further notes on the HSU dataset

While the health system uses the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it does not include people who do not use health services.

The HSU is an estimate of the number of people in New Zealand in a given 12-month period, based on information about who used health services in that period. The HSU 2020 was developed and used for the roll-out of the COVID-19 vaccine to calculate the proportion of the eligible population who were vaccinated against COVID-19.

While we use the HSU to determine vaccination coverage within the eligible population, the HSU is not a total population estimate and it is likely to miss highly marginalised groups.

For example, our analysis suggests that groups underrepresented in the HSU include young people aged 15-45 years (men in particular), and people of Asian and Middle Eastern, Latin American and African ethnicities.

There are other datasets that measure the number of people living in New Zealand produced by Stats NZ :[19]

1. Census counts produced every 5 years with a wide range of disaggregations
2. Population estimates (ERP) which include adjustments for people not counted by census:
    a. National population estimates (produced quarterly)
    b. Subnational population estimates (produced every year)
3. Population projections which give an indication of the future size and composition of the population:
    a. Official national and subnational projections
    b. Customised population projections (produced every year by Stats NZ for the Ministry of Health using requested ethnic groupings and DHB areas).

Differences between the HSU and Stats NZ population statistics arise because the population measures are:

- conceptually different – for example, the HSU includes people who may be visitors to New Zealand who used health services during their short stay, but are not in New Zealand long enough (for at least 12 months) for Stats NZ to define as a resident
- derived from different sources – for example, an individual may identify as one ethnicity when registering with a health service and a different ethnicity when completing a census response.

**Stats NZ:**
'The ERP and HSU have different target populations. In principle, the ERP is an estimate of the population usually living (resident) in New Zealand at a point in time, and the HSU is a measure of the population in New Zealand using (or potentially using) the health system at a point in time. For both the ERP and HSU, mean populations over a period of time can be derived from the point in time estimates.' [20]

While Stats NZ is the preferred source of New Zealand population statistics, the HSU is considered by the Ministry of Health to be the best option for estimates of vaccine coverage disclosed above.

The HSU allows for the assignment of the same demographics (location and ethnicity) to people in the numerator (the number of people vaccinated, from the CVIP database) as can be found in the denominator (the HSU dataset).

The HSU is available for every demographic contained in health data, including:

- age
- ethnicity
- DHB
- gender

These can be used separately or in combination. Other information such as neighbourhood deprivation, Statistical Area 2, or territorial local authority can also be added. It is also possible to generate flags for health-related information on the HSU (for example, those who are likely to have a long-term condition).

[19] https://www.stats.govt.nz/methods/population-statistics-user-guide.
[20] More information on the findings from the Stats NZ review of the HSU is available at: stats.govt.nz/reports/review-of-health-service-user-population-methodology/

**Comparison of HSU 2021 to the Stats NZ projected resident population**

The differences between the HSU datasets and Stats NZ projections of the resident population (PRP), prepared for the Ministry of Health in 2021, are demonstrated in the New Zealand population by ethnicity tables, below, for both HSU 2021 and HSU 2020.

## Comparison of HSU 2021 to the Stats NZ PRP for the DHB

As at 31 December 2021, there is an estimated 326,455 health service users in the HSU 2021. This is an increase of 11,214 people from the HSU 2020 (an approximate 4% increase), and 345 more people than the Stats NZ PRP for 30 June 2021. DHB population by ethnicity: HSU 2021 and Stats NZ PRP comparison[21]

| Ethnicity | HSU 2021 | Stats NZ PRP | Difference (Note 1) |
|---|---|---|---|
| Māori | 35,870 | 39,200 | 3,330 |
| Pacific peoples | 24,537 | 23,600 | -937 |
| Asian | 48,824 | 51,800 | 2,976 |
| European/other | 213,894 | 212,200 | -1,694 |
| Unknown | 3,330 | 0 | -3,330 |
| **Total (Note 1)** | 326,455 | 326,800 | 345 |

Note 1: The national total population estimate based on HSU 2021 (as at 31 December 2021) is 5,233,600. This is 111,000 above the Stats NZ total projected population of 5,122,600 (as at 30 June 2021) taken from the customised 2018-base population projections Stats NZ produced in 2021

## Comparison of HSU 2020 to the Stats NZ PRP

For reference, we have provided the HSU 2020 comparison

**DHB population by ethnicity: HSU 2020 and Stats NZ PRP[22]**

| Ethnicity | HSU 2020 | Stats NZ PRP | Difference |
|---|---|---|---|
| Māori | 34,718 | 38,400 | 3,682 |
| Pacific peoples | 23,745 | 23,400 | -345 |
| Asian | 43,884 | 51,100 | 7,216 |
| European/other | 210,387 | 212,300 | 1,913 |
| Unknown | 2,507 | 0 | -2,507 |
| **Total** (Note 1) | 315,241 | 325,200 | 9,959 |

Note 1: The total population estimate based on HSU 2020 (as at 1 July 2020) is 5,000,500. This is 89,700 below the Stats NZ total projected population of 5,090,200 (at 30 June 2020) taken from the customised 2018-base population projections Stats NZ produced in 2021.

**COVID-19 mortality rates**

The data used to determine deaths attributed to COVID-19 comes from EpiSurv[23] and the National Contact Tracing Solution (NCTS) databases. The data received through these systems is extensively checked for duplications using national health index (NHI) data.

[21] HSU 2021 data is as at 31 December 2021 and Stats NZ PRP data is as at 30 June 2021

[22] HSU 2020 data is as at 1 July 2020 and Stats NZ PRP data is as at 30 June 2020.

[23] EpiSurv is a secure national system used by Primary Health Units to report cases of notifiable diseases. It is operated by the Institute of Environmental Science and Research (ESR), on behalf of the Ministry of Health

The definition of COVID-19 deaths that the Ministry now uses in most situations, including in this section, is defined as 'deaths attributed to COVID-19'.

> 'Deaths attributed to COVID-19' include deaths where COVID-19 was the underlying cause of death, or a contributory cause of death. This is based on Cause of Death Certificates which are coded by the Mortality Coding Team within the Ministry.

There can be delays processing the Cause of Death Certificates being updated in our systems. For example, where a paper-based death certificate is issued, the data will not be recorded as quickly as if it was submitted electronically.

Whether an individual's death is attributed to COVID-19 relies on a variety of sources. These include self-declaration, notifications via health records, or additional tests that are undertaken after death.

## COVID-19 Deaths by age group

The following outlines the total number of deaths associated to COVID-19 in Capital, Coast and Hutt Valley (deaths data has been combined for these districts) by age group at the time of death (as at 30 June 2022).

| Age group (years) | |
|---|---|
| <10 | 0 |
| 10 to 19 | 0 |
| 20 to 29 | 0 |
| 30 to 39 | 1 |
| 40 to 49 | 2 |
| 50 to 59 | 3 |
| 60 to 69 | 7 |
| 70 to 79 | 17 |
| 80 to 89 | 41 |
| 90+ | 33 |
| **Total** | 104 |

## COVID-19 deaths by ethnicity

The following outlines the total number of deaths associated to COVID-19 in Capital, Coast and Hutt Valley by the ethnicity of the individual (as at 30 June 2022).

| Ethnicity | |
|---|---|
| Asian | 8 |
| European/other | 79 |
| Māori | 5 |
| Pacific peoples | 12 |
| Unknown[24] | 0 |
| **Total** | 104 |

[24] 'Unknown' refers to individuals where no ethnicity can be satisfactorily determined.

# Centre of Clinical Excellence

In 2020 the 2DHB CEO proposed that a Centre of Clinical Excellence (CoCE) should be formed combining the functions of Quick Impact Projects at CCDHB and QSII at HVDHB. This resulted in an expansion of clinical governance to clinical excellence; by a change in focus from structure and systems to the continual pursuit of excellence resulting from innovation, continuous improvement and empowering patients and their whānau.

On 1 December, 2021 the 2DHB Centre of Clinical Excellence was launched. The first six months of the CoCE were focussed on identity formation (both within the centre bringing two teams together and external to CoCE raising awareness of the CoCEs functions) and aligning systems and processes across the 2DHBs. On 1 June 2022 the Clinical Training team was formed in the CoCE. This team is a combination of the Simulation Centre, Resuscitation and Moving and Handling teams from both DHBs.

## Improvement and innovation

The Improvement & Innovation (I&I) team work to create a continuous improvement and innovation culture across the Capital, Coast and Hutt Valley district and enable and support staff to make meaningful and sustainable change.

Since the CoCE was established, the I&I team have worked to embed a culture of continuous improvement by offering three improvement training courses. These build improvement capability and support 2DHB staff with their improvement projects. Improvement training and policies have been aligned across the 2DHBs. The I&I team presented at multiple forums to raise awareness of improvement training, including the 2DHB Clinical Forum, 2DHB Allied Professions Education Forum, 2DHB Allied Health Leaders meeting and Victoria University for Masters Nursing students.

In addition to projects supported through training programmes, the I&I advisors have led and supported 37 larger 2DHB projects such as improving the completion rate of Patient Goals of Care Forms and Clinical Documentation Improvement Programme.

## Consumer engagement

### Consumer advisory groups

Consumer advisory groups (CAG) have been established at Wellington and Hutt sites. These groups meet every six weeks and membership continues to be stable and diverse with representation from Māori, Pacifica, Disability, Rainbow, Youth, MHAIDS, African and Asian communities. Consumers are embedded at many levels of the organisation including: involvement with serious event reviews, members of sub-committees, participation in service credentialing, supporting co-design projects and being part of strategic groups.

### Feedback

The feedback team and processes across the 2DHBs were reviewed and a 2DHB team was developed, which work across the District. The complaint process (HDC and non-HDC) have aligned, and HDC and non HDC complaint reports are auto-generated and provided to hospital services to support complaint management. Additionally, services are offered to provide personalised support to respond to complaints, e.g. coaching on writing a patient centred complaint response.

### National in-patient survey

Previously the in-patient survey has been promoted by consumers in the hospitals, however this has not been able to occur this year, due to COVID-19 restrictions. Promoting the survey by consumers at the bedside increased the response rate to more than forty percent compared to the national average return rate of around twenty-four percent.

### Health Quality and Safety Commission Consumer Engagement Quality & Safety Maker (QSM)

The QSM is a self-rated evaluation framework with the requirement to provide evidence to support the rating. Capital and Coast hospitals submitted a rating of four on all aspects of consumer engagement which is the highest rating. Hutt hospital submitted a rating of a mixture of two and three which was an increase on previous ratings of one for all domains.

### Consumer involvement

Consumers are involved in many areas of our hospital. Examples include the Front of Whare project at Wellington hospital, shared goals of care project and the Hutt Valley Breast Screening review. There are consumer representatives on many clinical governance committees such as Serious Events Review Committee, Safety Incident Review Committee and the Clinical Boards. The consumer advisory group members take part in other quality improvement activities such as credentialing and safety walk-rounds.

## Clinical governance

### Clinical governance systems

In March 2022, the '2DHB Clinical Board' was formed, across the former Hutt Valley and Capital Coast DHBs. The Board meets bi-monthly and membership consists of senior clinicians and operational leadership from the district, as well as consumer representatives. The 2DHB Clinical Board is chaired by the 2DHB Director, Clinical Excellence.

With the formation of the 2DHB Clinical Board, work has progressed to align the sub-committees that report to the Clinical Boards.

### Controlled documents

Hutt Valley and Capital and Coast DHBs have separate controlled documents systems. In 2021, a risk was highlighted that the Hutt Valley system was not sufficiently robust to meet the requirements under Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. Earlier this year, a project commenced to implement a single system for the 2DHBs. This system has been built, with documents expected to be migrated onto the platform by the end of the year.

### Service credentialing

Service credentialing, is an expectation of the Ministry of Health. The primary objective is to credential each service every five years to understand the skill mix of its staff, whether it meets clinical needs, and to identify any risks and opportunities for improvement. There has been a variable approach to service credentialing across the district.

A 2DHB service credentialing process has been agreed, with a single process for all services across the district. The new process is designed to review similar services at the same time to best utilise external reviewers where possible. Technology and innovation has also been a key factor in re-designing the process, using systems such as Survey Monkey and Sharepoint to reduce burden on services under review and the reviewers.

## Clinical training

The Wellington Regional Centre for Simulation and Skills Education (WRSSCE) moved into the Centre of Clinical Excellence on 1st June 2022. The primary function of this service is to support the health workforce to provide excellence in clinical care through quality simulation-based education.

The team includes expert simulation educators and technical specialists, and as a result of the restructure, is part of the Clinical Training team which includes resuscitation, intravenous (IV) and cannulation and moving and handling educators. The team provides core requirement learning opportunities to 2DHB staff as well as specialist courses and programmes that support national and international specialist medical workforce credentialing such as the Effective Management of Anaesthetic Crisis (EMAC) course.

## Quality and patient safety

The quality and patient safety team support managers and clinicians to achieve quality outcomes for patients, and the efficient functioning of services. The team's aim is to build a strong safety culture across 2DHB, bringing people together with a shared purpose and vision for the future.

### Standardised process for adverse events across Hutt and Wellington hospitals

Quality Advisors now support mirrored services across Hutt Valley and Capital & Coast (e.g. the same people support surgical services at both Hutt and Wellington hospitals). The adverse event review (AER) processes aligned across the 2DHBs using the best methodologies from both sites to develop an effective, efficient and sustainable system. Clinical Excellence staff are members of both Hutt and Wellington Serious Event Review Committees (SERC) with the aim of ensuring alignment of process across the committees. Continuing education was provided to all SERC members to ensure they are all aware of modern, effective review techniques.

## Research

The Research Office is the centralised function established under the auspices of the Centre of Clinical Excellence that provides guidance and support for those undertaking research. The Research Office holds the 2DHB register of projects with the objective of delivering and coordinating quality research activity in CCDHB and HVDHB.

The Research Office has been actively involved with the Māori consultation process for research and in the development of Tikanga resources. Working closely with the Māori Health Services on this project justifies our focus that will lead to better engagement from staff across the 2DHBs.

## Risk

The Enterprise Risk team is a small centralised function within the Centre of Clinical Excellence that provides advice, support and reporting to support the effective management of key risks across the 2DHB. The team also supports and administers the CCDHB and HVDHB operational risk registers.

The primary purpose of the team's role is to strengthen risk management maturity across the organisation through refreshed policies and frameworks that clarify accountabilities for different types of risk, targeted advice and reporting that support staff in making informed decisions and practical guidance and tools that support staff apply risk management in their work.

Clarifying and articulating the 2DHB's key strategic and enterprise risks to support the Executive Leadership Team's responsibilities has been a key area of work. Working directly with Executive members, this has involved re-setting how these risks are identified and reported to better support the Executive Leadership Team's oversight and monitoring of them.

Strengthening operational and enterprise risk management engagement has been another area of focus. This has involved prioritising risk management advice, support and reporting in those key operational areas of the business alongside those enterprise areas who manage key risks on behalf of the whole organisation. It has also involved preparing new online guidance and tools to embed a consistent approach to risk management and build 2DHB risk management capability.

## Audit

The 2DHB system tracer was established in February 2021 with a tracer audit schedule implemented across the inpatient areas, development of training and tools, online solutions and a policy to guide and support practice. It has been expanded to both ambulatory care and MHAIDS with a focus on improvement of monitoring and transparent self-audits. In order to align current process with the new Ngā Paerewa Health and Disability Services Standard (2021), work continues with improvement of monitoring:

- Pathways to Wellbeing (currently Continuum of Care),
- Patient-Centered and Safe Environment and
- Infection Prevention and Anti-Microbial Stewardship.

# Financial Statements

## Statement of comprehensive revenue and expense

**For the year ended 30 June 2022**

| | Note | 2022 Actual $000 | 2022 Budget $000 | 2021 Actual $000 |
|---|---|---|---|---|
| Revenue | 2 | 1,643,203 | 1,453,890 | 1,358,764 |
| ***Total revenue*** | | **1,643,203** | **1,453,890** | **1,358,764** |
| **Expenditure** | | | | |
| Clinical supplies | | 135,436 | 136,840 | 133,754 |
| Personnel costs | 3 | 755,351 | 650,852 | 616,902 |
| Infrastructure and non-clinical expenses | | 139,978 | 92,592 | 94,813 |
| Other operating expenses | 4 | 7,750 | 8,297 | 9,654 |
| Outsourced services | | 57,842 | 47,900 | 47,125 |
| Payments to other district health boards | | 110,516 | 110,300 | 108,768 |
| Payments to non-health board providers | | 417,341 | 339,657 | 338,357 |
| Capital charge | 5 | 21,339 | 17,729 | 19,316 |
| Depreciation and amortisation expense | 6,7 | 43,805 | 42,696 | 36,574 |
| ***Total expenses*** | | **1,689,358** | **1,446,863** | **1,405,263** |
| **Deficit** | | **(46,155)** | **7,027** | **(46,499)** |
| **Other comprehensive revenue and expense** | | | | |
| Revaluation of land and buildings | 18 | - | - | 72,804 |
| Impairment losses | 6 | - | - | (10,000) |
| *Total other comprehensive revenue and expense* | | **-** | **-** | **62,804** |
| **Total comprehensive revenue and expense** | | **(46,155)** | **7,027** | **16,305** |

Explanations of significant variances against budget are detailed in note 22.

*The accompanying notes form part of these financial statements.*

# Statement of financial position

**As at 30 June 2022**

| | Note | 2022 Actual $000 | 2022 Budget $000 | 2021 Actual $000 |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current assets** | | | | |
| Cash and cash equivalents | 12 | - | - | - |
| Trade and other receivables | 11 | 121,522 | 63,930 | 60,022 |
| Prepayments | | 9,774 | 7,902 | 7,142 |
| Inventories | 8 | 10,725 | 9,466 | 9,394 |
| Trust and special funds | 13 | 12,939 | 13,561 | 13,391 |
| ***Total current assets*** | | **154,960** | **94,859** | **89,949** |
| **Non-current assets** | | | | |
| Property, plant and equipment | 6 | 761,144 | 752,130 | 661,858 |
| Intangible assets | 7 | 21,413 | 18,127 | 18,103 |
| Investment in associate | 9 | 1,150 | 1,150 | 1,150 |
| ***Total non-current assets*** | | **783,707** | **771,407** | **681,111** |
| **Total assets** | | **938,667** | **866,266** | **771,060** |
| | | | | |
| **Liabilities** | | | | |
| **Current liabilities** | | | | |
| Cash and cash equivalents | 12 | 44,451 | 13,177 | 28,843 |
| Trade and other payables | 16 | 103,832 | 83,668 | 107,926 |
| Employee entitlements | 14 | 274,328 | 203,219 | 175,765 |
| Provisions | 15 | 883 | 593 | 731 |
| Patient and restricted funds | 17 | 109 | 92 | 90 |
| ***Total current liabilities*** | | **423,603** | **300,749** | **313,355** |
| **Non-current liabilities** | | | | |
| Employee entitlements | 14 | 16,619 | 6,564 | 16,287 |
| Provisions | 15 | 398 | 605 | 500 |
| ***Total non-current liabilities*** | | **17,017** | **7,169** | **16,787** |
| **Total liabilities** | | **440,620** | **307,918** | **330,142** |
| **Net assets** | | **498,047** | **558,348** | **440,918** |
| | | | | |
| **Equity** | | | | |
| Crown equity | 18 | 925,448 | 1,012,025 | 822,164 |
| Property revaluation reserves | 18 | 193,463 | 130,659 | 193,463 |
| Accumulated deficit | 18 | (620,864) | (584,336) | (574,709) |
| **Total equity** | | **498,047** | **558,348** | **440,918** |

Explanations of significant variances against budget are detailed in note 22.

*The accompanying notes form part of these financial statements.*

# Statement of changes in equity

**For the year ended 30 June 2022**

| | Note | 2022 Actual $000 | 2022 Budget $000 | 2021 Actual $000 |
|---|---|---|---|---|
| Balance at 1 July | | 440,918 | 369,257 | 404,391 |
| Total comprehensive revenue and expense | | (46,155) | 7,027 | 16,305 |
| Transfer from revaluation reserves | | - | - | - |
| *Owner transactions* | | | | |
| Contributions from the Crown | | 117,324 | 185,548 | 23,706 |
| Repayment of equity | | (14,040) | (3,484) | (3,484) |
| **Balance at 30 June** | 18 | **498,047** | **558,348** | **440,918** |

Explanations of significant variances against budget are detailed in note 22.

*The accompanying notes form part of these financial statements.*

# Statement of cash flows

**For the year ended 30 June 2022**

| | Note | 2022 Actual $000 | 2022 Budget $000 | 2021 Actual $000 |
|---|---|---|---|---|
| **Cash flows from operating activities** | | | | |
| Cash receipts from Ministry of Health and other Crown Entities | | 1,528,595 | 1,370,213 | 1,328,031 |
| Other receipts | | 19,109 | 23,676 | 34,169 |
| Payments to suppliers | | (877,544) | (743,511) | (727,456) |
| Payments to employees | | (674,595) | (650,849) | (599,227) |
| Interest paid | | (57) | - | - |
| *Cash generated from operations* | | *(4,492)* | *(471)* | *35,517* |
| GST (net) | | (1,364) | - | 3,197 |
| Capital charge | | (21,339) | (22,204) | (31,174) |
| **Net cash flows from operating activities** | | **(27,195)** | **(22,675)** | **7,540** |
| **Cash flows from investing activities** | | | | |
| Interest received | | 309 | 187 | 207 |
| Purchase of property, plant and equipment | | (82,649) | (129,056) | (60,109) |
| Purchase of intangible assets | | (1,833) | (6,000) | (1,539) |
| **Net cash flows from investing activities** | | **(84,173)** | **(134,869)** | **(61,441)** |
| **Cash flows from financing activities** | | | | |
| Contributions from the Crown | | 109,348 | 185,546 | 23,705 |
| Repayment of equity | | (14,040) | (3,484) | (3,484) |
| Interest paid | | - | - | (8) |
| **Net cash flows from financing activities** | | **95,308** | **182,062** | **20,213** |
| Net (decrease)/increase in cash and cash equivalents | | (16,060) | 24,518 | (33,688) |
| Cash and cash equivalents at beginning of year | | (15,452) | (24,134) | 18,236 |
| **Cash and cash equivalents at the end of the year** | | **(31,512)** | **384** | **(15,452)** |
| *Represented by:* | | | | |
| Cash and cash equivalents | 12 | (44,451) | (13,177) | (28,843) |
| Trust and special funds | 13 | 12,939 | 13,561 | 13,391 |

**Reconciliation of movements in liabilities arising from financing activities:**

| | Finance Leases $000 |
|---|---|
| Balance as at 1 July 2021 | - |
| Cash outflows | - |
| New leases | - |
| **Balance as at 30 June 2022** | **-** |

Explanations of significant variances against budget are detailed in note 22.

*The accompanying notes form part of these financial statements.*

# Reconciliation of net deficit to net cash flows from operating activities

**For the year ended 30 June 2022**

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Net deficit** | (46,155) | (46,499) |
| **Add non-cash items** | | |
| Depreciation and amortisation | 43,805 | 36,574 |
| Impairment on Intangibles | 1,203 | - |
| Increase in provisions | 4,250 | - |
| Donated assets | (66,472) | - |
| *Total non-cash items* | (17,214) | 36,574 |
| **Add/(less) items classified as investing or financing activities** | | |
| Net loss/(gain) on disposal of property, plant and equipment | (6) | 96 |
| Interest revenue on financial assets | (392) | (172) |
| *Total items classified as investing activities* | (398) | (76) |
| **Add/(less) movements in working capital** | | |
| (Increase)/decrease in trade and other receivables | (54,259) | (13,680) |
| (Increase)/decrease in prepayments | (2,632) | (885) |
| (Increase)/decrease in inventories | (1,331) | (399) |
| Increase/(decrease) in trade and other payables | (4,151) | 16,057 |
| Increase/(decrease) in employee entitlements | 98,895 | 16,457 |
| (Decrease)/increase in provisions | 50 | (9) |
| *Net movements in working capital* | 36,527 | 17,541 |
| **Net cash flows from operating activities** | **(27,195)** | **7,540** |

# Statement of contingent liabilities and contingent assets

**As at 30 June 2022**

### Quantifiable contingent liabilities

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Legal proceedings against the DHB | - | - |
| **Total quantifiable contingent liabilities** | **-** | **-** |

The DHB are not aware of any potential claims at 30 June 2022 (2021: Nil).

### Unquantifiable contingent liabilities

At 30 June 2022, there were one employment-related issues pending resolution. It is difficult to predict the final outcome of these matters with any great degree of certainty. Therefore, any possible financial reparations eventuating from the settlement decision of these matters are currently unquantifiable.

### Contingent assets

As at 30 June 2022, DHB has no contingent assets (2021: nil).

# Notes to the financial statements

## 1. Statement of accounting policies

**REPORTING ENTITY**

Capital & Coast District Health Board (DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. The DHB is a Crown entity as defined by the Crown Entities Act 2004, and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate parent is the New Zealand Crown.

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

The financial statements for the group are for the year ended 30 June 2022 and were approved for issue by the Health New Zealand Board on 22 March 2023.

**BASIS OF PREPARATION**

**Disestablishment of DHBs**

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review. The reforms replace all 20 District Health Boards (DHBs) and the Health Promotion Agency with a new Crown entity, Health New Zealand (Te Whatu Ora), responsible for running hospitals and commissioning primary and community health services. The legislation enabling the reform, the Pae Ora (Healthy Futures) Act 2022 (the Act), took effect on 1 July 2022, formally creating Te Whatu Ora, along with two other entities - the Māori Health Authority (Te Aka Whai Ora) to monitor the state of Māori health and commission services directly, and the Public Health Authority, which resides within the Ministry of Health to lead and strengthen public health.

The Act disestablished all DHBs and the Health Promotion Agency and transferred the Capital & Coast District Health Board's assets and liabilities to Te Whatu Ora on 1 July 2022. As a result, the financial statements have been prepared on a disestablishment basis.

However, because health services will continue to be provided through Te Whatu Ora, no changes have been made to the recognition and measurement basis, or presentation of assets and liabilities in these financial statements due to the disestablishment basis of preparation.

**Statement of compliance**

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

**Presentation currency and rounding**

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

**Changes in accounting policies**

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

**Standards issued that are not yet effective and not early adopted**

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

*PBE FRS 41 Financial Instruments*

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

# Notes to the financial statements

*PBE FRS 48 Service Performance Reporting*
PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 Presentation of Financial Statements and is effective for the year ending 30 June 2023, with earlier adoption permitted. The DHB has determined the main impact of the new standard is that additional information will need to be disclosed on those judgements that have the most significant effect on the selection, measurement, aggregation, and presentation of service performance information.

**SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

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

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

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

**Budget figures**
The budget figures are derived from the statement of performance expectations as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZGAAP. They comply with PBE standards and other applicable financial reporting standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by the DHB for the preparation of these financial statements.

**Critical accounting estimates and assumptions**
In preparing these financial statements, the DHB has made estimates and assumptions concerning the future. These assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Management has discussed with the Finance Risk & Audit Committee the development, selection and disclosure of the DHB's critical accounting policies and estimates and the application of these policies and estimates.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are in respect of:

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

## Notes to the financial statements

**New amendment applied - 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. The new information required by this amendment has been disclosed in Statement of cash flows.

# Notes to the financial statements

## 2 Revenue

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

***Crown funding***
The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year. The DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

***Goods sold and services rendered***
Revenue from goods sold is recognised when the DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold. Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to the DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by the DHB.

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

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

***Donated assets***
Where a physical asset is gifted to or acquired by the DHB for nil or nominal cost, the fair value of the asset received is recognised as revenue. Such assets are recognised as revenue when control over the asset is obtained.

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Ministry of Health contract funding | 1,189,769 | 1,007,207 |
| Other government | 17,132 | 14,056 |
| Inter-district flows (other DHBs) | 335,810 | 298,635 |
| Non-government and Crown agency sourced | 23,491 | 38,680 |
| Interest revenue | 392 | 172 |
| Donations received | 76,609 | 14 |
| **Total revenue** | **1,643,203** | **1,358,764** |

# Notes to the financial statements

## 3 Personnel costs

**Accounting policy**

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

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

Certain employees are members of defined contribution schemes and the DHB contributes to those schemes. A defined contribution scheme is a plan under which the employee and the DHB pay fixed contributions to a separate entity. The DHB has no legal or constructive obligation to pay further contributions in relation to employee service in the current and prior periods.

DEFINED BENEFIT PLAN CONTRIBUTOR SCHEMES
The DHB belongs to some defined benefit plan contributor's 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.

***Statutory remuneration disclosures***
Section 152 of the Crown Entities Act 2004 (CEA) requires DHBs to disclose information in the annual report about payments in respect of members, committee members, and employees. The relevant disclosures are included in the Separate Remuneration Disclosures section.

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Direct staff costs (excluding increases in employee entitlements) | 621,001 | 574,680 |
| Indirect staff costs (excluding defined contribution plan employer contributions and increases in employee entitlements) | 15,620 | 12,854 |
| Defined contribution plan employer contributions | 21,093 | 20,323 |
| Increase in liability for employee entitlements | 97,637 | 9,045 |
| **Total personnel costs** | **755,351** | **616,902** |

The increase in liability for employee entitlements includes a $78.926 million increase (2021: $8.661 million) in the Holidays Act 2003 remediation liability.

# Notes to the financial statements

## 4 Other operating expenses

**Accounting policy**

***Operating leases***

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

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

| | Note | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|---|
| Provision for impairment of receivables | 11 | 420 | 2,785 |
| Loss on disposal of property, plant and equipment | | (6) | 96 |
| Audit NZ fees for audit of financial statements | | 302 | 303 |
| Fees for other assurance services | | 152 | 190 |
| Board member fees | 21 | 307 | 284 |
| Operating lease expense | | 5,052 | 4,573 |
| Other operating expenses | | 1,523 | 1,423 |
| **Total other operating expenses** | | **7,750** | **9,654** |

## 5 Capital charge

**Accounting policy**

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

**Further information**

The DHB pays a capital charge to the Crown every six months. The charge is now based on the actual closing equity balance excluding the value of donated assets. The capital charge rate for the period ended 30 June 2022 was 5% (2021: 5%).

# Notes to the financial statements

## 6 Property, plant and equipment

**Accounting policy**

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

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

***Revaluations***

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

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

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

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

***Additions***

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

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

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

***Disposals***

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

***Subsequent costs***

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

# Notes to the financial statements

## 6 Property, plant and equipment (continued)

***Depreciation***

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

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

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

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

***Impairment of property, plant, and equipment***

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

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

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

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

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

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

**Critical accounting estimates and assumptions**

***Estimating the fair value of land and buildings***

Land and building valuations are done on a three year cycle. Desktop valuation updates are done in the interim years between full valuations. The most recent full valuation was as at 30 June 2021 and was performed by Milton Bevin, FPINZ, an independent registered valuer with Colliers International New Zealand Limited("Colliers").

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

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

The valuation conducted by Colliers 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".

## Notes to the financial statements

At 30 June 2022, the DHB engaged Colliers to undertake a desktop valuation to determine potential materiality movement since 30 June 2021, the date of the last full valuation. The desktop valuation refers to the market at 30 June 2022 but is undertaken without inspection. Colliers has assessed that there has not been a material change in fair value. The Board has assessed the Colliers' valuation assumption and conclusion and confirmed that the 30 June 2021 valuation remains an appropriate statement of fair value as at 30 June 2022, but notes the significant valuation uncertainty highlighted by Colliers.

## 6 Property, plant and equipment (continued)

| | Freehold land $000 | Freehold buildings $000 | Leasehold Improvements $000 | Plant and equipment $000 | Furniture and fittings $000 | Work in Progress $000 | Total $000 |
|---|---|---|---|---|---|---|---|
| **Cost or valuation** | | | | | | | |
| Balance at 1 July 2020 | 40,352 | 482,075 | 1,191 | 122,005 | 32,516 | 54,055 | 732,194 |
| Additions | 89 | 3,562 | - | 13,326 | 978 | 50,970 | 68,925 |
| Disposals | - | (1,302) | - | (5,158) | (34) | - | (6,494) |
| Impairment losses | - | (10,000) | - | - | - | - | (10,000) |
| Revaluation increase/(decrease) | 25,024 | (28,589) | - | - | - | - | (3,565) |
| Transfers | - | - | - | 370 | - | - | 370 |
| **Balance at 30 June 2021** | **65,465** | **445,746** | **1,191** | **130,543** | **33,460** | **105,025** | **781,430** |
| Additions | - | 12,708 | - | 16,672 | 2,728 | 106,891 | 138,999 |
| Disposals | - | - | - | - | - | - | - |
| Impairment losses | - | - | - | - | - | - | - |
| Revaluation increase/(decrease) | - | - | - | - | - | - | - |
| Transfers | - | (35) | 35 | 112 | - | - | 112 |
| **Balance at 30 June 2022** | **65,465** | **458,419** | **1,226** | **147,327** | **36,188** | **211,916** | **920,541** |
| | | | | | | | |
| **Accumulated depreciation** | | | | | | | |
| Balance at 1 July 2020 | - | (53,142) | (632) | (85,778) | (28,562) | - | (168,114) |
| Depreciation | - | (23,327) | (65) | (8,809) | (793) | - | (32,994) |
| Disposals | - | 100 | - | 5,062 | 5 | - | 5,167 |
| Reversal on revaluation | - | 76,369 | - | - | - | - | 76,369 |
| **Balance at 30 June 2021** | **-** | **-** | **(697)** | **(89,525)** | **(29,350)** | **-** | **(119,572)** |
| Depreciation | - | (29,230) | (69) | (9,706) | (770) | - | (39,775) |
| Disposals | - | - | - | (1) | (5) | - | (6) |
| Reversal on revaluation | - | - | - | (38) | (6) | - | (44) |
| **Balance at 30 June 2022** | **-** | **(29,230)** | **(766)** | **(99,270)** | **(30,131)** | **-** | **(159,397)** |

## Notes to the financial statements

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Carrying amounts** | | | | | | | |
| As at 1 July 2020 | 40,352 | 428,933 | 559 | 36,227 | 3,954 | 54,055 | 564,080 |
| As at 30 June 2021 | 65,465 | 445,746 | 494 | 41,018 | 4,110 | 105,025 | 661,858 |
| **As at 30 June 2022** | **65,465** | **429,189** | **460** | **48,057** | **6,057** | **211,916** | **761,144** |

## 6 Property, plant and equipment (continued)

**Restrictions**

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

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

**Borrowing costs**

The total amount of borrowing costs capitalised during the year ended 30 June 2022 was $nil (2021: $nil).

**Capital commitments**

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Buildings | 14,520 | 24,229 |
| Plant and equipment | - | 612 |
| Intangible assets | 369 | - |
| **Total capital commitments** | **14,889** | **24,841** |

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

# Notes to the financial statements

## 7 Intangible assets

**Accounting policy**

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

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

Staff training costs are recognised as an expense when incurred.

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

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

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

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

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

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

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

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

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

## Notes to the financial statements

## 7 Intangible assets (continued)

| | Software $000 | Licenses $000 | Work in progress $000 | Total $000 |
|---|---|---|---|---|
| **Cost** | | | | |
| Balance at 1 July 2020 | **36,197** | **4,727** | **14,888** | **55,812** |
| Additions | 2,685 | 215 | 1,841 | 4,741 |
| Transfers | (370) | - | - | (370) |
| Impairment | - | - | (10,530) | (10,530) |
| **Balance at 30 June 2021** | **38,512** | **4,942** | **6,199** | **49,653** |
| Additions | 4,553 | 404 | 3,665 | 8,622 |
| Transfers | (112) | - | - | (112) |
| Impairment | - | - | (1,203) | (1,203) |
| **Balance at 30 June 2022** | **42,953** | **5,346** | **8,661** | **56,960** |
| | | | | |
| Balance at 1 July 2020 | (24,616) | (3,354) | - | (27,970) |
| Amortisation | (3,191) | (389) | - | (3,580) |
| **Balance at 30 June 2021** | **(27,807)** | **(3,743)** | **-** | **(31,550)** |
| Amortisation | (3,582) | (448) | - | (4,030) |
| Transfers | 33 | - | - | 33 |
| **Balance at 30 June 2022** | **(31,356)** | **(4,191)** | **-** | **(35,547)** |
| | | | | |
| **Carrying amounts** | | | | |
| As at 1 July 2020 | 11,581 | 1,373 | 14,888 | 27,842 |
| As at 30 June 2021 | 10,705 | 1,199 | 6,199 | 18,103 |
| **As at 30 June 2022** | **11,597** | **1,155** | **8,661** | **21,413** |

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

**Work in progress**

Regional Health Informatics Programme (RHIP) is a programme to move the Central Region District Health Boards from a current state of disparate, fragmented and, in some cases obsolescent, clinical and administrative information systems to a future state of shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable regionalisation of services and reduce current operational risks. It was originally agreed that Technical Advisory Services Limited (TAS) would create the RHIP assets and provide services in relation to those assets to the DHBs. Each DHB would provide funding to TAS and in return for the funding relating to capital items the DHBs would be provided with Class B Redeemable Shares in TAS. The agreement to provide the RHIP assets and services was amended on 1 December 2014 to transfer the ownership of RHIP assets to the DHBs jointly. As at 30 June 2022, CCDHB had contributed $7.4 million towards capital expenditure which has been recognised as work in progress in respect of intangible assets. The investment has been tested for impairment during the year by DHB management and $1.2 million was written off as CCDHB's contribution to the Regional Clinical Portal, WebPAS and RADA IT applications.

# Notes to the financial statements

## 8 Inventories

**Accounting policy**

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Pharmaceuticals | 3,702 | 3,663 |
| Surgical and medical supplies | 6,711 | 5,404 |
| Other supplies | 312 | 327 |
| **Total inventories** | **10,725** | **9,394** |

The amount of inventories recognised as an expense during the year ended 30 June 2022 was $132 million (2021: $131 million). All inventories are distributed to operating areas in the normal course of business.

The write-down of inventories held for distribution amounted to $nil (2021: $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.

# Notes to the financial statements

## 9 Investment in associate

**Accounting policy**

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

**Breakdown of investment in associate and further information**

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Allied Laundry Services Limited unlisted ordinary shares | 6,900 | 6,900 |
| Capital & Coast DHB's share of ownership | 16.67% | 16.67% |
| **Carrying amount of investment in associate** | **1,150** | **1,150** |

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Revenue | 13,776 | 13,031 |
| Expense | 13,494 | 12,396 |
| Surplus | 282 | 635 |
| | | |
| Non-current assets | 10,768 | 10,810 |
| Current assets | 2,771 | 2,216 |
| Non-current liabilities | (2,300) | (2,638) |
| Current liabilities | (2,551) | (2,013) |
| Equity | 8,688 | 8,375 |
| | | |
| Contingent liabilities | - | - |
| Commitment | - | - |

## 10 Other financial assets

CCDHB holds a 16.67% shareholding in Central Region's Technical Advisory Services Limited (TAS) and participates in its commercial and financial policy decisions. The five other district health boards in the central region each hold 16.67% (2021: 16.67%) of the shares. TAS was incorporated on 6 June 2001.

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

# Notes to the financial statements

## 11 Trade and other receivables

**Accounting policy**

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

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

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Trade receivables from non-related parties | 4,104 | 5,238 |
| Ministry of Health receivables | 73,693 | 30,081 |
| Other DHB receivables | 11,489 | 9,015 |
| Less allowance for credit losses | (3,550) | (4,075) |
| Accrued revenue | 35,786 | 19,763 |
| **Total receivables** | **121,522** | **60,022** |
| *Receivables comprises of:* | | |
| Receivable from the sale of goods and services (exchange transactions) | 37,829 | 29,941 |
| Receivable from Ministry funding (non-exchange transactions) | 83,693 | 30,081 |
| **Total receivables** | **121,522** | **60,022** |

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

| Receivables days past due | Amount $000 | Estimate of losses | Impaired credit loss $000 | Expected credit loss $000 |
|---|---|---|---|---|
| Current | 103,681 | 0.0% | - | - |
| Past due < 6 months | 10,419 | 1.9% | - | 196 |
| Past due 6 months – 1 year | 3,501 | 3.7% | - | 130 |
| Past due 1 – 2 years | 458 | 34.7% | - | 159 |
| More than 2 years | 3,463 | 88.5% | - | 3,065 |
| Identified bad debts | - | 100.0% | 945 | - |
| **Total** | **121,522** | | **945** | **3,550** |

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.

# Notes to the financial statements

## 11 Trade and other receivables (continued)

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Balance at 1 July | 4,075 | 2,227 |
| Additional allowance made during the year | 420 | 2,785 |
| Receivables written off during period | (945) | (937) |
| **Balance at 30 June** | **3,550** | **4,075** |

## 12 Cash and cash equivalents

**Accounting policy**

Cash and cash equivalents include cash on hand, deposits held at call with banks, and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts that are repayable on demand and form an integral part of the DHB's cash management are included as a component of cash and cash equivalents for the statement of cash flows.

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Petty cash | 13 | 13 |
| Bank accounts | 2 | 21 |
| NZHPL call deposits | (44,466) | (28,877) |
| **Total cash and cash equivalents** | **(44,451)** | **(28,843)** |

**Patient funds**

The DHB administers certain funds on behalf of patients. These funds are held in separate bank accounts and interest earned is allocated to the individual patients. The funds are not included in the above balances.

**Bank facility**

Capital & Coast DHB is party to the "DHB Treasury Services Agreement" between New Zealand Health Partnership Limited and the participating DHBs. This Agreement enables NZHPL to "sweep" DHB bank accounts daily and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a negative balance with NZHPL, which will incur interest at the credit interest rate received by NZHPL plus an administrative margin. The maximum working borrowing facility available to the DHB is $71.3 million. (2021:$ 71.3 million). The highest overdrawn bank balance during financial year 2021/22 was $50.9 million. (2021: $44.7 million).

While cash and cash equivalents at 30 June 2022 are subject to the expected credit loss requirements of PBE IFRS 9, no loss allowance has been recognised because the estimated loss allowance for credit losses is trivial.

# Notes to the financial statements

## 13 Trust and special funds

Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived and are accounted for separately through the DHB's trust ledger. The revenue and expenditure in respect of these funds is included in the statement of comprehensive revenue and expense.

The DHB also administers funds on behalf of certain patients. Patient fund transactions are not recognised in the statement of comprehensive revenue and expense, but are recorded in the statement of financial position as both an asset and a liability.

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

| | Non-patient funds $000 | Patient funds $000 | Total $000 |
|---|---|---|---|
| Balance at 1 July 2020 | 11,591 | 92 | 11,683 |
| Monies received | 3,953 | 159 | 4,112 |
| Interest received | 71 | - | 71 |
| Payments made | (2,310) | (165) | (2,475) |
| **Balance at 30 June 2021** | **13,305** | **86** | **13,391** |
| Monies received | 3,563 | 156 | 3,719 |
| Interest received | 104 | - | 104 |
| Payments made | (4,142) | (133) | (4,275) |
| **Balance at 30 June 2022** | **12,830** | **109** | **12,939** |

# Notes to the financial statements

## 14 Employee entitlements

**Accounting policy**

***Short term employee entitlements***
Employee entitlements that are expected to be settled wholly before 12 months after the end of the reporting period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned but not yet taken at balance date, continuing medical education leave, and sick leave.

***Long term employee entitlements***

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

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

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

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

**Critical accounting estimates and assumptions**

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

***Other employee entitlement liabilities***
Liability for annual leave is calculated as the greater of average weekly earnings for the 12 months immediately before the end of the last pay period before the annual holiday is taken or the employee's ordinary weekly pay as at the beginning of the annual holiday.

Actuarial valuations have been obtained for the remaining liabilities. The actuarial valuations include a salary growth factor of 3.0%, (2021:1.9%) and a discount rate ranging from 3.34% to 4.31% (2021: 0.38% to 2.98%) from 1-10+ years.

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

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

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

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

## 14 Employee entitlements (continued)

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

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

The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance progressed during 2019, 2020 and current financial years. The. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

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

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

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Current entitlements** | | |
| Accrued salaries and wages | 25,504 | 17,750 |
| Annual leave | 72,587 | 61,418 |
| Holidays Act 2003 remediation | 165,914 | 86,988 |
| Sick leave | 578 | 490 |
| Sabbatical leave | 400 | 389 |
| Continuing medical education leave and expenses | 4,355 | 4,064 |
| Long service leave | 3,840 | 3,609 |
| Retirement gratuities | 1,150 | 1,057 |
| *Total current entitlements* | 274,328 | 175,765 |
| | | |
| **Non-current entitlements** | | |
| Sick leave | 2,109 | 1,935 |
| Sabbatical leave | 453 | 484 |
| Continuing medical education leave and expenses | 8,709 | 8,131 |
| Long service leave | 4,714 | 4,744 |
| Retirement gratuities | 634 | 993 |
| *Total non-current entitlements* | 16,619 | 16,287 |
| **Total employee entitlements** | **290,947** | **192,052** |

# Notes to the financial statements

## 15 Provisions

**Accounting policy**

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

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Current provisions** | | |
| ACC Partnership Programme | 883 | 731 |
| **Non-current provisions** | | |
| ACC Partnership Programme | 398 | 500 |
| **Total provisions** | **1,281** | **1,231** |
| **ACC Partnership Programme** | | |
| Undiscounted amount of claims at balance date | 964 | 952 |
| Discount | 25 | 3 |
| Central estimate of present value of future payments | 1,153 | 1,103 |
| Risk margin | 128 | 128 |

**The movement in provisions is represented by:**

| | ACC Partnership Programme $000 |
|---|---|
| Balance as at 1 July 2020 | 1,240 |
| Additional provisions during the year for the risks borne in current period | 726 |
| Additional provisions relating to a reassessment of risks in a previous period | 437 |
| Amounts used during the year | (1,172) |
| **Balance as at 30 June 2021** | **1,231** |
| Additional provisions during the year for the risks borne in current period | 792 |
| Additional provisions relating to a reassessment of risks in a previous period | 519 |
| Amounts used during the year | (1,261) |
| **Balance as at 30 June 2022** | **1,281** |

# Notes to the financial statements

## 15 Provisions (continued)

**ACC Partnership Programme**

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

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

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

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

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

An external independent actuarial valuer, Mr S Ferry, FNZSA of Aon New Zealand Ltd, has calculated the DHB's liability. The valuer has attested he is satisfied as to the nature, sufficiency and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report. Average inflation for the next 5 year has been assumed as 3.05% for the year ended 30 June 2022. Average discount rate over the next 5 years of 3.52% has been used for the year ended 30 June 2022. 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.

# Notes to the financial statements

## 16 Trade and other payables

**Accounting policy**

Short-term payables are measured at the amount payable.

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Payables under exchange transactions** | | |
| Trade payables | 13,744 | 17,568 |
| Revenue in advance | 896 | - |
| Capital charge due to the Crown | - | - |
| Other non-trade payables and accrued expenses | 62,840 | 62,521 |
| *Total payables under exchange transactions* | 77,480 | 80,089 |
| | | |
| **Payables under non-exchange transactions** | | |
| Revenue in advance | 2,118 | 958 |
| GST and other tax payables | 24,234 | 26,879 |
| *Total payables under non-exchange transactions* | 26,352 | 27,837 |
| **Total trade and other payables** | **103,832** | **107,926** |

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

## 17 Patient and restricted funds

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Patient funds** | | |
| Balance at 1 July | 86 | 92 |
| Monies received | 156 | 159 |
| Payments made | (133) | (165) |
| *Total patient funds* | 109 | 86 |
| | | |
| Holiday home funds due to Hutt Valley DHB | - | 4 |
| **Total patient and restricted funds** | **109** | **90** |

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 2022 are not recognised in the Statement of comprehensive revenue and expense, but are recorded in the Statement of financial position as at 30 June 2022, both as an asset and a liability.

# Notes to the financial statements

## 18 Equity

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Contributed capital** | | |
| Balance at 1 July | 822,164 | 801,942 |
| Capital contributions | 117,324 | 23,706 |
| Repayment of capital | (14,040) | (3,484) |
| *Balance at 30 June* | 925,448 | 822,164 |
| | | |
| **Property revaluation reserves** | | |
| Balance at 1 July | 193,463 | 130,659 |
| Revaluations | - | 72,804 |
| Impairments | - | (10,000) |
| *Balance at 30 June* | 193,463 | 193,463 |
| | | |
| **Accumulated deficit** | | |
| Balance at 1 July | (574,709) | (528,210) |
| Surplus/(Deficit) for the year | (46,155) | (46,499) |
| Transfer from revaluation reserves | - | - |
| *Balance at 30 June* | (620,864) | (574,709) |
| **Total equity** | **498,047** | **440,918** |

**Capital management**

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

The DHB is subject to financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

The DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities, investments, and general financial dealings to ensure that it effectively achieves its objectives and purpose, while remaining a going concern.

# Notes to the financial statements

## 19 Operating lease commitments

**Accounting policy**

***Operating leases***

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

Lease incentives received are recognised in surplus or deficit as a reduction of operating lease expense over the lease term.

**Operating lease commitments as lessee**

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Less than one year | 5,672 | 6,193 |
| Between one and five years | 12,930 | 13,817 |
| More than five years | 13,375 | 15,578 |
| **Total operating lease commitments as lessee** | **31,977** | **35,588** |

During the year ended 30 June 2022, $5.1 million (2021: $4.6 million) was recognised as an expense in the statement of comprehensive revenue and expense in respect of operating leases.

The DHB leases a number of buildings, vehicles and items of medical equipment under operating leases.
Leases are on normal commercial terms and include restrictions on sub-leasing. For leased buildings some leases have ratchet clauses, and most have rights of renewal.
Leased properties are not subleased by the DHB.

**Operating lease commitments as lessor**

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Less than one year | 3,135 | 3,338 |
| Between one and five years | 10,126 | 10,613 |
| More than five years | 41,412 | 43,488 |
| **Total operating lease commitments as lessor** | **54,673** | **57,439** |

The leases are comprised of:

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

# Notes to the financial statements

## 20 Financial instruments

### Financial instrument categories

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

| | Note | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|---|
| **Financial assets measured at amortised cost** | | | |
| Cash and cash equivalents | 12 | - | - |
| Trade and other receivables | 11 | 121,522 | 60,022 |
| **Total** | | **121,522** | **60,022** |
| | | | |
| **Financial liabilities measured at amortised cost** | | | |
| Cash and cash equivalents | 12 | 44,451 | 28,843 |
| Trade and other payables (excluding revenue in advance and taxes) | 16 | 77,480 | 80,089 |
| **Total** | | **121,931** | **108,932** |

### Financial instrument risks

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

**Market risk**

***Price risk***

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

***Fair value interest rate risk***

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

***Cash flow interest rate risk***

Cash flow interest rate risk is the risk that cash flows from a financial instrument will fluctuate because of changes in market interest rates. The DHB's exposure to cash flow interest rate risk is limited to on-call deposits. This exposure is not considered significant and is not actively managed.

*Sensitivity analysis*

If the Official Cash Rate had been 100 basis points higher, the working capital facility interest rate and the interest on surplus funds would be higher. The net impact on the DHB would have been favourable $0.19 million in 2022 (2021: $0.32 million).

# Notes to the financial statements

## 20 Financial instruments (continued)

**Credit risk**

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

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

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

Concentrations of credit risk from accounts receivable are limited due to the large number and variety of customers. The Ministry of Health is the largest single debtor, approximately 85.95% in 2022 (2021: 74.72%). It is assessed to be a low risk and high quality entity due to its nature as the government funded purchaser of health and disability support services.

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

***Credit risk exposure by credit risk grades, excluding receivables***

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

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Counterparties with credit ratings** | | |
| Cash at bank and term deposits | | |
| AA- (Standard & Poor's) | 12,757 | 13,119 |
| **Total cash at bank and term deposits** | **12,757** | **13,119** |

***Maximum exposure to credit risk for each class of financial instrument***

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Cash and cash equivalents | - | - |
| Trade and other receivables | 121,522 | 60,022 |
| Trust and special funds – bank | 12,757 | 7,919 |
| Trust and special funds – term deposit | - | 5,200 |
| Trust and special funds – debtors | 141 | 244 |
| | **134,420** | **73,385** |

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.

# Notes to the financial statements

## 20 Financial instruments (continued)

**Liquidity risk**

***Management of liquidity risk***

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

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

***Contractual maturity analysis of financial liabilities***

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

| | Carrying amount $000 | Contractual cash flows $000 | Less than 1 year $000 | 1-2 years $000 | 2-5 years $000 | More than 5 years $000 |
|---|---|---|---|---|---|---|
| **2022** | | | | | | |
| Cash and cash equivalents | 44,451 | 44,451 | 44,451 | - | - | - |
| Trade and other payables | 77,480 | 77,480 | 77,480 | - | - | - |
| Patient and restricted funds | 109 | 109 | 109 | - | - | - |
| **Total** | **122,040** | **122,040** | **122,040** | **-** | **-** | **-** |
| | | | | | | |
| **2021** | | | | | | |
| Cash and cash equivalents | 28,843 | 28,843 | 28,843 | - | - | - |
| Trade and other payables | 80,089 | 80,089 | 80,089 | - | - | - |
| Patient and restricted funds | 90 | 90 | 90 | | | |
| **Total** | **109,022** | **109,022** | **109,022** | **-** | **-** | **-** |

# Notes to the financial statements

## 21 Related party transactions and key management personnel

CCDHB is a wholly owned entity of the Crown.

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

**Key management personnel compensation**

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| Remuneration | 4,777 | 4,723 |
| Less: Amount paid by Hutt Valley DHB | (1,332) | (879) |
| Less: Amount paid by Wairarapa DHB | (22) | (6) |
| Amount paid by Capital & Coast DHB | 3,423 | 3,838 |
| | | |
| Full-time equivalent members | 12 | 12 |

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

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

# Notes to the financial statements

## 22 Explanations of major variances from budget

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

**Statement of comprehensive revenue and expense**

The DHB recorded a deficit of $46.2 million compared with a budgeted surplus of $7.0 million.

Revenue was $189.3 million higher than budget mainly due to :

- additional funding for COVID-19 response costs $122 million for community, MIQ, testing and the vaccine rollout
- Staff Pay Equity funding $28m
- $16.5m fair value increase in the New Children's Hospital Donation

Personnel costs were $104.5 million higher than budget mainly due to the provision for Holiday Act, pay equity settlement, and COVID-19 response costs.

Infrastructure and non-clinical expenses were $47.3 million higher than budget due to costs relating to COVID-19 Care in Community cost $20 million and Holiday Act provision $10.8 million.

Payments to non-health board providers were $77.7 million higher than budget due to COVID-19 community care related costs.

**Statement of financial position**

Trade and other receivables were over budget mainly due to the reimbursement of COVID-19 response cost from the Ministry.

Employee entitlements are higher than budget, mainly due to a $78.9 million increase in the Holidays Act 2003 remediation provision.

Crown equity is under budget due to $10.6 million repayment to the Ministry related to copper pipe settlement which is not budgeted for. Also the capital injection and deficit support are under budget for $40.5 million 27.8 million respectively.

**Statement of cash flows**

The Cash receipts from Ministry of Health and Payment to suppliers were over budget due to the COVID-19 response revenue and cost were not budgeted for.

Purchase of property, plant and equipment was below budget due to the unspent capital expenditure.

## 23 Events after balance date

On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, replacing the New Zealand Public Health and Disability Act 2000, and establishing Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora). District Health Boards were legally disestablished, and their assets and liabilities transferred to Health New Zealand on this date.

# Notes to the financial statements

## 24 Summary cost of services by output class

**Accounting policy**

***Cost of service***

The cost of service statements, as reported in the statement of performance, report the revenue and expenses of services for the outputs of the DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

***Cost allocation***

The DHB has determined the cost of outputs using the cost allocation system outlined below.

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

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

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

## 24 Summary cost of services by output class (continued)

| | Prevention services | | Early detection and management | | Intensive assessment and treatment | | Rehabilitation and support | | Total DHB | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2022 Actual $000 | 2021 Actual $000 | 2022 Actual $000 | 2021 Actual $000 | 2022 Actual $000 | 2021 Actual $000 | 2022 Actual $000 | 2021 Actual $000 | 2022 Actual $000 | 2021 Actual $000 |
| **Revenue** | | | | | | | | | | |
| Crown | 62,520 | 47,856 | 369,473 | 197,067 | 986,835 | 961,185 | 123,884 | 115,978 | 1,542,712 | 1,322,086 |
| Other | - | - | - | - | 100,491 | 36,678 | - | - | 100,491 | 36,678 |
| ***Total revenue*** | **62,520** | **47,856** | **369,473** | **197,067** | **1,087,326** | **997,863** | **123,884** | **115,978** | **1,643,203** | **1,358,764** |
| **Expenditure** | | | | | | | | | | |
| Personnel | 188 | 145 | 3,553 | 2,741 | 668,979 | 603,888 | 1,902 | 1,467 | 674,622 | 608,241 |
| Depreciation | - | - | - | - | 43,805 | 36,574 | - | - | 43,805 | 36,574 |
| Capital charge | - | - | - | - | 21,339 | 19,316 | - | - | 21,339 | 19,316 |
| Provider payments | 27,620 | 45,752 | 284,958 | 183,358 | 103,996 | 109,968 | 111,283 | 108,047 | 527,857 | 447,125 |
| Other | 34,712 | 1,959 | 80,962 | 10,968 | 214,633 | 265,955 | 10,699 | 6,464 | 341,006 | 285,346 |
| ***Total expenditure*** | **62,520** | **47,856** | **369,473** | **197,067** | **1,052,752** | **1,035,701** | **123,884** | **115,978** | **1,608,629** | **1,396,602** |
| **Net surplus/(deficit) before extraordinary item** | **-** | **-** | **-** | **-** | **34,574** | **(37,838)** | **-** | **-** | **34,574** | **(37,838)** |
| **Extraordinary item** | | | | | | | | | | |
| Holidays Act 2003 remediation | - | - | - | - | (80,729) | (8,661) | - | - | (80,729) | (8,661) |
| **Net surplus/(deficit)** | - | - | - | - | **(46,155)** | **(46,499)** | - | - | **(46,155)** | **(46,499)** |

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.

## 25 Impact Of COVID-19

In August 2021, New Zealand entered nationwide lockdown (alert level 4), capacity to provide planned care surgery was reduced. Due to the Delta outbreak and the level 4 lockdown, the vaccination programme was accelerated.

With new COVID-19 cases peaked in April 2022, a high prevalence of COVID infections impacted both staff and patients. Patients were deferred due to hospital capacity issues and also patient illness itself.

In the year to 30 June 2022, there were $124 million additional cost from the COVID-19 response, out of which, $109 million is related to the contracts and campaign that 2DHB COVID team managed collectively.

Note 22 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.

## 26 Note disclosure in entity's financial statements

**Breach of statutory reporting deadline**

The 2021/22 annual report of the Capital & Coast District Health Board was not completed by 31 December 2022, as required by section 156 of the Crown Entities Act 2004 (as amended by the Annual Reporting and Audit Time Frames Extensions Legislation Act 2021 which extended the reporting timeframes in the Crown Entities Act 2004 by two months).

## STATUTORY REMUNERATION DISCLOSURES

### 1 Employee remuneration

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

| Salary band $000 | 2022 Number of Employees | 2021 Number of Employees | Salary band $000 | 2022 Number of Employees | 2021 Number of Employees |
|---|---|---|---|---|---|
| 100 – 110 | 482 | 440 | 330 – 340 | 7 | 9 |
| 110 – 120 | 416 | 223 | 340 – 350 | 6 | 9 |
| 120 – 130 | 307 | 171 | 350 – 360 | 9 | 12 |
| 130 – 140 | 180 | 132 | 360 – 370 | 11 | 7 |
| 140 – 150 | 129 | 87 | 370 – 380 | 6 | 6 |
| 150 – 160 | 100 | 64 | 380 – 390 | 7 | 6 |
| 160 – 170 | 67 | 53 | 390 – 400 | 6 | 6 |
| 170 – 180 | 64 | 43 | 400 – 410 | 5 | 3 |
| 180 – 190 | 44 | 39 | 410 – 420 | 6 | 3 |
| 190 – 200 | 45 | 30 | 420 – 430 | 4 | 5 |
| 200 – 210 | 36 | 24 | 430 – 440 | - | 2 |
| 210 – 220 | 28 | 30 | 440 – 450 | 2 | 1 |
| 220 – 230 | 31 | 18 | 450 – 460 | 4 | 2 |
| 230 – 240 | 24 | 18 | 470 -- 480 | 3 | 2 |
| 240 – 250 | 20 | 23 | 480 – 490 | 3 | 3 |
| 250 – 260 | 20 | 17 | 490 – 500 | 2 | 3 |
| 260 – 270 | 17 | 15 | 510 – 520 | - | 1 |
| 270 – 280 | 17 | 13 | 540 – 550 | - | 1 |
| 280 – 290 | 18 | 21 | 580 – 590 | - | 1 |
| 290 – 300 | 16 | 20 | 600 – 610 | - | 2 |
| 300 – 310 | 14 | 9 | 610 – 620 | 2 | 1 |
| 310 – 320 | 14 | 9 | | | |
| 320 – 330 | 11 | 8 | **Total employees** | **2,183** | **1,592** |

Of the 2,183 employees shown above, 715 were medical or dental employees and 1,468 were neither medical nor dental employees. This represents an increase of 591 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 2,902 compared with the actual total number of 2,183.

During the year ended 30 June 2022, 32 employees (2021: 13) received compensation and other benefits in relation to cessation totalling $0.5 million (2021: $0.2 million).

## STATUTORY REMUNERATION DISCLOSURES

### 2 Board member and committee member remuneration

| | 2022 Actual $000 | 2021 Actual $000 |
|---|---|---|
| **Board members** | | |
| Remuneration | 307 | 284 |
| Full-time equivalent members | 1.0 | 0.8 |

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

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

| | | Board fees | | Committee fees | |
|---|---|---|---|---|---|
| | | 2022 $000 | 2021 $000 | 2022 $000 | 2021 $000 |
| **Board members as at 30 June 2022** | | | | | |
| David Smol, Chair | Appointed | 46.2 | 45.5 | 0.3 | 4.4 |
| Stacey Shortall, Deputy Chair | Appointed | 28.9 | 6.0 | 0.8 | 0.3 |
| Kathryn Adams | Elected | 23.2 | 23.2 | 1.8 | 2.5 |
| Roger Blakeley | Elected | 23.2 | 23.2 | 3.2 | 7.0 |
| Hamiora Bowkett | Appointed | 23.2 | 23.2 | 4.0 | 3.5 |
| Brendan Boyle | Appointed | 23.2 | 4.8 | 2.7 | 0.3 |
| ‘Ana Coffey | Elected | 23.2 | 23.2 | 2.0 | 4.4 |
| Tristram Ingham | Appointed | 23.2 | 23.2 | 2.3 | 3.2 |
| Chris Kalderimis | Elected | 23.2 | 23.2 | 1.4 | 3.9 |
| Sue Kedgley | Elected | 23.2 | 23.2 | 2.7 | 5.8 |
| Vanessa Simpson | Elected | 23.2 | 23.2 | 2.1 | 4.9 |
| **Board member who left during 2020/21** | | | | | |
| Ayesha Verrall, Deputy Chair | Elected | - | 1.7 | - | 2.1 |
| **Total Board member remuneration** | | **283.9** | **243.6** | **23.3** | **42.3** |

| | Committee fees | |
|---|---|---|
| | 2022 $000 | 2021 $000 |
| **Committee members (other than Board members and employees)** | | |
| Suzanne Jane Emirali | 2.7 | 2.5 |
| Peter Jackson | 1.8 | - |
| Paula King | 2.8 | 2.3 |
| Fa’amatuainu Tino Pereira | - | 0.7 |
| Jack Rikihana | 6.9 | - |
| Cherie Seamark | 2.0 | - |
| **Total Committee member remuneration** | **16.2** | **5.5** |

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

**STATUTORY REMUNERATION DISCLOSURES**

Meeting Attendance

**Key:**

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

| Board Member | Position | Meetings Attended | | | | |
|---|---|---|---|---|---|---|
| | | Board | FRAC | HSC | DSAC | MCPAC |
| **1 July 2021 to 30 June 2022** | | | | | | |
| David Smol | Chair – HVDHB and CCDHB | 10/10 | 7/7 | 1/7 | | 9/9 |
| Stacey Shortall | Board Deputy Chair – Current Member | 7/10 | 3/7 | | | |
| 'Ana Coffey | Current Member/ DSAC Chair | 6/10 | | 4/7 | 5/5 | |
| Brendan Boyle | Current Member | 7/10 | | | | 9/9 |
| Chris Kalderimis | Current Member | 9/10 | | 7/7 | | |
| Hamiora Bowkett | Current Member | 8/10 | 7/7 | | | 9/9 |
| Kathryn Adams | Current Member | 9/10 | 7/7 | | | |
| Roger Blakeley | Current Member/ FRAC Co Chair | 9/10 | 7/7 | 6/7 | | |
| Sue Kedgley | Current Member/ HSC Chair | 9/10 | 2/7 | 7/7 | 5/5 | |
| Tristram Ingham | Current Member | 9/10 | 5/7 | | 5/5 | |
| Vanessa Simpson | Current Member | 9/10 | | 7/7 | 4/5 | |

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

# Statement of Responsibility

**For the 12 months ended 30 June 2022**

Te Whatu Ora – Health New Zealand was established on 1 July 2022 under the Pae Ora (Healthy Futures) Act 2022.

As a result of the transitional arrangements in the Pae Ora Act all assets and liabilities of the Capital and Coast District DHB (the Health Board) were transferred to Te Whatu Ora. By Ministerial approval under s 45J of the Public Finance Act 1989, Te Whatu Ora now has responsibility for providing the final annual report of the Health Board, which was disestablished at the end of 30 June 2022.

The Board and Management of Te Whatu Ora take responsibility for the preparation of the Capital and Coast District Health Board group'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 Capital and Coast DHB group under section 19A of the Public Finance Act.

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 and Coast District Health Board group for the year ended 30 June 2022.

Signed on behalf of the Te Whatu Ora Board:

**Naomi Ferguson**

**Acting Chair**

**Dated: 22 March 2023**

**Hon Amy Adams**

**Board member**

**Dated: 22 March 2023**

# 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 2022**

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.

**Opinion**

We have audited:

- the financial statements of the Health Board on pages 57 to 96, that comprise the statement of financial position as at 30 June 2022, 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 30 to 42, 44 to 52 and 95.

In our opinion:

- the financial statements of the Health Board on pages 57 to 96, which have been prepared on a disestablishment basis:
    - present fairly, in all material respects:
        - its financial position as at 30 June 2022; 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 30 to 42, 44 to 52 and 95:
    - presents fairly, in all material respects, the Health Board's performance for the year ended 30 June 2022, 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 on the financial statements and the performance information was completed on 22 March 2023. This is the date at which our 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 of Te Whatu Ora – Health New Zealand 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 matters:

**The financial statements have been prepared on a disestablishment basis**

Note 1 on page 63 outlines that the Health Board has prepared its financial statements on a disestablishment basis because the Health Board was disestablished, and its functions transferred to Te Whatu Ora – Health New Zealand on 1 July 2022. There have been no changes to the values of the Health Board's assets and liabilities as a result of preparing the financial statements on a disestablishment basis.

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

Note 14 on pages 82 and 83, which 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 matters are complex and have resulted in underpayments of holiday pay to current and past employees over a number of years. The Health Board has estimated a provision of $165,914 million, as at 30 June 2022, to remediate these issues. However, until the process is completed, there are uncertainties surrounding the amount of this provision.

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

Pages 44 to 52 outlines the information used by the Health Board to report on its Covid-19 vaccine coverage. The Health Board uses the Health Service User (HSU) population data rather than the population data provided by Statistics New Zealand (Stats NZ), for the reasons set out on page 49 to 51. The notes on page 51 outlines that there would be differences in the reported results for the overall population if the Stats NZ population data was used. There would be further differences in the reported results of vaccination coverage if the Stats NZ population data is classified by ethnicity and age. The Health Board has provided a table that highlights the differences in the ethnicity groupings between the HSU population data and the Stats NZ population data.

**Impact of Covid-19**

Note 25 on page 96 to the financial statements outlines the ongoing impact of Covid-19 on the Health Board. We draw specific attention to note 6 on pages 70 and 71 which outlines the valuation uncertainty highlighted by the valuer in estimating the fair value of the Health Board's land and buildings.

**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 of Te Whatu Ora – Health New Zealand for the financial statements and the performance information**

The preparation of the final financial statements and performance information for the Health Board is the responsibility of the Board of Te Whatu Ora.

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

Up until 30 June 2022, the Health Board was responsible for such internal control as it determined necessary to enable it to prepare financial statements and performance information that were free from material misstatement, whether due to fraud or error. From 1 July 2022, the Board of Te Whatu Ora took over these responsibilities to enable the completion of the financial statements and performance information.

The responsibilities of the Board of Te Whatu Ora arise from the transition provisions in the Pae Ora (Healthy Futures) Act 2022.

**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 of Te Whatu Ora.

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

- We conclude on the appropriateness of the use of the disestablishment basis by the Board of Te Whatu Ora.

- 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 of Te Whatu Ora 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 of Te Whatu Ora is responsible for the other information. The other information comprises the information included on pages 2 to 29, 42 to 43 and 97 to 100, but does not include the financial statements and the performance information, and our auditor's report thereon.

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

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

**Independence**

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

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

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

# Ministerial Directions

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

- The 2011 Eligibility Direction issues under s.32 of the NZ Public Health and Disability Act 2000
- The requirement to implement the New Zealand Business Number (NZBN) in key systems by December 2018, issued in May 2016 under s.107 of the Crown Entities Act
- The direction to support a whole of Government approach issued in April 2014 under s.107 of the Crown Entities Act. The three directions cover Procurement, ICT and Property. Procurement and ICT apply to Capital & Coast 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

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| **Postal address:**<br>Capital & Coast District Health Board<br>Private Bag 7902<br>Wellington 6242<br>**Website:** www.ccdhb.org.nz<br>**Facebook:**<br>www.facebook.com/TeWhatuOraCapitalCoastHuttValley | **Wellington Regional Hospital physical address:**<br>Riddiford Street,<br>Newtown, Wellington 6021<br>**Phone:** (04) 385 5999 |
| **Bankers:** Bank of New Zealand | **Auditor:** Audit New Zealand Wellington, on behalf of the Controller and Auditor-General |
| **CCDHB Board Members as at 30 June 2022**<br>The Board has eleven members. Seven are elected. Four are appointed by the Minister of Health *(marked*)* | |
| **David Smol, Chair Hutt Valley and Capital & Coast DHB*** | |
| **Stacey Shortall, Deputy Chair*** | **Kathryn Adams** |
| **'Ana Coffey** | **Roger Blakely** |
| **Brendan Boyle*** | **Sue Kedgley** |
| **Chris Kalderimis** | **Tristram Ingham*** |
| **Hamiora Bowkett*** | **Vanessa Simpson** |
| **Executive Leadership Team as at 30 June 2022** | |
| **Fionnagh Dougan,** Chief Executive Officer 2DHB | **Rosalie Percival,** Chief Financial Officer 2DHB |
| **Joy Farley,** Director Provider Services 2DHB | **Sarah Jackson,** Acting Director Clinical Excellence 2DHB |
| **Chris Kerr,** Director of Nursing 2DHB | **Arawhetu Gray,** Director of Māori Health 2DHB |
| **John Tait,** Chief Medical Officer 2DHB | **Junior Ulu,** Director of Pacific People's Health 2DHB |
| **Christine King,** Director of Allied Health 2DHB | **Rachel Haggerty,** Director Strategy Planning and Performance 2DHB |
| **Declan Walsh,** Director People, Culture and Capability 2DHB | **Steve Earnshaw,** Acting Chief Digital Officer, 3DHB |
| **Karla Bergquist,** Executive Director Mental Health, Addiction and Intellectual Disabilities, 3DHB | **Sally Dossor,** Director of the Office of the Chief Executive |
| **Helen Mexted,** Director, Communications and Engagement 2DHB | |
| **3DHB Disability Support Advisory Committee as at 30 June 2022** | |
| **'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,** Te Upoko o te Ika A Maui Māori Council |

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|---|---|
| **Bernadette Jones,** Chair, Sub-regional Disability Advisory Group | **Marama Tuuta,** Chair of Kaunihera Whaikaha, Wairarapa |
| **Combined Health System Committee as at 30 June 2022** | |
| **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 |
| **Ria Earp,** Hutt Valley | **Roger Blakeley,** Capital & Coast |
| **Paula King,** Te Upoko o te Ika A Maui Māori Council | **Fa'amatuainu Tino Pereira,** Sub-regional Pacific Strategic Health Group |
| **Sue Emirali,** Sub-regional Disability Advisory Group | **Bernadette Jones,** Sub-regional Disability Advisory Group |
| **Teresea Olsen,** Community Māori Representative, Hutt Valley | |
| **Finance Risk and Audit Committee as at 30 June 2022 - CCDHB** | |
| Roger Blakeley, Chair – Capital & Coast | Stacey Shortall, Capital & Coast |
| Tristram Ingham, Capital & Coast | Kathryn Adams, Capital & Coast |
| Hamiora Bowkett, Capital & Coast | |

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|---|---|
| **Major Capital Projects Advisory Committee as at 30 Jun 2022** | |
| Brendan Boyle, Chair – CC | Wayne Guppy, Hutt Valley |
| Hamiora Bowkett, Capital & Coast | David Smol, Hutt Valley |
| Tony Lloyd, Ministry of Health | Bruce McLean, appointed independent expert |

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| **Chief Executive Employment Committee (CEEC) as at 30 June 2022. Members are:** | |
| David Smol, Chair CCDHB/HVDHB Boards | |
| Wayne Guppy, Deputy Chair HVDHB | Stacey Shortall, Deputy Chair CCDHB |