Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 March 2022

Capital & Coast District Health Board
Ūpoko ki te uru hauora

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22.
- Excluding the COVID-19 net expenses the DHB's result for the nine month's to 31 March 2022 is $37.7m surplus, versus a budget surplus of $30.6m.
- Additional net COVID-19 related expenditure above funding, year to date is $16.0m.
- For the nine month's to 31 March 2022 the overall DHB year to date result, including COVID-19 costs is $29.5m deficit.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $66.2m year to date.
- The DHB has a positive cash Balance at month-end of $7.9m and a positive "Special Funds" of $13.4m, net $21.3m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Executive Summary continued

Hospital: The impact of COVID-19 response for the newer variant Omicron saw our plans for service delivery alongside our COVID reality in full operations. Many hospital programme deliverables and service delivery took second place to these demands.

- We have continued to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this is increasingly limited by COVID inpatient demands and staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- Continued intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists remain at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- The national cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list still remains well above outside the target waitlist size set by the Ministry programme. Factors impacting on our waitlist size is the reduction in surgery due to COVID 19 related additional cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in in the waiting time.
- The financial performance of the hospital provider arm deteriorated this month across the areas of revenue, personnel and outsourced costs and outsourced clinical services . A number of responses are in place to meet the forecast trajectory, but this is a difficult and challenging positon in the financial year especially coupled with the current health environment (COVID and workforce). However, we know what actions need to be taken to manage through this as outlined in this section 2.2 and section 4

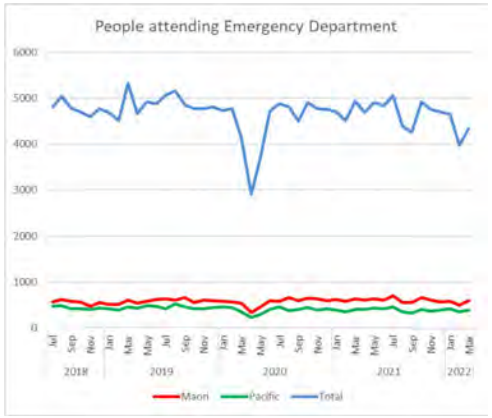
Funder:: In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:

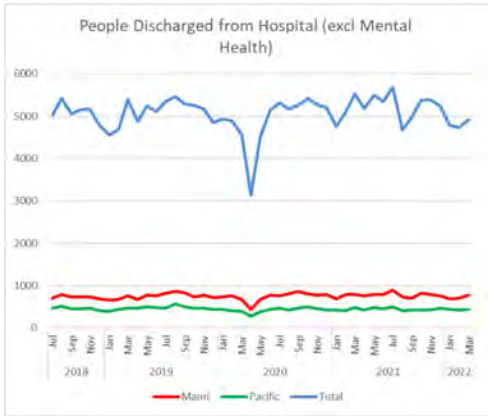
- Complex Care and Long Term Conditions
  - Improve access and reduce inequities for Maori and Pacific
- Locality Services Integration
  - We are waiting on feedback on the Porirua Prototype proposal to iHNZ and are now focusing our efforts on Lower Hutt and the Wainuiomata community.
- 2DHB Community Health Networks
  - Strengthen Kapiti Community Health Network. An EOI for new members has closed and is being worked through.
  - Develop Community Health Networks in Wellington and the Hutt Valley
  - Allied Health Integration
  - Community Accident and Medical redesign/ Community Radiology redesign where we are in receipt of the report and are working through its implications
- Intersectoral Priorities
  - Disability – World of Difference
  - Strengthen our response to family violence

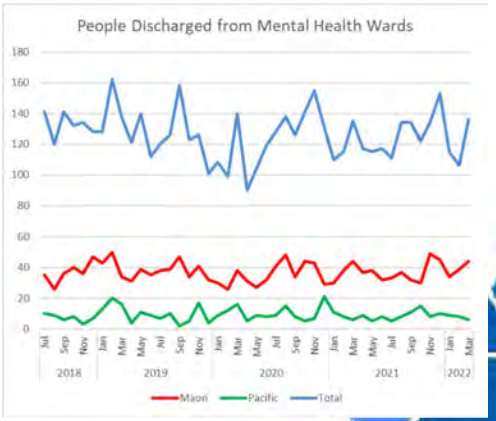
Performance Overview: Activity Context (People Served)

CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**4,343**	591 Maori, 388 Pacific
People receiving Surgical Procedures (in main theatres)	**932**	128 Maori, 70 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**4,925**	776 Maori, 443 Pacific
People discharged from Mental Health Wards	**136**	44 Maori, 6 Pacific

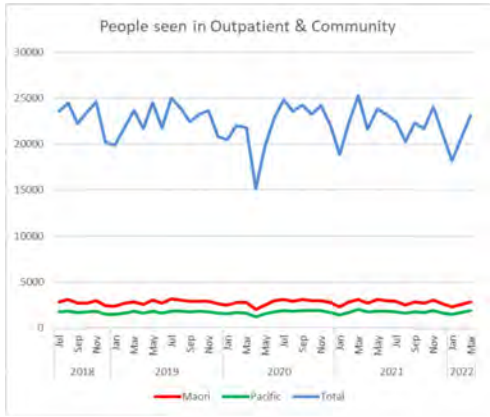


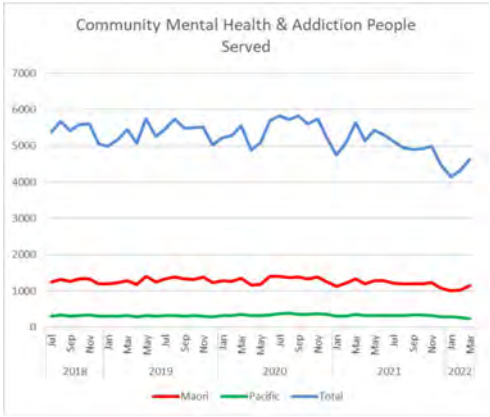


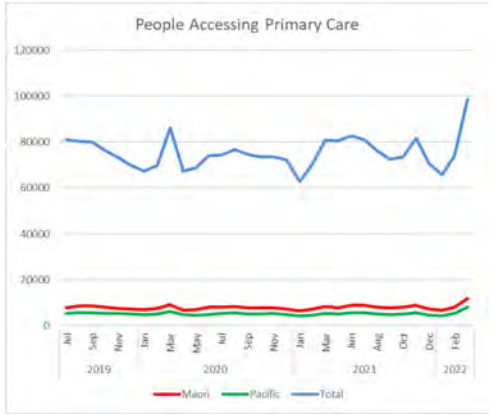


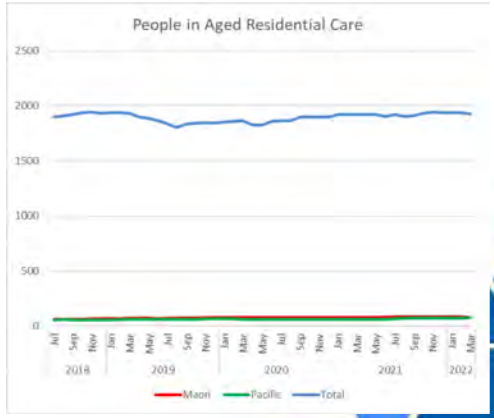
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**23,120** 2,849 Maori, 1,852 Pacific
Community Mental Health & Addiction People Served	**4,633** 1,142 Maori, 229 Pacific
People accessing primary care	**98,650** 11,845 Maori, 7,981 Pacific
People in Aged Residential Care	**1,927** 79 Maori, 76 Pacific









Financial Overview – March 2022

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$21.7m surplus Incl. $16.0m net COVID-19 costs	$29.7m surplus Incl. $16.0m net COVID-19 costs	$8.3m deficit	$66.2m spend Incl. $30.8m strategic capex
Against a budgeted YTD surplus of $30.6m. BAU Month result was $3.5m favourable. YTD $7.1m favourable BAU variance.	Against a budgeted YTD surplus of $39.3m. BAU Month result was $2.9m favourable. BAU YTD $6.4m favourable variance.	Against a budgeted YTD Deficit of $8.7m. BAU Month result was $612k favourable result. YTD $361k favourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $31.7m. Strategic incorporates funded project such as Children's Hospital & ISU

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.38% behind[1]	5,920[3]	($11.9m) annualised[4]
-2055 CWDs behind PVS plan (-968 IDF CWDs , but -424 Hutt behind). Month result - CWDs excluding work in progress.	YTD 117 FTE below annual budget of 6,037 FTE. There is 848 FTE vacancies at end of February	Underlying YTD annual leave taken is under by 4 days per FTE and Lieu leave taken for public holidays is short by 3.4 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1,842 cwd outsourced (854 events) ~$11.2m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.

[3] Paid FTE ignores leave balance movement which is YTD 10FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $6.5m adverse to budget.

CWD – Case weights (also known as WEIS for a year) WEIS – Weighted Inlier Equivalent Separations

4 – Only annual leave & Lieu excludes long service, LILO & other types, note that public holidays build up the Lieu leave in the second half of the financial year. This assumes the YTD continues for 12 months

Hospital Performance Overview – March 2022

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
61%	924	1,423**	8
34% below the ED target of 95% Monthly -7%	Against a target of zero long waits a monthly movement of +212	Against a target of zero long waits, a monthly movement of -8 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.38% behind[1]	3,837[3]	$6,856*
-2055 CWDs behind PVS plan (-968 IDF CWDs , but -424 Hutt behind). Month result - CWDs excluding work in progress.	YTD 8 behind annual budget of 3,829 FTE. 419 FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Jan 2022

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1,842 cwd outsourced (754 events) ~$11.2m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $1.3m adverse

ELOS – Emergency Dept 6 hour length of stay rule of 95%
CWD – Case weights (also known as WEIS for a year) WEIS – Weighted Inlier Equivalent Separations

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- The net favourable YTD variance in the Funder Arm of $0.36m consists of a favourable revenue variance of $110.43m offset by an unfavourable cost variance of ($110.07m) mainly due to unbudgeted COVID-19 revenue and costs as set out below.
- COVID-19 accrued and paid revenue of $84m is offset by COVID-19 costs of ($84m). MoH has agreed to a full cost recovery for the COVID-19 response. The ongoing demand for vaccination sites and community isolation surveillance continues. The COVID-19 Care in the Community (CitC) delivery phase continues alongside the COVID-19 testing and vaccination programmes The booster injection continues to support reducing the impact of Omicron spread into the community. The programmes are managed using community sites across the CCDHB and Hutt region, some with drive through options, which can be ramped up or down at short notice. Equity priorities for Māori, Pacific and vulnerable communities are part of all the programmes to make sure vaccinations and community care is delivered promptly and that those populations are not at risk.
- The cost of funding BAU community services is ($1.8m) unfavourable to budget. Some of these costs have offsetting revenue. Additional Age Residential Care costs reflect the impact of stronger homecare support services. Some Pharmaceutical costs are also impacted by COVID. These are offset by lower costs in Primary Care demand driven services such as immunisations (excl COVID) and child dental services.
- The volume throughput in HHS is still below target due to COVID related lockdowns and now the Omicron wave impact. The funder paid $1.5m less to the Provider Arm for services and received ($3.2m) less IDF revenue from other DHBs. The Funder Arm had to pay back planned care 2020-21 target wash-up of ($0.7m).
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant needs for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:
    - Complex Care and Long Term Conditions
        - Improve access and reduce inequities for Maori and Pacific
    - Locality Services Integration
        - We are waiting the Minister's announcement on the Porirua Prototype. Engagement has begun on the Lower Hutt/ Wainuiomata community centred on an analysis of health need categorised by people, place and investment.
        - HSC and Boards have endorsed the application of existing Health Care Home funding to support Locality Development.
    - 2DHB Community Health Networks
        - Strengthen Kapiti Community Health Network. New members are in the process of being appointed
        - Develop Community Health Networks in Wellington and the Hutt Valley
        - Allied Health Integration
        - Community Accident and Medical redesign/ Community Radiology redesign. We have received the Synergia report and are at the early stages of engaging with community and provider leaders to understand its implications
    - Intersectoral Priorities
        - Disability – World of Difference implementation is underway
        - Strengthen our response to family violence

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 March 2022	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
76,176	76,176	72,885	(0)	3,291	- Base Funding	685,582	685,582	655,965	(0)	29,617
5,841	5,292	5,701	549	140	- Other MOH Revenue - Funder	52,389	47,629	45,060	4,759	7,328
1,200	0	0	1,200	1,200	- Other MOH Revenue - MECA	23,710	0	0	23,710	23,710
19,585	0	1,352	19,585	18,233	- COVID Revenue from MOH	84,058	0	12,768	84,058	71,290
69	46	106	23	(37)	- Other Revenue	504	415	1,217	89	(712)
2,893	2,892	2,937	1	(44)	- IDF Revenue Inflows PHOs	26,495	26,027	27,073	468	(578)
26,023	23,133	18,407	2,890	7,616	- IDF 2021-2022 wash-up provision	205,537	208,193	164,256	(2,656)	41,281
131,787	**107,539**	**101,389**	**24,248**	**30,398**	**Total Revenue**	**1,078,275**	**967,847**	**906,339**	**110,428**	**171,936**
					Internal Provider Payments					
839	839	824	0	(15)	- DHB Governance & Administration	7,550	7,550	7,413	0	(137)
65,010	61,726	54,638	(3,284)	(10,372)	- DHB Provider Arm Costs - HHS	528,426	529,110	472,906	684	(55,519)
11,564	11,558	7,767	(6)	(3,796)	- DHB Provider Arm Costs - MHAIDS	104,322	104,021	69,907	(301)	(34,415)
(204)	(204)	2,056	0	2,260	- DHB Provider Arm costs - Corporate	(1,523)	(1,614)	15,067	(91)	16,590
1,200	0	0	(1,200)	(1,200)	- DHB Provider Arm costs - MECA	23,710	0	0	(23,710)	(23,710)
12,081	0	0	(12,081)	(12,081)	- DHB Provider Arm costs - COVID	28,803	0	0	(28,803)	(28,803)
90,489	**73,918**	**65,285**	**(16,571)**	**(25,204)**	**Total Internal Provider**	**691,287**	**639,066**	**565,293**	**(52,221)**	**(125,994)**
					External Provider Payments:					
6,560	6,571	5,284	11	(1,275)	- Pharmaceuticals	60,186	59,136	58,393	(1,050)	(1,793)
6,680	6,550	6,693	(129)	14	- Capitation	60,167	58,954	60,298	(1,214)	130
7,820	7,454	7,240	(366)	(580)	- Aged Care and Health of Older Persons	67,601	67,085	64,782	(516)	(2,819)
3,238	3,184	3,122	(54)	(116)	- Mental Health	29,794	28,655	26,728	(1,139)	(3,066)
770	879	1,166	109	396	- Child, Youth, Families	7,584	7,914	7,637	330	53
295	662	431	366	136	- Demand driven Primary Services	3,968	5,956	4,934	1,987	965
3,029	3,005	2,573	(24)	(456)	- Other services	27,770	27,043	20,791	(727)	(6,980)
3,411	4,002	3,815	590	403	- IDF Outflows Patients to other DHBs	35,426	36,017	34,342	590	(1,085)
5,255	5,190	5,253	(65)	(2)	- IDF Outflows Other	46,865	46,708	47,688	(157)	823
37,057	**37,496**	**35,578**	**439**	**(1,480)**	**Total External Providers**	**339,363**	**337,467**	**325,592**	**(1,895)**	**(13,770)**
7,115	0	1,210	(7,115)	(5,905)	- Community COVID Testing & Vax	50,506	0	9,890	(50,506)	(40,616)
389	0	0	(389)	(389)	- Community COVID Pharmacy	389	0	0	(389)	(389)
0	0	(135)	0	(135)	- Community COVID Maori & Pacific	4,360	0	1,351	(4,360)	(3,009)
0	0	0	0	0	- IDF Wash-up 2020-2021	696	0	0	(696)	(696)
135,051	**111,415**	**101,939**	**(23,636)**	**(33,113)**	**Total Expenditure**	**1,086,600**	**976,534**	**902,126**	**(110,067)**	**(184,475)**
(3,264)	**(3,876)**	**(550)**	**612**	**(2,715)**	**Net Result**	**(8,326)**	**(8,687)**	**4,213**	**361**	**(12,539)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	1,897	10,580
COVID-19 Community Testing	7,115	54,866
COVID-19 CitC NGO & Pharms	9,983	12,255
COVID-19 HHS Funding	589	6,357
MECA - Additional Funding	1,200	24,911
PHOs volume variances offset	125	1,727
Mental Health, Aged Care, Family CFAs	784	2,942
CWD IDF 2021/22 below target	2,554	(3,209)
Year to Date Revenue Variances	**24,248**	**110,428**

External Revenue Variances

- COVID-19 actual funding and accrued provision of **$84m** in support of GP assessment testing, vaccine rollout, quarantine hotel staffing, Care in the Community & response funding for Maori and Pacific groups. The DHB will be fully funded for all COVID response and vaccination rollout costs for community activities.
- PHO additional wash-ups and volume funding variance of **$1.7m**. There are increased costs of ($1.3m) offsetting this revenue.
- New funding for Mental Health and Child & Youth services of **$2.9m** has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by **($3.2m)** due to COVID periods since Aug 2021. MECA pay equity funding of **$24.9m** passed through to Provider Arm,

Total CCDHB Funder Arm NET year to date Mar 22 variance is favourable by $0.36m.

Payments to External and Internal Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(1,897)	(10,580)
COVID-19 Community Testing	(7,115)	(54,866)
COVID-19 CitC NGO & Pharms	(9,983)	(12,255)
COVID-19 HHS Funding	(589)	(6,357)
MECA - Additional Funding	(1,200)	(24,911)
HHS PVS services reduced due to COVID	(3,290)	1,527
PHOs volume variances offset revenue	(129)	(1,274)
Volume driven costs	1,053	1,235
Aged Care and Mental Health	(484)	(1,891)
2020/21 IDF and Planned Care washup	0	(696)
Year to Date Payment Variances	**(23,636)**	**(110,067)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs **($84m)** due to ongoing GP test assessment claims, vaccine rollout and Care in the Community in support of the COVID-19 response as directed by the Ministry. This includes Price per Dose vaccinations costs.
- PHO Capitation expenses are **($1.3m)** unfavourable. Additional costs due to volume changes are offset by additional revenue $1.7m.
- Other Community NGO contracts have a net YTD unfavourable variance of (**$0.7m)**. Increased Aged Care volumes in home support and Pharmacy claims offsets favourable volumes in demand driven services such as immunisations (excl COVID) & child dental.

Internal Provider Payments:

- Provider Arm was paid **$1.5m** less due to lower volumes achieved related to COVID lockdown periods. MECA pay equity Ministry funding of (**$24.9m)** passed through to Provider Arm,

IDF 2020-21 wash-up Payment

2020-21 unachieved IDF and planned care wash-up **has resulted in an added cost of ($0.7m).**

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Mar2022 $000's
Inpatient CWD	(2,534)
Outpatient Non DRG	(421)
Uncoded & PCT	(254)
Mental Health Providers	585
PHO Volume changes	470
Other IDF Inflows	(34)
Total per Financials	**(2,188)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($5,2m) YTD. Breakdown of the variance commented below:

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($5.0m): Cardiology ($2.1m), General Surgery ($1.1m), Spec Paediatric Surgery Neonates ($1.1k), Haematology ($661k), Vascular Surgery ($615k), Oncology ($543k), Gen Med ($441k), Neurosurgery ($429k), Urology ($402k), Renal ($303k), Respiratory Medicine ($292k), Paediatric Medicine ($121k)and Offset by Orthopaedic Surgery $1.1m, Neurology $574k, Otorhinolaryngology (ENT) $433k, Maternity Service $347k,, Gynaecology $142k, Ophthalmology $98k
  - Planned Care: ($1.3m); Cardiology ($816k), Cardiothoracic ($637k), Neurosurgery ($617k), General Surgery ($556k) , Vascular Surgery ($387k), Gynaecology ($133k), Paediatric Surgical Services ($122k) and offset by Orthopaedic Surgery $1.1m, Otorhinolaryngology (ENT) $406k, Ophthalmology $226k, Urology $173k,
  - There is a $3.8m COVID-19 adjustment for undelivered IDF CWD due to the Sep /Oct 21 lockdown, on the expectation that this will be funded by MOH at year end.
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry
- Non DRG inflow relates to all IDF patient visits that do not require a overnight stay

Note: negative is CCDHB not delivering services to other DHBs therefore unfavourable from both a patient treatment and P&L perspective

Commissioning: Families & Wellbeing

What is this measure?

Babies and children

- 90% of babies living in a smokefree home at 1st WCTO Contact
- 90% of infants receive all WCTO core contacts in first year of life
- 95% of children fully immunised at 8 months

Why is this important?

The early years of life set the foundation for lifelong health and wellbeing:

- Reducing infant exposure to smoking requires integrated approaches between maternity, community and primary care and a focus beyond maternal smoking to the home and whānau environment.
- Immunisation rates at age 8 months are a measure of timely protection against whooping cough and other vaccine-preventable diseases.
- The WCTO programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to 5 years.

How are we performing?

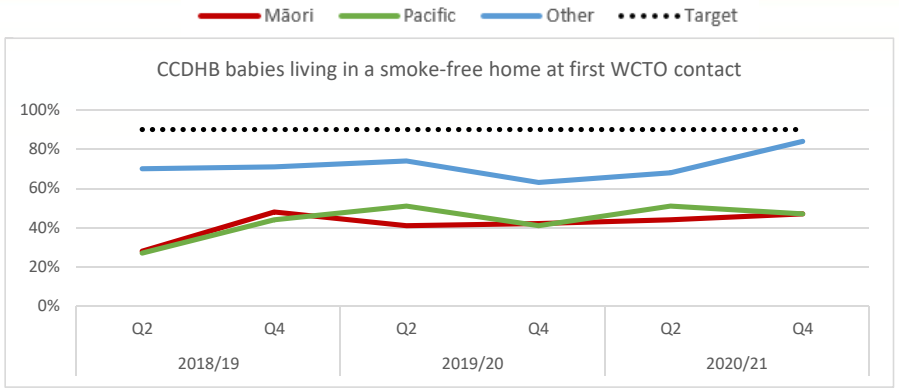
- Performance is below the 90% target for smoke-free homes for Māori (47%), Pacific (47%), and non-Māori, non-Pacific (84%).
- Performance is below the 90% target for WCTO Core Contacts in first year of life for Māori (36%), Pacific (39%), and non-Māori, non-Pacific (54%).
- Performance is below the 95% target for 8 month immunisation for Māori (76%) and Pacific (79%), and at target for non-Māori, non-Pacific (95%).

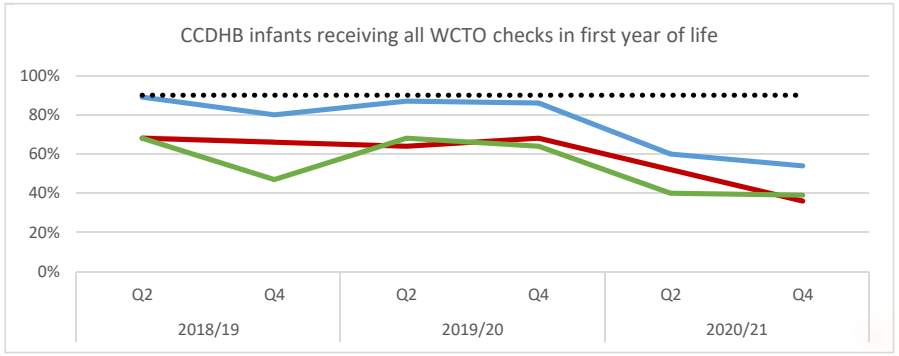
What is driving performance?

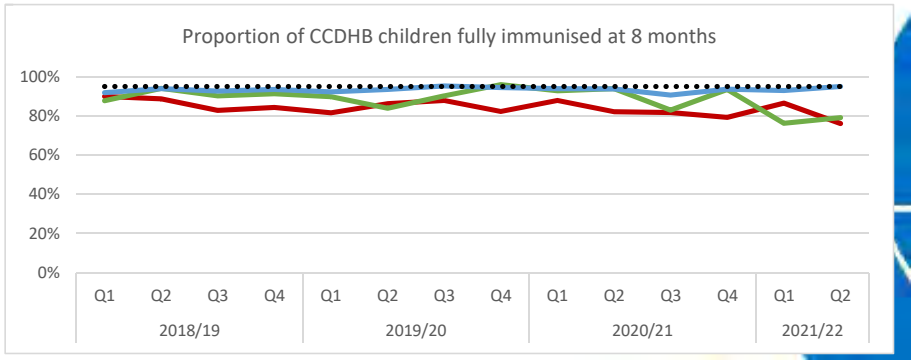
- Engagement with the full set of WCTO visits in the first year of life is challenging. CCDHB is one of the highest performing DHBs for this metric across all ethnicities. Providers have experienced additional challenges as they are implement their COVID-19 response.
- All providers experience restrictions in face to face contacts, and there has been a heightened sense of risk around face to face contacts for whānau. Our providers work hard to met the WCTO targets. However, activity is sometimes documented as an 'Additional' rather than 'Core' contact.

Management comment

- We are focused on developing a pro-equity commissioning approach adopting the learnings of our COVID-19 vaccine programme. We know from our COVID Vaccine programme is that commissioning vaccination with our priority populations (Māori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but, is expected to deliver equity gains.







Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

- Percentage of people aged 75+ living in their own home
- Acute bed day rate per 1,000 for people aged 75+
- Acute readmission rate for people 75+ within 28 days

Why is this important?

- A significant pressure on our health system over the next 15 years is our ageing population.
- We can support older people to maintain their independence through prevention and early intervention activities using a range of community-based supports. Managing frailty earlier in the home and primary care reduces older peoples' demand for hospital services. This increases the likelihood of maintaining their independence and function at home for longer when measures against the life curve.

How are we performing?

- The proportion of CCDHB domiciled 75+ year olds living at home is 92% for Māori, 92% for Pacific, and 92% for non-Māori, non-Pacific.
- The acute bed day rate is 1,977 for Māori, 2,441 for Pacific, and 1,713 for non-Māori, non-Pacific 75+ year olds.
- Performance for 0-28 day acute readmissions is 12% for Māori, 12%for Pacific, and 12% for non-Māori, non-Pacific 75+ year olds.

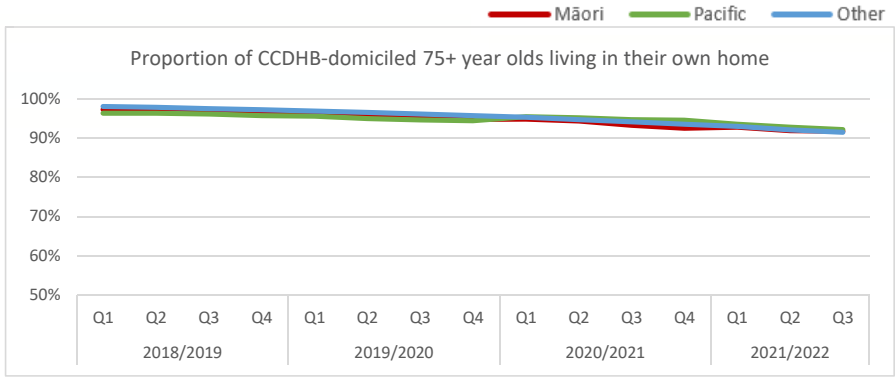
What is driving performance?

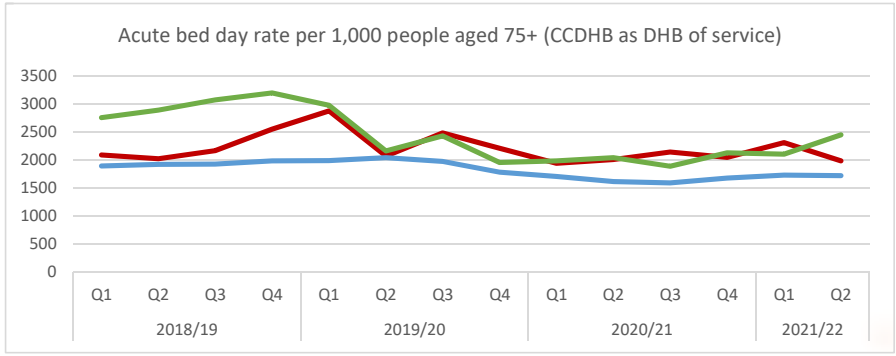
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

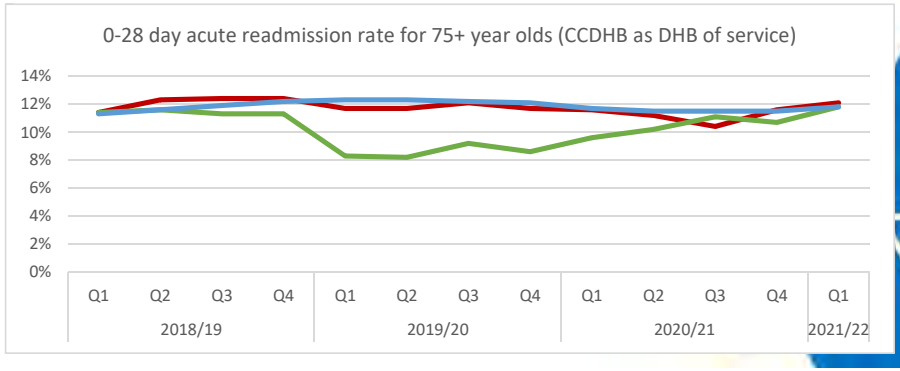
Management comment:

CCDHB has invested in a range of initiatives to support older people living in the region, including:

- **CHOPI** uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings.
- **AHOP** is effective at moving older people with frailty through ED faster. Although AHOP patients have a slightly longer average length of stay in hospital, they are less likely to be readmitted.
- **AWHI** works to reduce the functional decline of patients. It optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings.







Commissioning: Hospital & Speciality Services

What is this measure?
Average length of stay (ALoS) is a measure of the average amount of time a patient spend in Hospital.

Why is this important?
ALoS is an important indicator of the Hospital efficiency. Reduction in the number in ALoS results in decreased risk of infection and medication side effects, improvement in the quality of treatment, and more efficient bed and resource management.

Measurement of ALoS is important because it helps hospitals to more effectively manage resources and patients. Specifically, identifying factors which are associated with the ALoS in order to plan and manage the number of inpatient days, helpful aligning resources hospital resources to patient need and may enable the development of a Clinical Pathway useful for inpatient treatment.

ALoS is used in part to set an agreed national price for each Diagnosis Related Grouping (DRG), reflective of the general complexity and cost of providing care.

How are we performing?
There has been a steady increase in acute medical ALoS that is beginning to rise above the national average. Medical planned care is sitting in line with the national average.

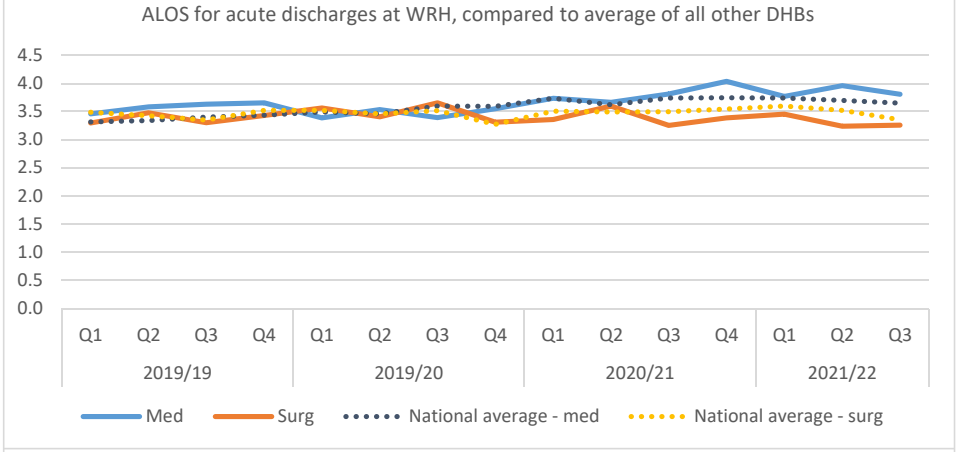
Acute surgical ALoS remains aligned with the national average. Planned surgical ALOS has consistently been above the national average. This is currently trending down due to the reduction in planned care in response to our COIVD-19 surge planning.

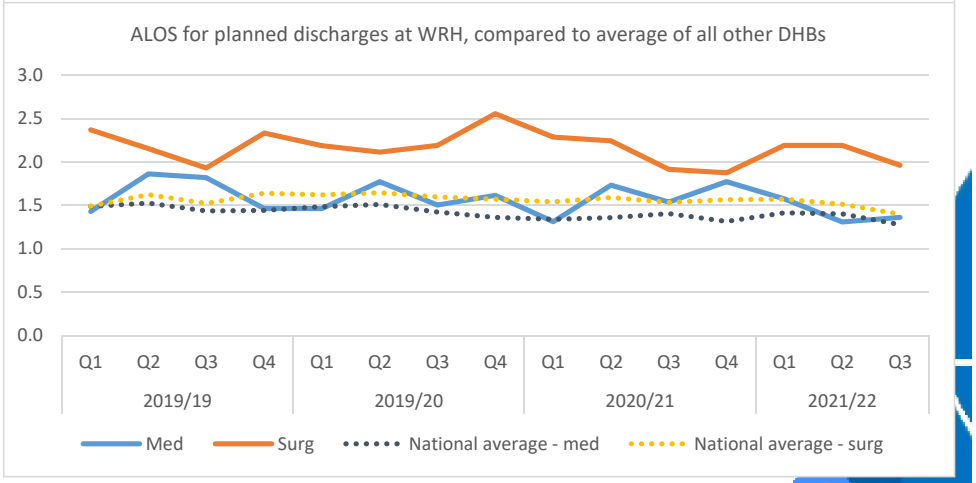
What is driving performance?
As Wellington Regional Hospital is a tertiary centre the events are generally more complex. The hospital often outsources its low complexity events. As a result, the events on site have a higher ALoS as reflected in the deviation from the national average in the planned surgical discharges.

Further, responses to COVID-19 have reduced planned care activity. Medical services have seen an increase in the ALoS as patients complexity increases.

Management comment:
ALoS plays an important part in measuring Hospital efficiency. Within the context of COVID-19 and a constrained Hospital and Health System monitoring ALoS against historical performance and national averages helps us understand Hospital performance within our wider system.

	2020 Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	2021 Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	2022 Jan-Mar
Wellington Hospital occupancy %	90%	81%	99%	96%	94%	99%	94%	96%	93%





Commissioning: Mental Health & Addictions

What is this measure?

Child and youth

- Access to primary and specialist mental health services for 12-19 year olds
- Access to Piki and specialist mental health services for 18-25 year olds
- Comparison of access by service type and ethnicity

Why is this important?

- Access to specialist mental health services has been stable over the last 5 years, while the number of young people accessing primary mental health, telehealth, and digital support services is increasing.
- However, Māori mental health and addiction needs are not being met early enough, with high rates of access to specialist mental health services, and lower rates of access to primary mental health.

How are we performing?

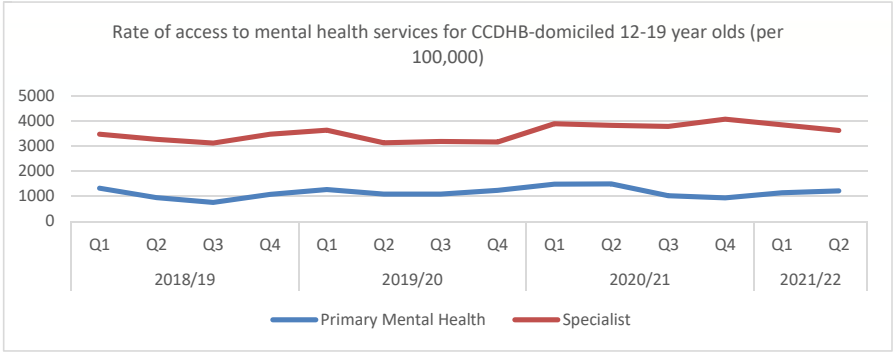
- Access per 100,00 CCDHB-domiciled 12-19 year olds is 1,125 for primary mental health services, and 3,613 for specialist mental health services.
- Access per 100,000 2DHB-domiciled 18-25 year olds is 4,748 for Piki services, and 2681 for specialist mental health services.
- In 2021/22 Q2: access to primary mental health services for 12-19 year olds was 1,724 for Māori, 685 for Pacific, and 1,173 for non-Māori, non-Pacific. Access to specialist services was 4,791 for Māori, 2,530 for Pacific, and 3,340 for non-Māori, non-Pacific.
- In 2021/22 Q2: access to Piki services (2DHB) for 18-25 year olds was 2,420 for Māori, 1,137 for Pacific, and 3,427 for non-Māori, non-Pacific. Access to specialist services was 4,065 for Māori, 2,321 for Pacific, and 2,240 for non-Māori, non-Pacific.

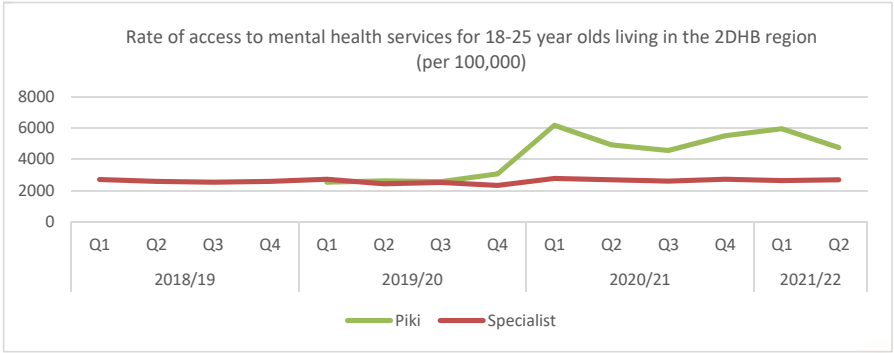
What is driving performance?

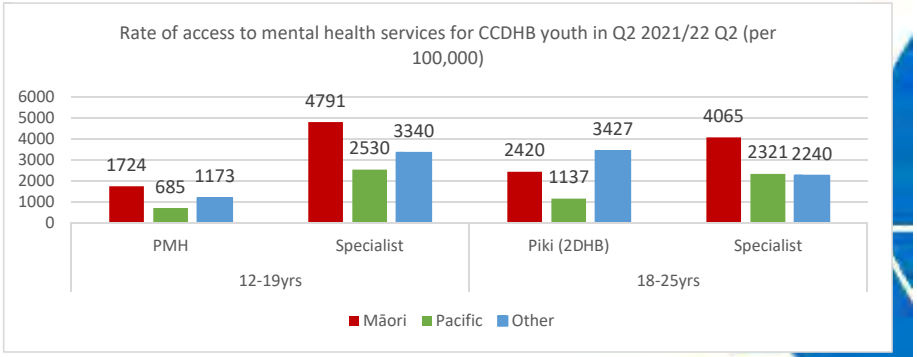
- The stable rate of access to both primary and specialist mental health services for 12-19 year olds reflects ongoing high demand for services and the need to grow more "youth friendly" primary mental health services.
- The increase in access to primary mental health services for 18-25 year olds beginning in Q1 2020/21 reflects the Piki Programme's maturity and ongoing expansion.

Management comment

- The Piki Programme expansion shows that young people will access counselling services when available enabling specialist services to manage demand more sustainably.
- We need to increase access to youth friendly kaupapa Māori and Pacific primary mental health services providing early intervention before problems escalate, focused on our more deprived communities.
- The Mental Health and Addiction Commissioning Forum is overseeing a strategic work programme focused on reducing inequities. The Forum is commissioning a whole of population model of care, for the full continuum of need, through investment in early intervention for children and young people and their whānau; primary and specialist service integration; and strong intersectoral links.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination programme - Boosters and Children

Why is this important?

- The COVID-19 vaccine roll-out aims to protect Aotearoa by ensuring that everyone 5 years and over has free and equitable access to vaccination. The 2DHB COVID-19 vaccination programme is currently implementing the vaccine roll-out to those 18 years and over eligible for a boosters dose, and to children 5-11 years of age. We continue to provide first and second dose vaccinations to people who are yet to be vaccinated.

How are we performing?

- 278,813 eligible people in the 2DHB region have received a booster dose (80% of eligible)
  - 22,717 Māori (65%), 15,329 Pacific Peoples (66%), 240,767 'Other' (83%)
- 27,685 children 5-11 years in the 2DHB region have received a 1st dose (66%)
  - 4,001 Māori (48%), 2,240 Pacific Peoples (52%), 21,444 'Other' (73%)
- 389,863 people 12+ years in the 2DHB region are fully vaccinated (97%)
  - 42,839 Māori (93%), 27,574 Pacific Peoples (95%), 319,450 'Other' (98%)

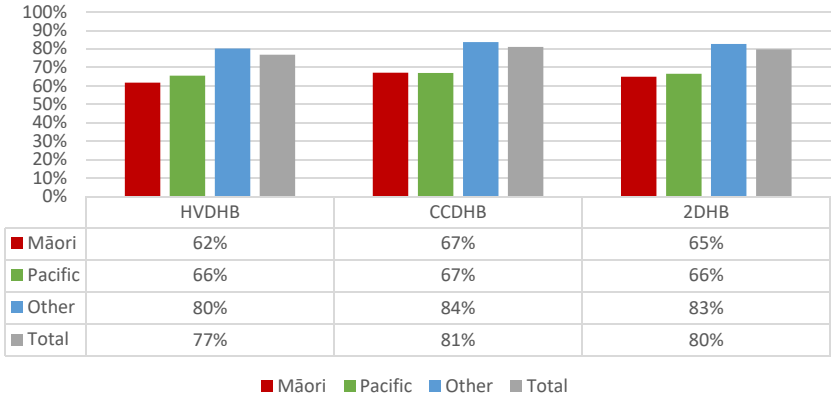
What is driving performance?

- The reduction in booster eligibility periods (from six to three months) has created a significant overhang of people eligible for booster vaccinations in early 2022.
- COVID-19 vaccination requirements and training for children were not fully available until New Year 2022 and required a material re-orientation of vaccination sites (e.g. child friendly spaces) and vaccinator practice (e.g. distraction management and parental consent processes).
- The availability of 2DHB general practice vaccination sites was very limited given the holiday period and subsequent timeframes required to regenerate vaccination capacity.
- The delayed release of booking options for Boosters on Book-My-Vaccine (only available from Monday 18th January 2022) has impacted uptake. The 2DHB community were the highest users of the Book-My-Vaccine website in 2021.

Management comment (i.e. what we are doing about it)

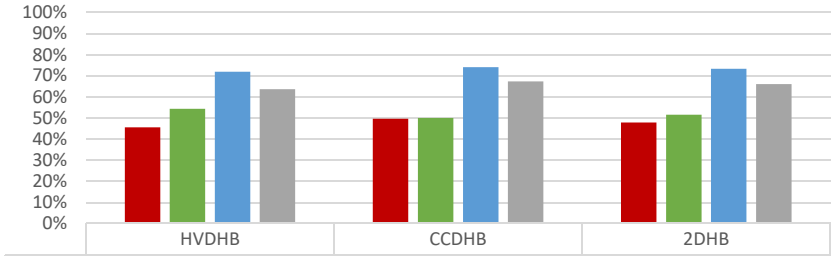
- We have initiated the on boarding of 20+ additional pharmacy sites to increase booster, paediatric and ongoing first and second dose vaccination capacity. This will increase the availability of vaccination capacity on Book-My-Vaccine website. We continue to organise a range of targeted pro-equity, school-based and community vaccination events to increase pro-equity vaccinations particularly in Maori, Pacific and Porirua.

COVID-19 Eligible Booster Uptake by DHB and Prioritised Ethnicity



	HVDHB	CCDHB	2DHB
Māori	62%	67%	65%
Pacific	66%	67%	66%
Other	80%	84%	83%
Total	77%	81%	80%

COVID-19 1st Dose Uptake for Children 5-11 years by DHB and Prioritised Ethnicity



	HVDHB	CCDHB	2DHB
Māori	46%	50%	48%
Pacific	54%	50%	52%
Other	72%	74%	73%
Total	64%	67%	66%

Data Source: MOH Covid-19 Vaccine Data
Date Range: 22/02/2021 to 31/03/2022
Data current at: 01/04/2022 @1.30pm

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 response for the newer variant Omicron saw our plans for service delivery alongside our COVID reality in full operations. Many hospital programme deliverables and service delivery took second place to these demands.
- We have continued to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this is increasingly limited by COVID inpatient demands and staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- Continued intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists remain at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- The national cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list still remains well above the target waitlist size set by the Ministry programme. Factors impacting on our waitlist size is the reduction in surgery due to COVID 19 related additional cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in the waiting time.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- The financial performance of the hospital provider arm deteriorated this month across the areas of revenue, personnel and outsourced costs and outsourced clinical services. A number of responses are in place to meet the forecast trajectory, but this is a difficult and challenging positon in the financial year especially coupled with the current health environment (COVID and workforce). However, we know what actions need to be taken to manage through this as outlined in this section 2.2 and section 4

Executive Summary – Hospital Performance ctd

The financial performance of the hospital provider arm deteriorated this month in the following areas:

1. Reduced Revenue
   - While ACC revenue was slightly ahead of target, other patient sourced income was down by ($0.8m), particularly for non-residents (closed borders) and patient co-payments. Offsetting this loss in real income was additional revenue from other-DHBs, NASC, and external organisations – but most items were simple recoveries of increased costs incurred.
   - *PVS Revenue* – was behind target by ($6.3m) following reduced patient throughput, with IDF CWDs ($6.1m) lower, IDF PCT ($0.5m) lower, and both ATR and non-CWD wash-ups also behind.

2. Higher Personnel and outsourced costs – Despite high vacancy rates of 10.5% sick leave taken reached a historic high of 8% due to Covid-19 infections and isolation requirements, leading to overspends for overtime, penals, and call-backs. On top of this we saw an adverse leave movement of $3.4m. This coupled with outsourced personnel costs of ($2.3m) for locum SMO cover, Anaesthetic Techs and Medical Typing, covering vacancies.

3. Higher Outsourced Clinical – there was decreased outsourcing across surgery of $4.3m, but this was partially offset by increased outsourcing in Radiology ($2.3m) and ($0.7m) in Gastro. Both Radiology and Gastro are included in the additional IAP funding plan, but no additional revenue has been recognised to date as we have yet to sight the formal CFA variation. Outsourced Clinical Services were overspent, with the ongoing outsourced underspend more than offset by increased IAP-related costs for Cardiothoracic, Radiology, and colonoscopies in Gastro, increased by backdated HVDHB radiology charges for outsourced clinics in Neurology.

A number of responses are in place to meet the forecast trajectory that include:

- Negotiations to establish certainty of planned care revenue - this will drive planned care delivery over the last quarter;
- Timing of recruitments planned against need for outsourced clinical services;
- Balancing our recovery from COVID-19 response against service delivery and workforce support in particular leave management;
- Line by line review of costs to ensure appropriate alignment vis COVID-19;
- Evaluation of supply chain impacts and opportunities .

This is a difficult and challenging positon in the financial year especially coupled with the current health environment (COVID and workforce), however we know what actions need to be taken to manage through this.

CCDHB Contract Activity Performance

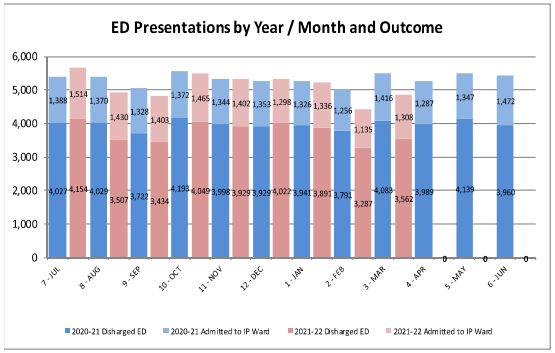
Capital and Coast DHB: March 2022

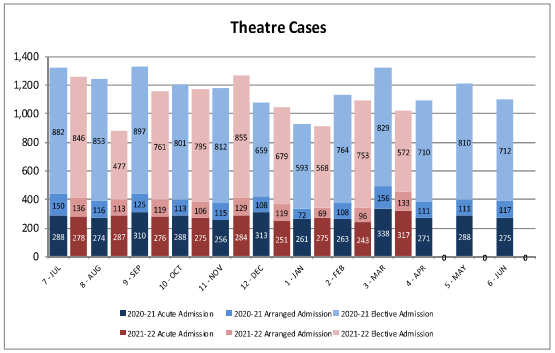
ED Presentations

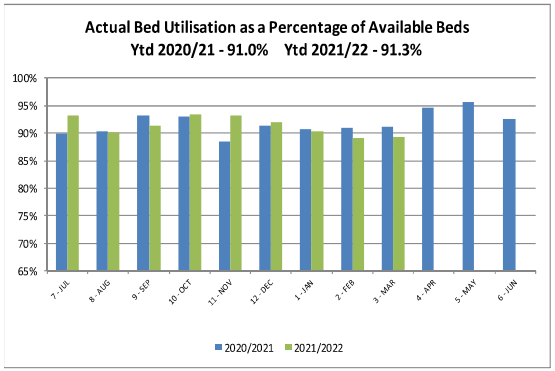
	2020/21	2021/22
YTD Totals	47,866	46,126
Change		-1,740
% Change		-4%

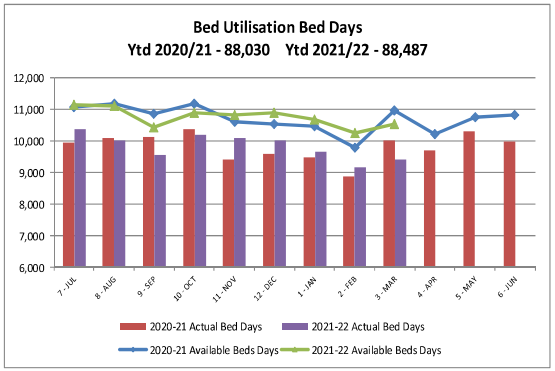
Theatre Cases

	2020/21	2021/22
YTD Totals	10,744	9,812
Change		-932
% Change		-9%









ED

- The total number of presentations to ED in March 2020 was 4,583 (this includes 461 DNWs)
- The total number of presentations to ED in March 2021 was 5,507 (this includes 445 DNWs)
- The total number of presentations to ED in March 2022 was 4,850 (this includes 353 DNWs)
- The average number of daily presentations in March 2022 was 156, this is significantly lower than the average of 178 presentations per day in March 2021.
- CCDHB SSIED performance for March 2022 was 62.2%. This result is a decrease on the 67.7% recorded last month in February 2022.

ED Covid-19

- During the month of March 2022 there were 748 presentations (15% of total presentations) where the patient was found to be either positive for COVID-19 when presenting or diagnosed shortly after presenting to ED.
- Out of the 748 presentation a total of 205 of the patients presented with symptoms related to COVID-19 the remaining 543 presenting with other non-COVID-19 diagnosis such as Trauma / Abdominal Pain / Mental Health etc.
- Out of the 748 presentation a total of 213 of the patients were admitted, 29 did not wait and the remaining 506 were discharged home.

Bed Utilisation

- The utilisation of available of adult beds in core wards in March 2022 was 89.2% which is lower than the rate of 91.2% recorded in March 2021. The number of available beds in March 2022 (340) is lower than in March 2021 (354) and can be attributed largely to closure of Kenepuru Ward 7 for 16 days in March 2022 due to a COVID outbreak .
- The number of Elective theatre cases has decreased for the month of March 2022 by 31.0% (-257) when compared to March 2021, unsurprisingly.

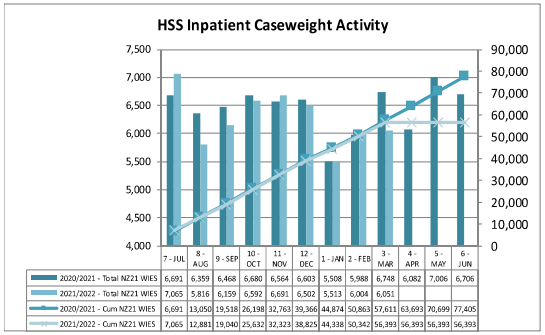
CCDHB Activity Performance

Capital and Coast DHB: March 2022

HSS Inpatient Caseweight Activity

	2020/21	2021/22
YTD Totals	57,611	56,393
Change		-1,218
% Change		-2.1%

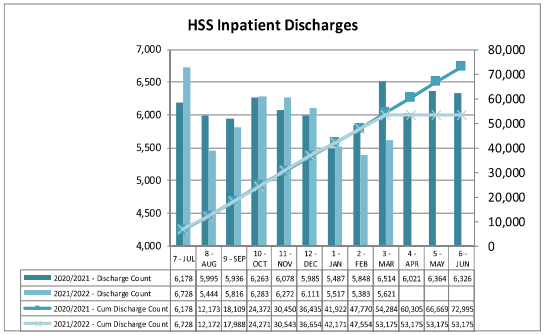
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



HSS Inpatient Discharges

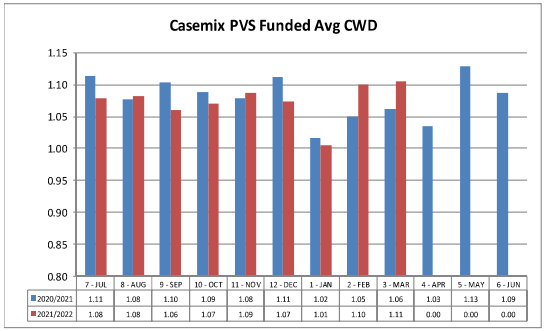
	2020/21	2021/22
YTD Totals	54,284	53,175
Change		-1,109
% Change		-2.0%

** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



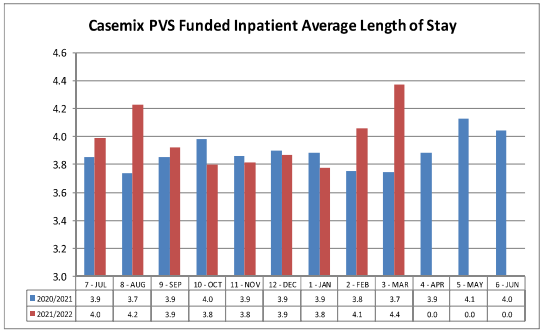
Casemix PVS Funded Avg CWD

	2020/21	2021/22
YTD Totals	1.08	1.07
Change		-0.01
% Change		-1%



Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	3.97
Change		0.09
% Change		2.3%



Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (286 CWDs) with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine, Paediatric Medicine Obstetrics and Cardiology. The CWD increase is driven primarily by General Medicine, Paediatric Medicine, Neonatal Gastroenterology and Emergency Medicine.
- Local Elective CWDs are lower than the previous financial year (-1,182 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by Cardiology, General Surgery, Orthopaedics and ENT. The CWD decrease is driven primarily by Orthopaedic Surgery, Cardiology, General Surgery, ENT and Gynaecology.
- IDF acute CWDs are lower than the than the previous financial year (-68 CWDs) with a decrease in discharges); a similar ALOS and average CWD. The discharge increase is driven primarily by Haematology, Emergency Medicine, Respiratory Medicine and Neonatal. The CWD decrease is driven primarily by Haematology, Neonatal, Cardiology, and Oncology.
- IDF Elective CWDs are lower than the previous financial year (-411 CWDs) with less discharges; a higher ALOS and a similar average CWD. The discharge decrease is driven primarily by Paediatric Surgery, General Surgery and Vascular Surgery. The CWD decrease is driven by Cardiothoracic Surgery, Vascular Surgery, Cardiology and Paediatric Surgery.
- In combination these four admission groups equate to a decrease of (-1,375, CWDs) compared to the previous year. The services that most significantly impact this shift are General Surgery (-618), Cardiology (-324), Haematology (-225) and Vascular Surgery (-179) countered by increases in General Medicine (326), Paediatric Medicine (182), Urology (103) and Gastroenterology (56).
- The decrease in General Surgery can be partly attributed to a significant acute outlier discharged in November 2020 which had a CWD value of 112.
- The decrease in Haematology can be largely attributed to a number of significant outliers discharged in 2020/2021 which saw a far greater mix of Bone Marrow Transplant and complex Leukaemia cases which have not been evident in 2021/2022.
- The increases in both General Medicine (161) and Paediatric Medicine (170) were realised predominantly in July 2021 and August 2021 and relate to significant number of patient presenting with RSV.

Discharges:

- The number of publicly funded casemix discharges for the month of March 2022 has decreased by 846 (-14.3%) in comparison to the number of discharges recorded in March 2021. This decrease in the number of discharges is most evident in Obstetrics (-76 Mother, -27 Babies), General Surgery (-29 Acute, -75 Elective), Orthopaedics (-15 Acute, -66 Elective), Emergency Medicine (-77 Acute), Gynaecology (-17 Acute, -52 Elective) ENT (-13 Acute, -54 Elective), Cardiology (-63 Elective), Paediatric Surgery (-19 Acute, -41 Elective). The overall decrease was countered by an increase in Cardiology (26 Acute) and Cardiothoracic (11 Acute).
- The number of outsourced discharges recorded in March 2022 was 61 which is 101 lower than March 2021. This decrease largely accounts for the reductions in Orthopaedic and Gynaecology Elective activity and partly account for General Surgery. In March 2022 Orthopaedics had less 46 discharges, Gynaecology 20 less discharges and General Surgery 22 less discharges than in March 2021. CCDHB in March 2022 utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Mar 21 to Mar 22

Domain	Indicator	2021/22 Target	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb	2022-Mar	14/03/22	21/03/22	28/03/22	4/04/22
Care	Serious Safety Events	TBD	8	19	8	13	11	8	12	12	13	9	10	10	8				
	Total Reportable Events	TBD	1,458	1,426	1,540	1,369	1,487	1,260	1,170	1,445	1,461	1,383	1,120	1,107	1,159	256	243	212	184
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	92.3%	93.7%	93.3%	87.9%	77.1%	89.5%	88.4%	87.1%	83.8%	68.3%	85.0%	75.9%	95.9%	83.3%	100.0%	88.9%	100.0%
	% Discharges with an Electronic Discharge summary	TBD																	
Access	Emergency Presentations		5,499	5,276	5,486	5,432	5,668	4,937	4,837	5,514	5,331	5,320	5,227	4,422	4,870	1,054	1,070	1,141	1,136
	Emergency Presentations Per Day		177	176	177	181	183	159	161	178	178	172	169	158	157	151	153	163	162
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	66.3%	63.3%	66.8%	64.0%	56.2%	66.6%	64.8%	61.9%	61.8%	65.7%	65.9%	68.0%	61.8%	63.3%	57.9%	61.8%	54.1%
	ELOS % within 6hrs - non admitted	TBD	77.5%	74.0%	78.3%	75.2%	66.4%	79.3%	75.9%	72.5%	72.0%	75.5%	74.8%	78.0%	72.6%	74.5%	67.2%	70.9%	64.9%
	ELOS % within 6hrs - admitted	TBD	47.2%	45.0%	45.6%	45.3%	39.6%	44.0%	41.4%	43.2%	44.9%	48.3%	50.4%	50.7%	43.4%	42.0%	43.8%	48.7%	38.0%
	Total Elective Surgery Long Waits	Zero Long Waits	513	515	343	362	427	550	694	699	683	675	789	772	924				
	Additions to Elective Surgery Wait List		1,456	1,229	1,455	1,351	1,239	940	1,125	1,042	1,385	1,057	762	1,055	1,157	250	270	190	99
	% Elective Surgery treated in time	TBD	72.2%	72.1%	75.0%	82.4%	83.2%	81.5%	72.4%	71.1%	75.5%	78.7%	79.5%	76.2%	77.8%	76.6%	77.6%	80.8%	82.8%
	No. surgeries rescheduled due to specialty bed availability	TBD	11	7	13	21	16	6	0	9	7	2	13	7	1	0	0	0	2
	Total Elective and Emergency Operations in Main Theatres	TBD	1,270	1,063	1,190	1,085	1,209	807	1,062	1,145	1,229	1,001	869	1,071	960				
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	88.0%	86.0%	83.0%	96.0%	85.0%	83.0%	84.0%	87.0%	93.0%	96.0%	83.0%	82.0%	93.0%				
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	96.0%	79.0%	84.0%	91.0%	76.0%	81.0%	85.0%	67.0%	93.0%	90.0%	95.0%	81.0%	79.0%				
	Specialist Outpatient Long Waits	Zero Long Waits	302	244	211	265	295	412	607	735	697	775	1,177	1,431	1,423				
	% Specialist Outpatients seen in time	Zero Long Waits	85.4%	80.0%	90.5%	90.2%	89.1%	88.4%	82.1%	80.0%	79.8%	82.7%	83.9%	78.8%	77.1%	79.6%	72.8%	78.1%	81.3%
	Outpatient Failure to Attend %	TBD	7.3%	7.2%	7.4%	7.1%	7.4%	7.2%	6.3%	7.0%	7.1%	6.9%	7.3%	7.8%	7.8%	7.2%	7.5%	7.3%	7.1%
	Maori Outpatient Failure to Attend %	TBD	15.8%	15.9%	15.2%	15.3%	16.9%	14.7%	15.2%	14.7%	16.0%	15.3%	15.6%	16.4%	15.9%	14.3%	12.8%	17.8%	16.7%
	Pacific Outpatient Failure to Attend %	TBD	16.9%	15.8%	16.4%	15.7%	15.7%	16.8%	15.3%	17.8%	17.9%	17.4%	17.5%	18.3%	18.8%	16.4%	16.4%	16.0%	17.2%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1.0m	$1.0m	$1.0m	$7.0m	$3.2m	$3.2m	$3.2m	$3.2m	$3.2m				
	Contracted FTE (Internal labour)		5,346	5,366	5,364	5,340	5,336	5,363	5,385	5,412	5,434	5,457	5,465	5,545	5,551				
	Paid FTE (Internal labour)		5,727	5,792	5,784	5,746	5,767	5,837	5,801	5,871	5,881	5,948	6,114	6,031	6,000				
	% Main Theatre utilisation (Elective Sessions only)	85.0%	83.0%	83.0%	81.0%	80.0%	79.0%	79.0%	81.0%	79.0%	80.0%	80.0%	80.0%	81.0%	81.0%				
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	23.2%	25.3%	23.6%	25.3%	20.7%	21.8%	20.5%	22.6%	23.0%	21.2%	18.4%	21.9%	18.8%	15.0%	15.5%	21.5%	19.7%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	41	37	35	38	44	40	30	40	38	34	29	43	33	42	37	37	41
	Adult Overnight Beds - Average Occupied WLG	TBD	381	381	386	387	383	355	349	362	367	363	353	367	347	349	339	352	364
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	19	19	22	17	32	34	21	26	25	25	19	22	20	22	29	15	17
	Adult Overnight Beds - Average Occupied KEN	TBD	69	72	73	73	79	83	80	82	81	76	69	76	63	56	51	55	67
	Child Overnight Beds - Average Occupied	TBD	22	22	22	25	30	23	19	24	22	22	21	20	19	18	14	13	16
	NICU Beds - ave. beds occupied	36	44	39	42	36	40	38	32	35	29	35	37	37	31	31	26	28	30
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.75	3.88	4.13	4.04	3.99	4.23	3.92	3.80	3.82	3.87	3.77	4.06	4.37	4.12	4.80	4.81	3.93
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.5%	4.7%	4.6%	4.0%	4.0%	4.3%	4.0%	4.2%	4.3%	4.7%	4.2%	3.6%	4.1%	4.2%	3.7%	2.7%	3.8%
	Presentations to ED within 48 hours of discharge	TBD	194	247	253	218	224	211	194	231	228	252	219	161	202	44	40	31	43
Staff Experience	Staff Reportable Events	TBD	165	157	149	159	157	130	143	170	198	161	130	95	118	32	17	19	17
	% sick Leave v standard	TBD	3.5%	3.0%	3.6%	3.8%	4.3%	3.9%	2.7%	3.2%	3.6%	3.5%	2.0%	2.6%	3.3%				
	Nursing vacancy	TBD	239	241	250	266	295	374	422	508	526	528	519	447	450				
	% overtime v standard (medical)	TBD	1.9%	1.8%	2.1%	2.0%	2.5%	2.2%	2.0%	2.2%	2.2%	2.3%	2.1%	2.2%	2.5%				

Refer to later pages for more details on CCDHB performance. Highlighted where an identified target.

Shorter Stays in ED (SSIED)

What is this measure?

- The Ministry of Health (MoH) Target: 95% of patients presenting to ED will be seen, treated, and discharged or seen, assessed and admitted or transferred from the Emergency Department within six hours.

Why is this important?

- Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the emergency department therefore improves the health services DHBs are able to provide.
- During the month of March 2022 there were 748 presentations (15% of total presentations) where the patient was found to be either positive for COVID-19 when presenting or diagnosed shortly after presenting to ED.
- Out of the 748 presentation a total of 205 of the patients presented with symptoms related to COVID-19 the remaining 543 presenting with other non-COVID-19 diagnosis such as Chest Pain / Abdominal Pain / Mental Health etc.
- Out of the 748 presentation a total of 213 of the patients were admitted, 29 did not wait and the remaining 506 were discharged home.
- Throughout March Wellington was at 'Red' in the National COVID Protection Framework setting and at COVID Stage two and subsequently 3 of the DHB COVID Hospital Response Plan.
- The average number of daily presentations in March 2022 was 156, this is significantly lower than the average of 178 presentations per day in March 2021.

How are we performing?

- Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.
- CCDHB performance for March 2022 was 62.2% which is lower than March 2021 (66.3%). Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for March 2022 was 89%.
    - The total number of presentations to ED in March 2020 was 4,583 (this includes 461 DNWs)
    - The total number of presentations to ED in March 2021 was 5,507 (this includes 445 DNWs)
    - The total number of presentations to ED in March 2022 was 4,850 (this includes 353 DNWs)
- The average number of daily presentations in March 2022 was 156, this is significantly lower than the average of 178 presentations per day in March 2021.

Performance	JAN	FEB	MAR
2019-20	80%	76%	79%
2020-21	69%	63%	66%
2021-22	66%	68%	62%

Breaches	JAN	FEB	MAR
2019-20	997	1,180	919
2020-21	1,507	1,678	1,687
2021-22	1,619	1,316	1,693

ED Volumes	JAN	FEB	MAR
2019-20	4,998	4,822	4,285
2020-21	4,807	4,490	5,012
2021-22	4,781	4,079	4,473

What is driving performance?

- CCDHB performance for March 2022 was 62.2% which is lower than March 2021 (66.3%).
- CCDHB SSiED performance for March 2022 is 32.8% lower than the Target for SSiED. The count of breaches in ED 1,693 in March 2022 is higher than the 1,687 recorded in March 2021.

Management Comment

- CCDHB continues to face a significant capacity issue as demonstrated by the consistently high occupancy rate and the bed blockage experienced across hospital flow as a consequence. Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for March 2022 was 89%.
- According to Capplan the number of available beds in March 2022 (340) which is lower than March 2021 (354) and can be attributed to less beds being available at Kenepuru.
- In view of addressing bed blocks, the Complex Care Forum has been working closely with Clinicians to facilitate supported discharge at an early stage in order to vacate beds and facilitate flow of patients from ED. During the month of March 2022, the Complex Care Forum has managed to facilitate the discharge of one of our patient who had a Length of stay of 613 days.
- Clinicians are encouraged to do early rounding and nurse-led discharge processes are being reinforced.
- Charge Nurse Managers from General Medicine are meeting on a daily basis at 8am in view of assessing planned discharges and ensuring that a proper follow up is in place with the Medical Team.
- Our Medical Assessment and Planning Unit (MAPU) is working in partnership with our Emergency Department to drive the flow of patients from ED to MAPU through early assessment and referral.
- Similarly, working groups have been set up in relation to the Front of Whare project in order to identify the barriers and confirm the need for improved resources (facilities and personnel).
- During the month of March 2022 the additional assessment Unit with 4 Bed space adjacent to our ED has been utilised by different specialties for assessment of patients presenting with COVID. This Unit serves as a dedicated zone for assessment of Medical and non-medical COVID positive patients with direct referral to the services they need so reducing the volume of presentation to ED.
- On the other hand, work is in progress for the setting up of a new Minor Care Unit which in turn will free up 6 bed space in EDOU. This work is inextricably linked to other ongoing work to assess and address overall hospital capacity.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

- There is a requirement that DHBs manage the Planned Care programme through the monitoring framework in line with the principles of equity, access, quality, timeliness and experience. Planned Care is measured by a performance framework which includes ESPIs (Elective Services Performance Indicators).

Why is this important?

- Providing timely access to Planned Care services is important to improve the health of our population and maintain public confidence in the health system.

How are we performing?

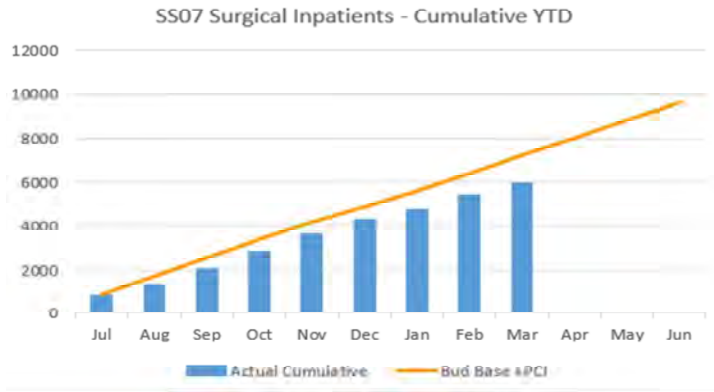
- Total Planned care results for March month end show us 366 adverse to the 977 target; Year to day we are reporting 1,431 discharges behind our target of 8,051 – 83% overall .
- Our in-house elective surgical PUC results show 220 discharges adverse to the planned 574, this is a significant drop from last month where we discharged more than planned.
- Outsourcing 117 adverse to the planned 159. Elective non-surgical PUC adverse 8 to the planned 15, arranged surgical PUC adverse 10 and arranged non-surgical 4 behind of the month's plan.
- IDF outflow results are 7 adverse to the planned 98 for March.
- Minor procedures in-house reporting 69 over the planned 465 for March.

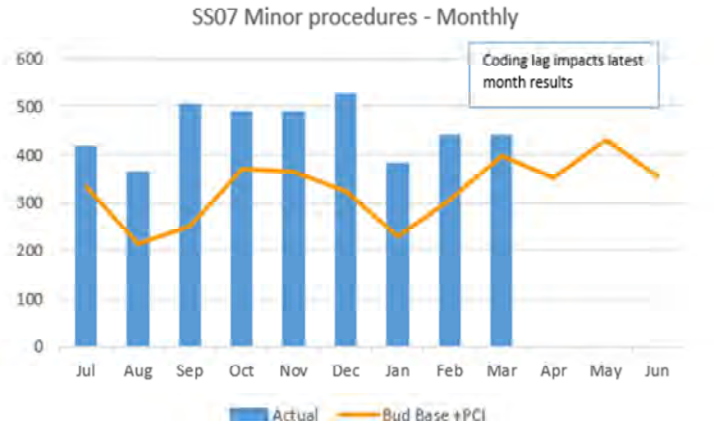
What is driving performance?

- March in-house of 220 behind is the result of theatre closures due to Covid during the month, we were working at about 45% capacity in Wellington while Kenepuru closed for more than a week.
- Our private providers are not able to provide the usual volume due to their own staffing restraints currently. Panel agreements are currently being worked through, with statements of work now underway for two specialities, however we anticipate ongoing deficits in outsourced volumes for the foreseeable future.

Management Comment

- March result were expected in the current climate. Significant work continues to be done to deal with COVID surge and ensure patients with the greatest clinical need are being scheduled. Staffing and capacity is monitored on a daily basis to ensure we use all resources available. First week of April we have increase out theatre throughput to about 75% in Wellington and back normal scheduling in Kenepuru, however this is still very fluid.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.





Planned Care – Waiting Times

What is this measure?

- ESPI 2 – patients waiting longer than four months for their first specialist assessment.
- ESPI 2 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.

Why is this important?

- The goal is to assess all patients accepted for an FSA within 4 months. This improves the health outcome and ensures patients receive advice or are referred for treatment in a timely way.

How are we performing?

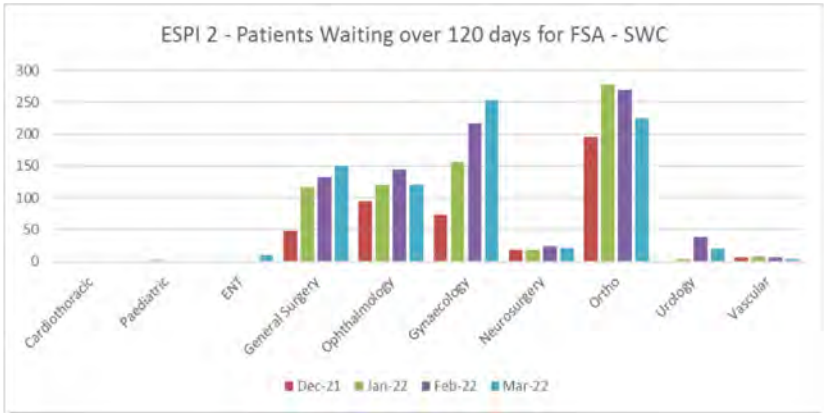
- March EPSI 2 results show a 139 decline in performance from the previous month. Services have deteriorated due to cancellation of face to face clinics during the last month. All specialties will work on addressing the back log waiting and longest waiting patients.

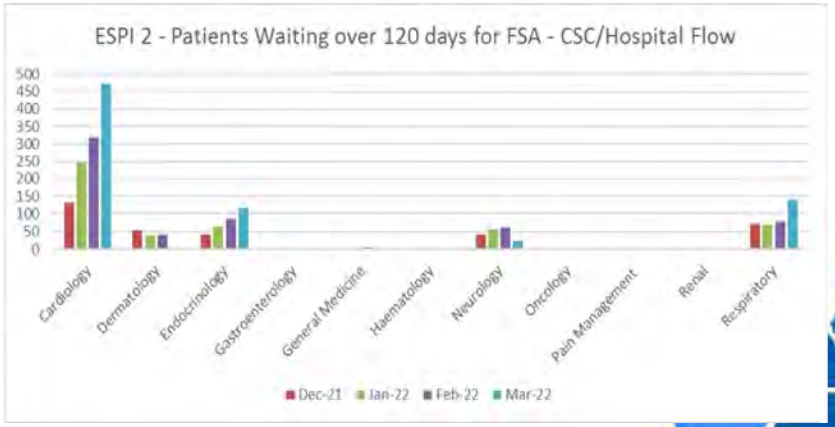
What is driving performance?

- Cancellation of face to face consultations will continue to deteriorate our FSA position. As we allow more people into the hospital face to face clinics are beginning to resume.

Management Comment

- Specialities are working to address the back log and prioritise those with clinical urgently to return to outpatient clinics.





Planned Care – Waiting Times

What is this measure?

- ESPI 5 - patients given a commitment to treat but not treated within four months.
- ESPI 5 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 11 patients or less than 0.99%, and Red if 1% or higher.

Why is this important?

- Providing surgical procedures within 4 months from the FSA improves the health outcome and lifestyle to our population.

How are we performing?

- CCDHB performance in ESPI 5 is shown in the table below. We have been non-compliant at an organisational level since January 2019. March is reporting 910 non-compliant, an expected deterioration the previous month due to work not performed due to COVID, we continue to be experiencing staffing and capacity shortages into April.
- Currently Maori are experiencing slightly longer delays in accessing treatment compared to Pacifica and others. We are currently investigating long waiting patients to identify reasons for this. All services are aware of this and are working on scheduling our long waiting patients onto lists as soon as possible.

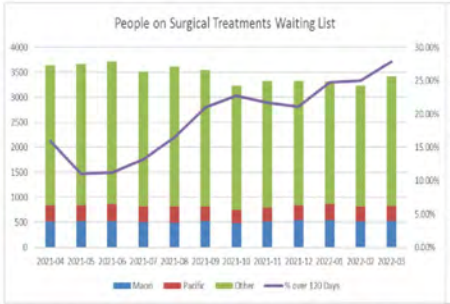
What is driving performance?

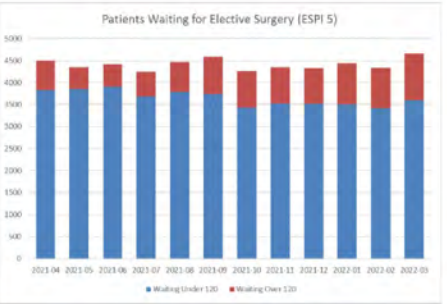
- Cancellation of theatres session is the main driver of our results, staff illness on wards and in theatres has limited the number of patients we can treat.

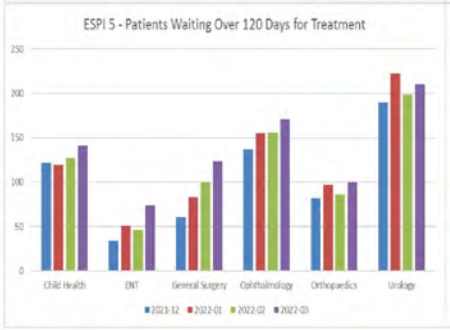
Management Comment

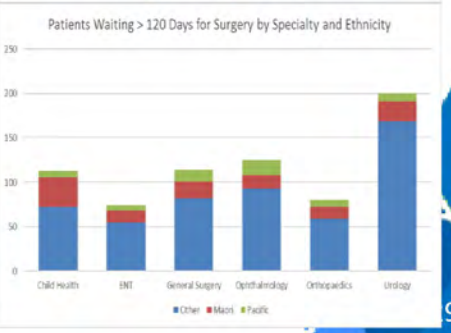
- Currently we are managing our session on a daily basis, treating those most clinically urgent and long waiting, while insuring those having been deferred are offered the next available date.

ESPI 5 monitoring 21/22	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Organisation wide	**-343**	**-362**	**-427**	**-550**	**-694**	**-700**	**-684**	**-677**	**-792**	**-773**	**-91**
Cardiology	-2	-2	-4	-4	-8	-5	-5	-4	-6	-6	-5
Cardiothoracic	-3	-4	-7	-12	-22	-23	-31	-35	-34	-37	-42
Dental	-18	-21	-15	-29	-45	-39	-38	-39	-31	-34	-53
ENT	-32	-31	-34	-40	-52	-56	-49	-44	-62	-56	-75
General Surgery	-30	-24	-34	-42	-47	-56	-52	-53	-74	-89	-114
Gynaecology	-5	-9	-16	-22	-25	-14	-13	-7	-11	-12	-27
Neurosurgery	-3	-3	-4	-5	-12	-13	-9	-15	-29	-20	-29
Ophthalmology	-87	-100	-95	-134	-155	-125	-103	-82	-99	-97	-110
Orthopaedics	-30	-39	-65	-89	-98	-96	-71	-56	-63	-53	-68
Paediatric Surgical	-16	-17	-24	-28	-39	-64	-84	-98	-92	-99	-109
Urology	-101	-106	-120	-129	-164	-166	-173	-175	-202	-183	-192
Vascular Surgery	-16	-6	-9	-16	-27	-43	-56	-69	-89	-87	-86









Coronary

Coronary Angiography Waiting Times

What is this measure?

- DHBs are required to collect, measure and monitor how long people are waiting for Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)

Why is this important?

- Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management.

How are we performing?

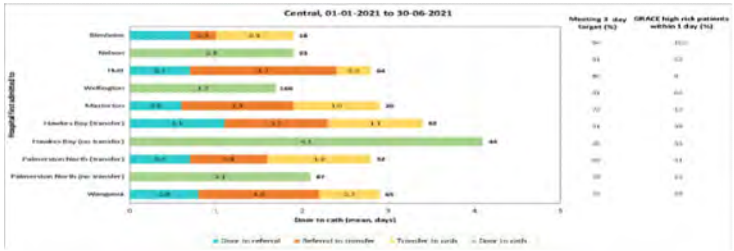
- The proportion of patients waiting less than 90 days for angiography is 94.8% this month.

What is driving performance?

- 8 patients did not meet target this month. Reducing Elective capacity to anticipate Acute demand due to Covid, Acute demand, and clinical reasons for delay were main contributors to these patients not meeting the target this month

Management Comment

- We have gaps in our interventionist workforce currently as well as a number of clinicians taking annual leave over the past month, and one clinician absent on sick leave. This has made it difficult to consistently find cover for vacant sessions. An additional, permanent interventionist is due to commence work in August 2022.



Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

- We are required to report agreed indicators from ANZACS-QI data for acute heart services.

Why is this important?

- Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Maori and Pacific peoples and people who experience mental illness and addiction. As the population ages and lifestyles change these conditions are likely to increase significantly. Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk.

How are we performing?

Door to cath. <= 3 days December results (Target is ≥70%):

National Performance	71.0% (485/683)
Central Region	62.1% (87/140)
CCDHB	84.6% (22/26)
Hawkes Bay	30.3% (10/33)
Hutt Valley	76.9% (10/13)
Mid Central	65.7% (23/35)

As a region we did achieve the target. Only CCDHB achieved target this month.

What is driving performance?

- Achievement of the target differs for each centre. The table below provides a breakdown (Please note this data is updated 6 monthly). The referral to transfer is directly influenced by CCDHB, ultimately this relates to access to beds. Demand for beds has been high this month. Other factors include regional decision making timeframes, and timing of presentation.

Management Comment

- We have created additional capacity in the Transit Lounge capacity which we are using on a daily basis both for cardiology and cardiothoracic patients. Requested cardiac monitoring equipment will widen the criteria of patients who can go there and will free up more beds on the Cardiac ward. This equipment has not yet been installed
- We have been using beds in Hutt CCU for surgical waiters on a frequent basis.
- Hutt valley DHB are increasingly taking their patients back post procedure saving beds in the cardiac ward.
- Improvements have been made in repatriation of patients to the regions.
- A Cardiothoracic CNS has been employed and will help to reduce LOS and improve criteria led discharge.
- We have submitted plans for an additional 6 beds on the ward and Hutt are doing the same.
- A pilot to develop a Rapid Access Chest Pain Service is in progress which will provide alternatives to ED and avoid a small number of admissions.
- While these actions are in progress, we continue to remain short of beds and there are times when patients wait longer than desired for admission or transfer to Wellington. There are still physical limitations in where we can provide additional bed spaces in the short term.

MRI and CT Waiting Times

What is this measure?

- A percentage measure that shows the proportion of CT or MRI outpatient referrals that are scanned within of a 42-day time period. The 'clock' begins from the date Radiology receives the referral for imaging.

Why is this important?

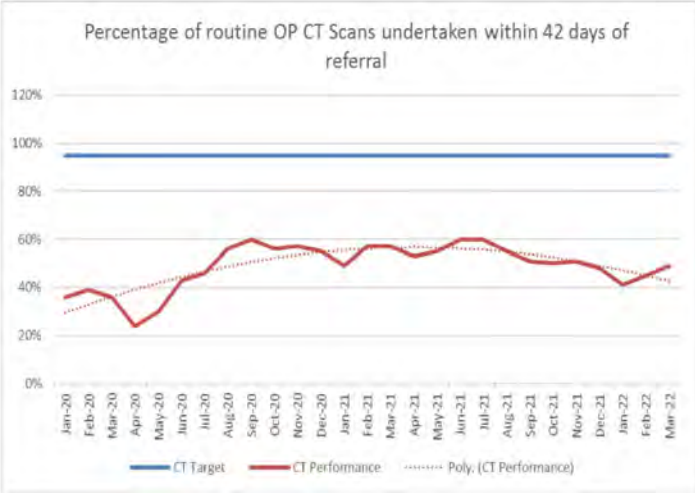
- Delayed diagnosis can lead to poorer health outcomes as a patient's condition may deteriorate while waiting. The period of 6 weeks (i.e. 42 days) is generally accepted as the reasonable clinical timeframe to receive imaging results for non-acute outpatient referrals.

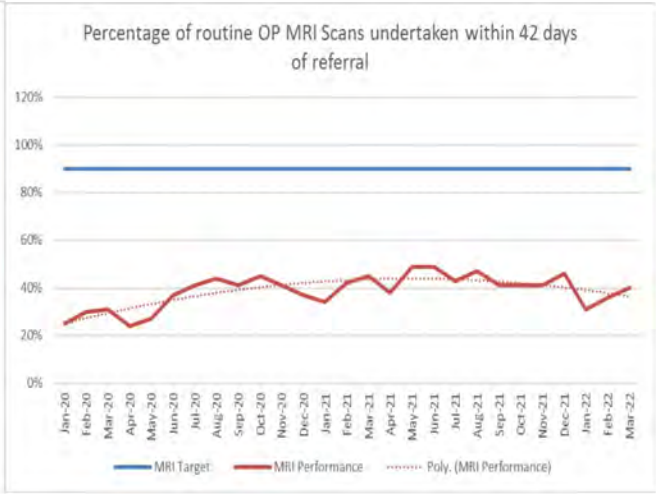
How are we performing?

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time. The combination of high vacancy in the technical team (over 20%) through 2021, the effect of the pandemic response on Radiology services and increasing Inpatient/ED and outpatient demand leaves performance static for MRI and a slow drop in performance for CT.

What is driving Performance?

- Long-term growth in demand for Radiology services has not been matched with Radiology capacity (internal resource or outsourcing capacity).





Management Comment

- With current waiting times there is risk of patient harm including disease progression while waiting for imaging appointments. The service continues to prioritise based on clinical urgency and process images for inpatient and ED patients within expected timeframes in order to maximise inpatient flow.

- Unfortunately, we expect waiting times to increase steadily. Technical team staffing remains problematic with vacancies all over New Zealand and little successful overseas recruitment. Steadily increasing ED and IP demand for both modalities (CT & MRI) further squeezes the outpatient capacity.

- During March/April we have had one MRI scanner out for three weeks due to major failure. This will have some effect on waiting times as it will be very difficult to recover from this length of downtime.

- Outsourcing continues at the maximum capacity across service providers available within the region even at this increased rate of outsourcing we will not improve waiting times for the foreseeable future due to increased demand and imaging complexity.

- It is estimated that we will need to increase the outsourcing budget to to keep waiting times around their current timeframes.

Faster Cancer Treatment

What is this measure?

a) 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

b) 31 day indicator: The maximum length of time a patient should have to wait from a date of decision to treat, to receive their first treatment (or other management) for cancer, is 31 days. Target compliance is 85% of patients start within 31 days.

Why is this important?

- The target aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins. It supports DHBs to monitor the whole cancer pathway from referral to first treatment to identify any bottlenecks in the system and opportunities for improvement that will benefit all cancer patients. Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.

How are we performing?

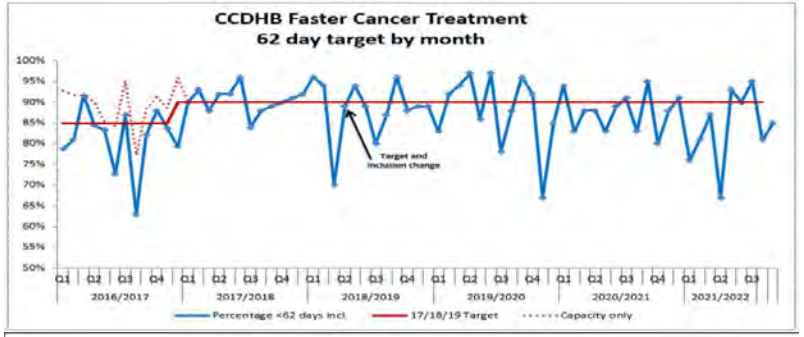
- CCDHB is non-compliant with the 62 day target for March at 85% which is below the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.

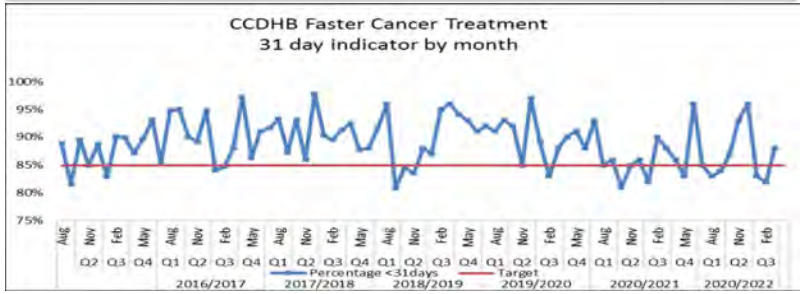
- CCDHB is compliant with the 31 day indicator for March at 88% which is above the aim of 85% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- There were four breaches for the 62 day target. Two experienced delays in the front end of the pathway, due to a combination in delays in histology reporting and the impact of statutory holiday interruptions, the remaining two were due to surgery wait times. The breaches were across a number of tumour streams which included breast, upper gastrointestinal and skin. Two Māori and one Pacifica patients were covered by the 62 day target. There were no Māori or Pacifica breaches. Note, acute presentations are excluded from the 62 day target.

- Of the nine breaches in the 31 day indicator, four were due to capacity reasons relating to access to surgery. 31 day indicator compliance was 100% for Māori and Pacifica and 87% for other ethnicities (59/68). Average delay for all 31 day capacity breach patients was 37 days (range 35 – 39 days) a decrease from last month (45 days).





Management Comment

Acute demand and staffing vacancies continue to cause delays in access to FSA, diagnostic services (imaging & pathology) and surgical services. These were compounded through statutory holiday leave interruptions across all services. The majority of March breaches had surgery as first treatment and surgery wait times are being affected by staffing vacancies, illness, leave and acute demand.

Work underway includes:

- Working with gynaecology service to improve compliance -establishment of a bleeding clinic being scoped.
- Continued work on the diagnosis via ED presentation pathway improvement project.
- Review of the Skin lesion referral pathway for CCDHB domiciled patients

The largely manual process for prospectively tracking patients can make it difficult to intervene in a timely manner. Overall, March's data shows improved performance from the previous month.

Colonoscopy

What is this measure?

Diagnostic colonoscopy

a) 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.

b) 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.

Surveillance colonoscopy

70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.

Why is this important?

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Improving access to diagnostics will improve patient outcomes, specifically Cancer pathways will be shortened with better access to colonoscopy.

How are we performing?

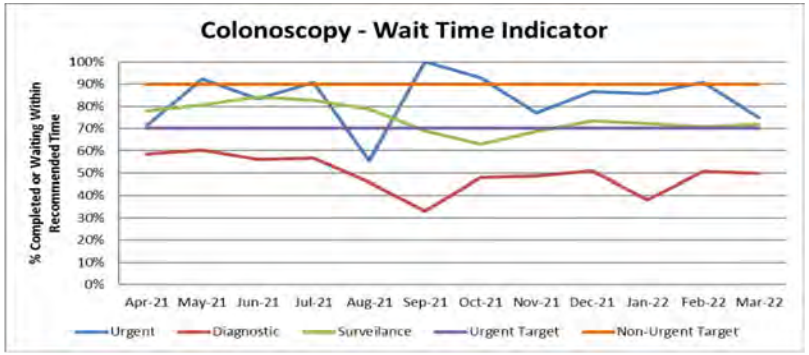
- CCDHB missed the Ministry of Health target for urgent colonoscopies with a performance of 75% (target 90%) although this equated to 1 patient. This was a reduction on the 91% achieved in February 2021. For diagnostic waits, we achieved 50% (target 70%) in March, which was the same as the February performance of.
- We met the Ministry of Health target for surveillance achieving 72% (target 70%). This is a slight increase against the February performance of 71%.

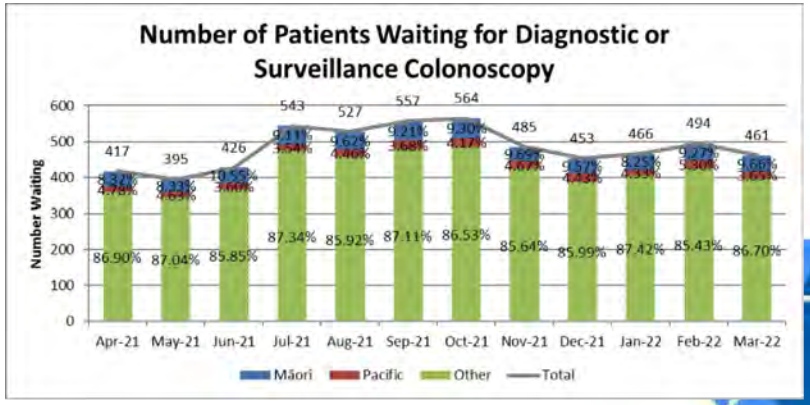
What is driving performance?

- COVID has had less of an impact this month than we envisaged and the majority of lists in both public and private sector outsourcing have been able to continue with the resultant increase in procedures.

Management Comment

The March performance is similar to the February report in terms of % achieved, but the actual number of procedures carried out in month has increased. We have been fortunate that most lists have continued and staff absences due to COVID or patients unable to have their procedure due to COVID has been low in the Department.





Maternity and Neonatal Intensive Care services

Maternity

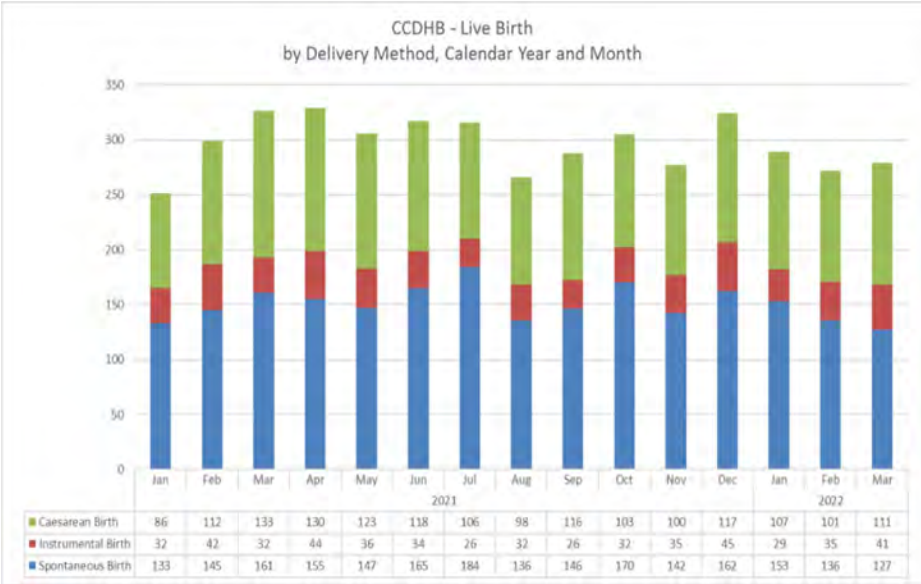
What is the issue?

- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal Intensive Care service.

WHS Management Comment

- March vacancy rate for 4NM and WRH Birthing Suite continues to sit high over February, currently at 38.3 %. Staffing as a result COVID alongside the vacancy rate is impacting our ability to provide safe care.

- The service is working with HVDHB on recruitment and retention packages for midwives. We are pleased to confirm that this has been implemented.



Neonatal Intensive Care Unit

What is the measure?

To provide:

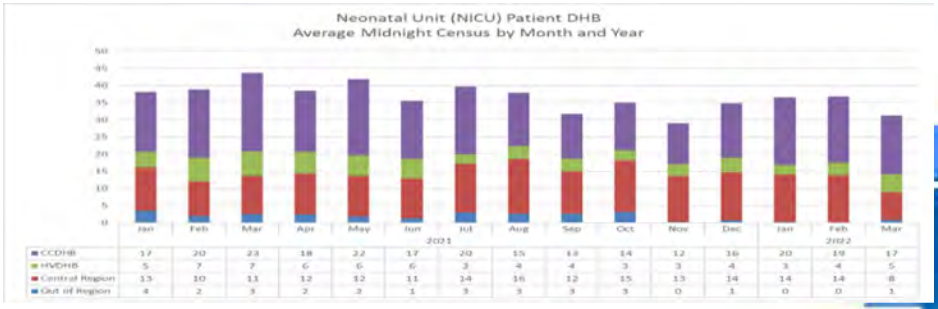
- A culturally and clinically safe 24/7 acute admitting service for infants from 23 weeks' gestation. Care is provided primarily for infants who are premature; those that require surgical intervention; perinatal intervention and support; and infants with congenital or metabolic abnormalities. These infants are referred from WHS delivery suite, CHS or regionally, and at times, nationally. Ideally the service would be provided within the resourced 36 beds.
- An infant retrieval service to the central region. Infants are referred and transferred for care either in utero or by NICU.

What is the issue?

- Lower occupancy and acuity over the last month.
- In March NICU saw a decrease in occupancy to an average of 31 down from 37 the previous month.

How are we performing?

- CCDM RN staffing uplift of 20 RNs is being recruited into, however resignations have impacted on the ability to do this.
- NICU is safely managing the physical wellbeing of infants and families (with the above impacts).



Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

- The DHB hospital performance is under pressure in many of the key areas measured and reported on in this report. Both Acute Mental Health Inpatient Units in CCDHB and HVDHB are managing high occupancy.
- There are initiatives underway to intervene in mental health crises early and reduce pressure on ED presentations and wait times. The number of Mental Health (MH) Nurses in CCDHB and HVDHB Emergency Departments will be increased. A pilot is underway for the Co Response Team and commenced early March 2020 where MH Nurses will team up with Police and Ambulance as the first responders to 111 calls. A General Practitioners (GPs) Liaison team is to be established and this team will work alongside GPs to address mental health issues at the primary level.
- Focus for the next 12 months will be on addressing equity which will include increasing the Māori and Pacific mental health and addictions workforce, improving access for Māori and Pacific to services and reducing the number of Māori under the CTO Sec 29.
- The toward Zero seclusion project is fully underway with the aim of reducing the incidence of seclusion particularly for Māori.

Mental Health, Addiction and Intellectual Disability Service - Monthly Performance Report (1 of 2)

Indicator	2020/21 Target	13 Months Performance Report												
		2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb	2022-Mar
Access Rate	3%	3.8%	3.9%			3.8%			3.7%					
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	59.9%	64.8%	72.0%	79.9%	71.1%	65.9%	58.9%	50.0%	36.7%	24.8%	31.4%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	46.8%	50.1%	50.2%	61.9%	64.0%	53.3%	58.3%	51.6%	73.3%	66.9%	72.1%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	87.4%	90.0%	89.2%	91.4%	83.6%	91.5%	85.4%	92.4%	70.8%	57.8%	93.8%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	84.1%	81.2%	90.2%	83.2%	80.0%	84.3%	84.0%	89.0%	83.5%	85.0%	94.9%		
Community service users seen in person in last 90 days	95%	80.3%	80.2%	80.5%	82.9%	82.4%	78.7%	76.7%	75.9%	79.2%	80.8%	76.5%	74.7%	75.0%
Community DNA rate	<= 5%	9.3%	9.1%	9.2%	8.8%	8.9%	8.0%	7.9%	8.1%	8.0%	7.9%	7.2%	8.3%	7.5%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		450	458			472			478					
Wellness Plan Compliance	95%	47.2%	48.6%			47.4%			43.5%					
Wellness Plans - Acceptable Quality	95%	75.0%	71.5%			78.8%								
Community Services Transition (Service Exit) Plan Compliance	95%	51.0%	54.3%			56.9%			57.6%					
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	66.7%	67.5%			75.3%								

Adverse Performance requiring immediate corrective Action

Performance is below target, corrective action may be required

Performance on or better than Target / Plan

Mental Health, Addiction and Intellectual Disability Service - Monthly Performance Report (2 of 2)

Indicator	2020/21 Target	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb	2022-Mar
Pre-Admission Community Care	75%	82.4%	78.6%	75.6%	79.1%	75.7%	75.0%	72.0%	70.2%	62.0%	60.8%	66.7%	63.6%	64.0%
Post-Discharge Community Care	90%	77.5%	73.8%	79.1%	78.1%	74.1%	82.1%	79.2%	75.0%	80.5%	61.9%	66.7%	62.0%	75.9%
Acute Inpatient Readmission Rate (28 Day)	<= 10%	7.7%	7.1%	5.3%	9.6%	3.0%	11.0%	9.5%	5.3%	10.0%	4.3%	3.8%	7.8%	10.0%
Inpatient Services Transition Plan	95%	78.9%	77.8%			76.5%			74.8%					
Inpatient Services Transition Plan - Acceptable Quality	95%	84.6%	83.3%			86.3%								
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru	90%	95.2%	101.3%	109.4%	100.7%	102.4%	102.8%	92.4%	105.9%	91.8%	89.4%	94.1%	84.4%	92.7%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi	90%	99.9%	106.0%	107.6%	104.6%	105.5%	111.5%	107.2%	108.2%	99.4%	99.8%	99.9%	88.3%	85.0%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	763	431	289	226	296	684	454	178	253	79	48	274	325
Seclusion Hours - Māori		418	104	59	145	171	623	228	22	208	16	10	133	190
Seclusion Hours - Pacific Peoples		57	128	0	0	18	20	8	95	34	6	29	63	35
Seclusion Events		25	22	16	14	10	15	28	12	13	10	8	18	21
Seclusion Events - Māori		11	7	7	8	5	10	14	3	9	2	3	9	12
Seclusion Events - Pacific Peoples		2	4	0	0	1	2	1	6	3	1	3	1	2

Adverse Performance requiring immediate corrective Action | **Performance is below target, corrective action may be required** | **Performance on or better than Target / Plan**

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.

- Excluding the COVID-19 net expenses the DHB's result for the nine month's to 31 March 2022 is $37.7m surplus, versus a budget surplus of $30.6m.

- Additional net COVID-19 related expenditure above funding, year to date is $16.0m.

- For the nine month's to 31 March 2022 the overall DHB year to date result, including COVID-19 costs is $21.7m deficit.

- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).

- Capital Expenditure including equity funded capital projects was $56.2m year to date.

- The DHB has a positive cash Balance at month-end of $7.9 million including a positive "Special Funds" of $13.4 million net $21.3m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

COVID-19 Revenue and costs

Full Last Year		Capital & Coast DHB Operating Results - $000s	Part Year to Date		
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	YTD March 2022	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	COVID-19 change from MOH Unfunded
	(31,026)	Devolved MoH Revenue		(85,386)	
		Non-Devolved MoH Revenue			
693		Other Revenue	0		197
		IDF Inflow			1,179
		Inter DHB Provider Revenue			
693	**(31,026)**	**Total Revenue**	**0**	**(85,386)**	**1,376**
		Personnel			
(6,336)		Medical	(91)		(5,118)
(4,360)		Nursing	(2,753)		(5,886)
		Allied Health	(513)		(1,505)
		Support	(25)		(232)
		Management & Administration	(4,108)		(1,853)
(10,696)	**0**	**Total Employee Cost**	**(7,490)**	**0**	**(14,595)**
		Outsourced Personnel			
(88)		Medical	(351)		
		Nursing	0		
		Allied Health	0		
		Support	(2)		
		Management & Administration	(490)		
(88)	**0**	**Total Outsourced Personnel Cost**	**(844)**	**0**	**0**
(5,088)		Treatment related costs - Clinical Supp	(957)		
(564)		Treatment related costs - Outsourced	(385)		
(2,028)		Non Treatment Related Costs	(9,207)		
		IDF Outflow			
	(15,828)	Other External Provider Costs (SIP)		(66,503)	
		Interest Depreciation & Capital Charge			
		Recharging			
(7,680)	**(15,828)**	**Total Other Expenditure**	**(10,550)**	**(66,503)**	**0**
(18,464)	**(15,828)**	**Total Expenditure**	**(18,883)**	**(66,503)**	**(14,595)**
19,157	**(15,198)**	**Net result**	**18,883**	**(18,883)**	**15,971**

- The year to date financial position includes $100.6m of additional costs in relation to COVID-19.
- Revenue of $85.3m has been received to fund additional costs for community providers however this has not been sufficient to over all the costs.
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – March 2022

Capital & Coast DHB Operating Results - $000s	Year to Date									Annual		
				Variance		Adjustments			Variance			
YTD March 2022	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend MOH Funded	COVID-19 change from Trend MOH Non Funded	Actuals exc COVID	Actuals exc COVID vs Budget	Annual Budget	Last year	Last year exc COVID
Devolved MoH Revenue	845,739	733,212	713,794	112,527	131,945	85,386	0	760,353	27,141	977,615	962,513	962,513
Non-Devolved MoH Revenue	34,938	34,972	32,888	(34)	2,050		0	34,938	(34)	48,353	42,516	42,516
Other Revenue	90,064	87,843	42,688	2,221	47,376	0	(197)	90,262	2,418	97,051	52,921	52,921
IDF Inflow	232,032	234,220	191,328	(2,188)	40,703		(1,179)	233,211	(1,009)	312,294	258,694	258,694
Inter DHB Provider Revenue	14,133	13,888	29,956	245	(15,823)		0	14,133	245	18,577	42,120	42,120
Total Revenue	**1,216,906**	**1,104,135**	**1,010,654**	**112,771**	**206,252**	**85,386**	**(1,376)**	**1,132,896**	**28,761**	**1,453,890**	**1,358,764**	**1,358,764**
Personnel												
Medical	153,101	147,875	140,761	(5,227)	(12,340)	91	5,118	147,892	(18)	198,575	191,666	191,666
Nursing	227,844	195,195	189,883	(32,650)	(37,962)	2,753	5,886	219,206	(24,011)	264,321	256,973	256,973
Allied Health	58,315	60,256	55,898	1,941	(2,417)	513	1,505	56,296	3,960	81,110	74,244	74,244
Support	9,005	8,696	7,916	(309)	(1,089)	25	232	8,747	(51)	11,772	10,747	10,747
Management & Administration	70,869	70,471	61,568	(399)	(9,302)	4,108	1,853	64,908	5,562	95,074	83,274	83,274
Total Employee Cost	**519,135**	**482,493**	**456,026**	**(36,642)**	**(63,109)**	**7,490**	**14,595**	**497,050**	**(14,558)**	**650,852**	**616,904**	**616,904**
Outsourced Personnel												
Medical	8,581	4,731	6,713	(3,851)	(1,869)	351	0	8,230	(3,499)	6,302	8,145	8,145
Nursing	515	905	425	390	(90)	0		515	390	1,206	897	897
Allied Health	1,424	1,278	1,187	(146)	(237)	0		1,424	(146)	1,702	1,704	1,704
Support	161	197	325	35	164	2		159	37	262	428	428
Management & Administration	4,153	2,205	3,163	(1,949)	(990)	490		3,663	(1,458)	3,005	4,491	4,491
Total Outsourced Personnel Cost	**14,835**	**9,315**	**11,813**	**(5,520)**	**(3,022)**	**844**	**0**	**13,992**	**(4,677)**	**12,477**	**15,664**	**15,664**
Treatment related costs - Clinical Supp	102,212	103,488	100,108	1,277	(2,104)	957		101,255	2,233	138,237	135,244	135,244
Treatment related costs - Outsourced	22,963	23,129	19,516	166	(3,447)	385		22,577	551	30,750	26,761	26,761
Non Treatment Related Costs	94,732	75,380	79,611	(19,353)	(15,121)	9,207	0	85,525	(10,145)	104,120	107,768	107,768
IDF Outflow	82,558	82,725	81,140	167	(1,417)			82,558	167	110,300	108,768	108,768
Other External Provider Costs (SIP)	313,022	254,743	255,692	(58,279)	(57,330)	66,503		246,519	8,223	339,657	338,357	338,357
Interest Depreciation & Capital Charge	45,714	42,225	41,898	(3,489)	(3,816)			45,714	(3,489)	60,468	55,798	55,798
Recharging	0	1	0	1	0					0	0	
Total Other Expenditure	**661,201**	**581,690**	**577,965**	**(79,511)**	**(83,236)**	**77,052**	**0**	**584,149**	**(2,459)**	**783,532**	**772,695**	**772,695**
Total Expenditure	**1,195,171**	**1,073,498**	**1,045,803**	**########**	**(149,367)**	**85,386**	**14,595**	**1,095,190**	**(21,693)**	**1,446,861**	**1,405,263**	**1,405,263**
Net result	**21,735**	**30,637**	**(35,149)**	**(8,902)**	**56,884**	**0**	**(15,971)**	**37,706**	**7,068**	**7,028**	**(46,499)**	**(46,499)**
Funder	(4,526)	(8,687)	4,213	4,161	(8,739)					(9,420)	8,007	
Governance	351	(11)	687	362	(336)					(11)	649	
Provider	25,909	39,335	(40,050)	(13,425)	65,959					16,459	(55,155)	
Net result	**21,735**	**30,637**	**(35,149)**	**(8,902)**	**56,884**					**7,028**	**(46,499)**	

Note
Adjustments are made for COVID-19

COVID-19 forms part of the DHB deficit;
as revenue from MoH is only funding certain costs incurred by the DHB, but is excluded from our responsible deficit and was excluded from our budget submission.

Executive Summary – Financial Variances

- The DHB surplus year to date is $21.7m compared to a budget surplus of $30.6m.
- Included within this result is recognition of the adjustment to an estimated net impact of COVID-19 of ($16.0m).
- Excluding the COVID-19 above this brings the year to date surplus to $37.7m being $7.1m favourable to budget.
- Revenue is favourable by $100k YTD, after excluding COVID-19 & Pay Equity revenue.
- Personnel costs including outsourced is ($42.1m) unfavourable YTD, excluding COVID-19 related costs of ($22.9m) and Pay Equity ($27.6m) Personnel is $8.4m favourable YTD. Currently the DHB has a large number of vacancies which has been offset by ($29.7m) of vacancy savings targets.
- Treatment related clinical supplies is $1.5m favourable including favourable variances for Implants/Prostheses & Treatment disposables as volumes are down through the COVID-19 ($957k), which is offset by increase cost in Pharmaceuticals
- Outsourced clinical services is unfavourable YTD by $18k.
- Non treatment related costs ($22.9m) YTD unfavourable, however after excluding COVID-19 related costs of ($21.6m), the unfavourable variance was due to additional depreciation on 30 June building revaluation, seismic assessments costs, catch-up of deferred maintenance & Capital Charge
- The funder arm is favourable YTD due to additional revenue from spend requirements for the community COVID-19 response which is fully funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $112.5m favourable YTD
- The variance is due to revenue for special MHAIDS additional funding $676k, Pay Equity funding $26.7m The funder is also favourable by $56.6m revenue and the provider arm is favourable by $53.8m, however with offsetting community cost and COVID-19 related costs' including the reduction in IDF revenue of ($2.2m)

Personnel (including outsourced)

- Medical Personnel is ($2.0m) unfavourable for the month, ($9.1m) YTD. The unfavourable position for the month is driven by leave liability movement and vacancies across other services, most notably MHAIDS offset by centrally held vacancy savings targets and increased outsourcing in SWC & MHAIDS
- Nursing Personnel is ($2.3m) unfavourable to budget for the month. ($32.2m) YTD is driven by Pay Equity $26.7m. Operationally nursing across the hospital is on budget, however the variance is a result of COVID-19 related costs.
- Allied Personnel labour is $301k favourable to budget, $1.8m YTD as a result of vacancies.
- Support Personnel labour is ($16k) unfavourable to budget for the month, ($273k) YTD
- Management/Admin Personnel is favourable in the month by $1.3m, ($2.4m) YTD Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings and increased outsourcing as a result of Vacancies and COVID

Section 4

Financial Position

Cash Management – 31 March 2022

Month : Mar 2022					Capital & Coast DHB Statement of cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Mar 2022	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating activities					
129,774	**116,157**	**124,936**	**13,617**	**4,838**	**Receipts**	**1,168,150**	**1,044,135**	**1,048,329**	**124,014**	**119,821**
					Payments					
52,756	57,404	46,345	4,648	(6,411)	Payments to employees	494,996	482,491	443,438	(12,505)	(51,558)
76,960	62,240	76,297	(14,721)	(664)	Payments to suppliers	663,712	546,186	560,318	(117,526)	(103,394)
-	-	-	-	-	Capital charge paid	9,048	22,204	21,845	13,156	12,798
101	-	(6,445)	(101)	(6,546)	GST (net)	3,023	-	(3,697)	(3,023)	(6,719)
129,817	**119,643**	**116,197**	**(10,174)**	**(13,620)**	**Total payments**	**1,170,778**	**1,050,881**	**1,021,905**	**(119,897)**	**(148,873)**
(43)	**(3,487)**	**8,739**	**3,443**	**(8,782)**	**Net cash flow from operating activities**	**(2,629)**	**(6,746)**	**26,424**	**4,117**	**(29,052)**
					Investing activities					
82	**16**	**9**	**(67)**	**(73)**	**Receipts**	**155**	**140**	**164**	**(14)**	**9**
					Payments					
9,967	3,525	5,051	(6,442)	(4,916)	Purchase of fixed assets	66,210	93,562	45,005	27,352	(21,205)
9,967	**3,525**	**5,051**	**(6,442)**	**(4,916)**	**Total payments**	**66,210**	**93,562**	**45,005**	**27,352**	**(21,205)**
(9,885)	**(3,509)**	**(5,041)**	**(6,509)**	**(4,989)**	**Net cash flow from investing activities**	**(66,055)**	**(93,422)**	**(44,841)**	**27,338**	**(21,196)**
					Financing activities					
-	-	-	-	-	Equity - capital	65,000	39,814	-	25,186	65,000
4,103	-	16,323	4,103	(12,220)	Other equity movement	40,420	61,840	23,705	(21,420)	16,715
-	-	-	-	-	Other	-	-	-	-	-
4,103	**-**	**16,323**	**4,103**	**(12,220)**	**Receipts**	**105,420**	**101,654**	**23,705**	**3,766**	**81,715**
					Payments					
-	-	-	-	-	Interest payments	-	-	8	-	8
-	-	-	-	-	**Total payments**	-	-	8	-	8
4,103	**-**	**16,323**	**4,103**	**(12,220)**	**Net cash flow from financing activities**	**105,420**	**101,654**	**23,697**	**3,766**	**81,723**
(5,825)	**(6,996)**	**20,021**	**1,037**	**(25,992)**	**Net inflow/(outflow) of CCDHB funds**	**36,736**	**1,487**	**5,279**	**35,221**	**31,475**
27,109	(15,652)	3,495	(42,761)	(23,614)	**Opening cash**	(15,452)	(24,134)	18,236	(8,682)	33,688
133,959	116,172	141,268	17,653	(7,455)	Net inflow funds	1,273,724	1,145,930	1,072,197	127,766	201,545
139,784	123,168	121,247	(16,616)	(18,537)	Net (outflow) funds	1,236,988	1,144,443	1,066,918	(92,545)	(170,070)
(5,825)	**(6,996)**	**20,021**	**1,037**	**(25,992)**	**Net inflow/(outflow) of CCDHB funds**	**36,736**	**1,487**	**5,279**	**35,221**	**31,475**
21,284	**(22,648)**	**23,516**	**43,932**	**(2,232)**	**Closing cash**	**21,284**	**(22,648)**	**23,516**	**43,932**	**(2,232)**

Reconciliation of net cash flow to operating balance

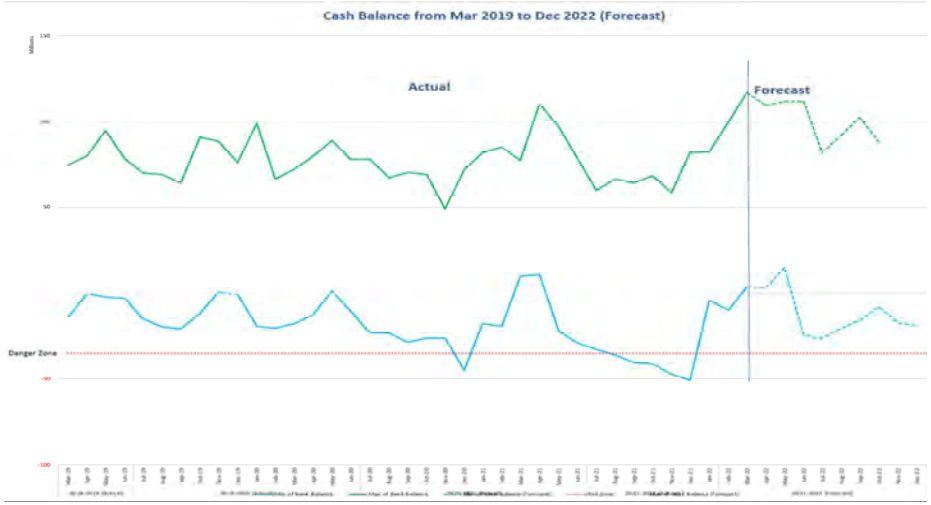
	YTD Mar 2022		
	Actual $000	Budget $000	Variance $000
Net cashflow from operating	(2,629)	(6,746)	4,117
Non operating financial asset items	168	-	168
Non operating non financial asset items	(2,616)	-	(2,616)
Non cash PPE movements	30,582	30,695	(113)
Working capital movement			
Inventory	1,256	-	1,256
Receipts and prepayments	26,253	-	26,253
Payables and accruals	(31,279)	6,689	(37,967)
Total working capital movement	**(3,769)**	**6,689**	**(10,458)**
Operating balance	**21,735**	**30,637**	**(8,902)**

1. Payments for operating activities in March were more than budget mainly due to additional COVID-19 related expenses.
2. Receipts for operating activities is favourable to budget in March mainly due to additional receipts from MOH compensating for COVID-19 related expenditure and MECA payments.

Debt Management / Cash Forecast – 31 March 2022

Accounts Receivable
31-Mar-22

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	29,732	15,237	6,263	10	3,861	4,361	29,791
Other DHB's	3,023	644	130	319	42	1,888	3,129
Kenepuru A&M	314	95	32	16	171	-	194
ACC	81	1,077	(1,084)	-	(31)	119	223
Misc Other	5,830	3,701	330	48	6	1,745	3,875
Total Debtors	38,980	20,754	5,671	393	4,049	8,113	37,212
less : Provision for Doubtful Debts	(4,252)						(4,224)
Net Debtors	34,728						32,988



Debt management

1. The MOH overdue is for invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.

2. The single largest debtor in 'Other DHB's' outstanding is HVDHB with $1.97m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $126k

4. 'Misc Other' debtors includes non resident debt of approx. $2.06m. About 77.61% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash management

We have projected our cash position based on the proposed capital budget and a forecast deficit of $40.11m for 2021/22. However any deterioration in these forecasts may put the facility limit at risk and we continue to monitor this closely.

Statement of financial position as at 31 March 2022

Feb-22	Month : Mar 2022					Capital & Coast DHB Statement of financial position
				Variance		
Actual	Actual	Budget	At Mar 2020	Actual vs Budget	Actual vs Mar 2020	YTD Mar 2022
13	13	31	31	(17)	(17)	Bank
12,419	7,890	824	10,270	7,066	(2,380)	Bank NZHP
14,677	13,381	13,561	13,216	(180)	165	Trust funds
76,357	82,443	63,930	46,926	18,513	35,518	Accounts receivable
12,856	10,650	9,466	9,613	1,184	1,037	Inventory/stock
13,020	12,381	7,902	8,929	4,478	3,451	Prepayments
129,342	**126,757**	**95,714**	**88,984**	**31,043**	**37,774**	**Total current assets**
548,483	543,351	633,272	508,904	(89,921)	34,447	Fixed assets
16,058	5,875	5,875	14,796	-	(8,920)	Work in progress - CRISP
143,329	222,056	103,005	86,449	119,051	135,607	Work in progress
707,870	**771,282**	**742,153**	**610,149**	**29,130**	**161,134**	**Total fixed assets**
1,150	1,150	1,150	1,150	-	-	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	-	-	**Total investments**
838,362	**899,190**	**839,017**	**700,283**	**60,173**	**198,908**	**Total assets**
-	-	37,063	-	37,063	-	Bank overdraft NZHP
88,547	87,956	72,575	96,072	(15,380)	8,117	Accounts payable, accruals and provisions
3,050	4,575	5,551	4,603	976	28	Capital charge payable
593	593	593	593	-	-	Insurance liability
12,359	11,603	11,441	118,203	(161)	106,600	Current employee provisions
194,142	196,036	180,467	64,877	(15,570)	(131,160)	Accrued employee leave
13,287	19,172	22,515	15,720	3,343	(3,452)	Accrued employee salary & wages
311,978	**319,935**	**330,206**	**300,068**	**10,271**	**(19,867)**	**Total current liabilities**
99	105	92	97	(12)	(8)	Restricted special funds
605	605	605	605	-	-	Insurance liability
6,222	6,222	6,564	6,564	343	343	Long-term employee provisions
6,925	**6,931**	**7,262**	**7,266**	**330**	**335**	**Total non-current liabilities**
318,903	**326,867**	**337,468**	**307,335**	**10,601**	**(19,532)**	**Total liabilities**
519,458	**572,323**	**501,549**	**392,948**	**70,774**	**179,375**	**Net assets**
933,856	937,959	931,617	832,493	6,342	105,466	Crown equity
-	-	-	-	-	-	Capital repaid
4,103	1,673	-	953	1,673	720	Capital injection
193,463	193,463	130,659	130,659	62,804	62,804	Reserves
(611,963)	(560,772)	(560,727)	(571,157)	(45)	10,385	Retained earnings
519,458	**572,323**	**501,549**	**392,948**	**70,774**	**179,375**	**Total equity**

Balance Sheet

1. Bank overdraft NZHP is favourable to budget due to receipt of deficit support $65m in January.
2. Fixed assets is under budget while WIP is over budget caused by the backlog of capitalisation to be completed in the coming months.
3. Favourable variance in entity is due to the budgeted opening revaluation reserve not factoring in the 2020/21 revaluation.

Financial ratios

1. Current ratio – this ratio determines the DHB's ability to pay back its short term liabilities.
   DHB's current ratio is 0.40 (February - 0.41).
2. Debt-to-equity ratio - this ratio determines how the DHB has financed the asset base.

   DHB's total liability to equity ratio is 0.57 (February - 0.61).

Capital Expenditure Summary on Prior Year Approved February 2022

						Forecast					
Prior Year Projects	Approved Budget Value	Spend to 30 Jun 2021	Carry Forward to FY2021/22	Spend to Feb 2022	To Spend	Mar-22	Apr-22	May-22	Jun-22	Carry Forward	Net Savings
Buildings	33,242,453	16,721,683	16,520,770	4,312,020	12,208,750	674,907	686,917	1,521,508	1,505,755	7,147,332	744,106
Clinical Equipment	8,797,244	3,557,763	5,239,481	4,044,771	1,194,710	60,222	93,642	127,784	119,028	138,279	655,755
ICT	4,788,297	2,540,611	2,247,686	1,303,465	944,221	-113,077	-177,071	158,698	134,532	559,283	381,855
Other Equipment	3,532,421	686,660	2,845,761	1,339,216	1,506,545	11,918	78,004	2,924	5,420	1,251,253	157,026
Grand Total	50,360,414	23,506,717	26,853,697	10,999,472	15,854,225	633,970	681,491	1,810,914	1,764,736	9,096,148	1,938,742

Key highlights (excludes New Children's Hospital, CT Scanner, Water Remediation Project & ISU for MHAIDS):

- $26.9m in approved but incomplete projects was carried forward from the previous year to FY2020/21
- Total cash spend to February 2022 was $11.0m
- A further $4.9m is forecast to be spent by 30 June 2022, leaving an estimated $9.1m to be carried forward to FY2022/23
- The cash spending forecast will be reviewed monthly and adjusted to reflect changes from both internal and external factors (workforce, logistics, supply chain)

Capital Expenditure Summary 2021/22 February 2022

				Forecast					
Current Year Projects	Approved Budget Value	Spend to Feb 2022	To Spend	Mar-22	Apr-22	May-22	Jun-22	Carry Forward	Net Savings
Buildings	16,605,538	3,046,313	13,559,225	164,529	1,145,377	2,033,057	2,640,240	7,580,755	- 4,733
Clinical Equipment	12,999,103	5,908,255	7,090,848	186,346	743,060	1,736,206	1,412,802	2,943,065	69,369
ICT	6,026,288	2,777,680	3,248,608	421,717	531,590	497,627	380,596	1,410,385	6,693
Other Equipment	9,894,738	2,727,141	7,167,597	374,224	1,337,610	- 118,192	528,525	5,059,595	- 14,164
Grand Total	**45,525,666**	**14,459,389**	**31,066,277**	**1,146,816**	**3,757,638**	**4,148,697**	**4,962,162**	**16,993,800**	**57,165**

Key highlights to FY2021/22 Capital plan:

- $68.7m was approved by the Board in the FY2021/22 Capital Plan, which includes equity funded projects
- The development of business cases from the 2021/22 Capital Plan are at various stages with $45.5m having been approved to February 2022
- Total cash spend for the half year to February 2022 was $14.5m
- Business units have indicated a further $14.0m will be spent by 30 June 2022, and $17.0m carried forward to next financial year
- The cash spending forecast will be reviewed on a monthly basis and adjusted to reflect our capacity to submit business cases for approval, procure and install projects

Board Information – Public

13 May 2022

2DHB People and Culture Update	
Action Required **The Boards note:** (a) The impact of the changes to the Health Order (vaccination mandate) for health and disability sector workers on the People and Culture work programme. (b) The progress on actioning the terms of settlement for bargaining and pay equity.	
Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and the Sub Regional Disability Strategy
Author	Rachel Gully, 2DHB Director People and Culture 2DHB People and Culture Leadership Team
Endorsed by	John Tait, Acting Chief Executive
Presented by	Rachel Gully, 2DHB Director People and Culture
Purpose	To provide information and advice on people related matters in order to support the Boards for both DHBs to exercise their governance responsibilities.
Contributors	N/A
Consultation	N/A

Executive Summary

The Health Order requiring workers in the health and disability sector to be fully vaccinated against COVID-19 was updated in January 2022 requiring this group to also have a booster.

This remains a significant piece of work for the People and Culture Directorate -- to educate, support and consult with staff who are hesitant or unwilling to be vaccinated or boosted. Given this a legal requirement that is time-based, some business-as-usual and project work has been delayed or deferred to prioritise working with these staff.

Despite this, progress has been made across many initiatives including:

- Development of a Korero Ake (Speak Up) line for staff
- Flexible working guidelines
- Implementation of MECA and pay equity claims
- International recruitment campaign
- Single sign-on to the learning management tool

In the last quarter, organisational turnover has increased from 15% to >18% across 2DHB. This is the highest rate in three years and is higher than leading practice (12%). People and Culture will consider appropriate retention, reward and recognition options over the next quarter.

Strategic Considerations

Service	Work underway in People and Culture to reflect the strategic priorities identified by the Executive Leadership Team and to integrate our people systems, and develop metrics to better inform our organisation.
People	Ongoing Change process impacts are being managed with the relevant employees and stakeholders. Engaging and retaining our people and working to sustain their wellbeing
Financial	N/A
Governance	N/A

Engagement/Consultation

Patient/Family	N/A
Clinician/Staff	N/A
Community	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating

Attachment/s

1. 2DHB People and Culture Report to 31 March 2022.

2DHB People and Culture Report

to 31 March 2022

Prepared by: People & Culture Directorate
Endorsed by: Rachel Gully
Kaiwhakahaere Tangata, Ahurea, Pūmanawa hoki
Director People and Culture 2DHB

This report is presented for the Board's information.

The structure and content will continue to evolve inline with the People & Culture change programme, and work to improve our people systems.

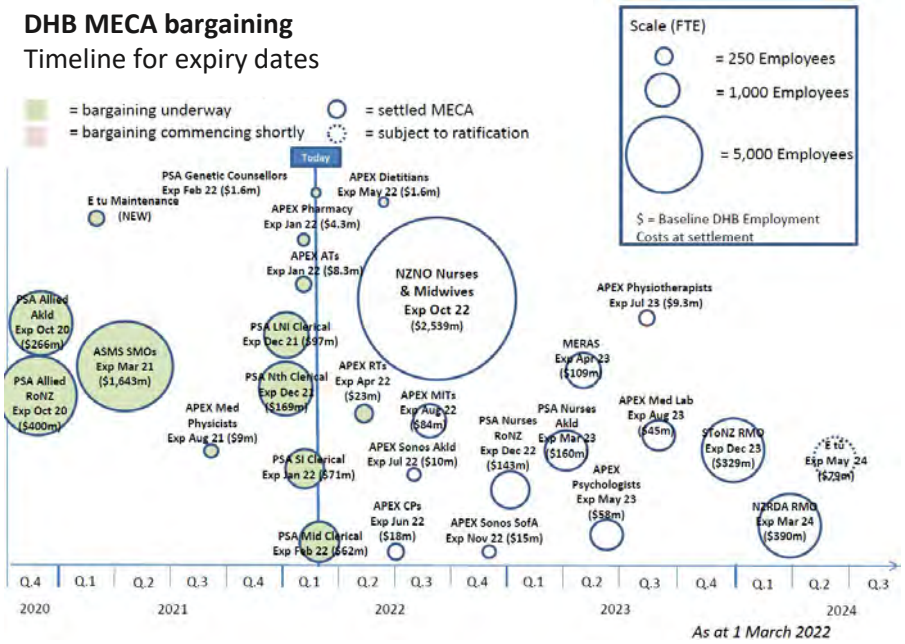
The report covers strategic workforce priorities and core metrics:

- Change programmes and industrial relations
- Turnover and vacancy
- Recruitment
- Equity and diversity
- Organisational and capability development
- COVID vaccination mandate

Change programmes

Acute Health of the Older Person	Final decision document released, with implementation underway
Capability Development (2DHB)	Proposal released for consultation for transition of simulation, education and training capability from Capability Development to Centre of Clinical Excellence
Centre of Clinical Excellence (2DHB)	Consultation underway for alignment of Medical Leadership
Community Health Nursing	After Hours on Call - Final decision document released, with implementation underway
Health and Safety (2DHB)	Implementation underway with appointment of leadership roles
ICT (3DHB)	Strategy discussed with ICT team on leadership and service realignment, consultation proposal being developed
MHAIDS	Early co-design phase with stakeholders to transform mental health and addiction services
Property & Facilities (2DHB)	Proposal released for consultation
Regional Public Health (National)	Upcoming changes linked to MoH and national Public Health group under 1 July changes
RMO 2DHB	Currently paused
SPP (National)	Upcoming changes linked to Transition Unit

Industrial relations and bargaining



The large majority of staff employed at 2DHB are covered by national Multi-Union Collective Agreements. Since the last industrial relations report was tabled, national Collective Agreements covering the work undertaken by our Nurses, Midwives, Resident Medical Officers (SToNZ), Administration and Service and Food Workers across both DHBs have been settled and ratified. A number of national Collective Agreements covering our Senior Doctors, Allied Health, Anaesthetic Technicians and Trades staff continue to be renegotiated.

The PSA has notified DHBs of planned industrial action to support bargaining for the Allied Health workforce. This is expected to include Working to Rule during 9 – 15 May, a full withdrawal of labour for 24 hours on 16 May, and a further period of Working to Rule during 17 – 20 May pending settlement of the Collective Agreement.

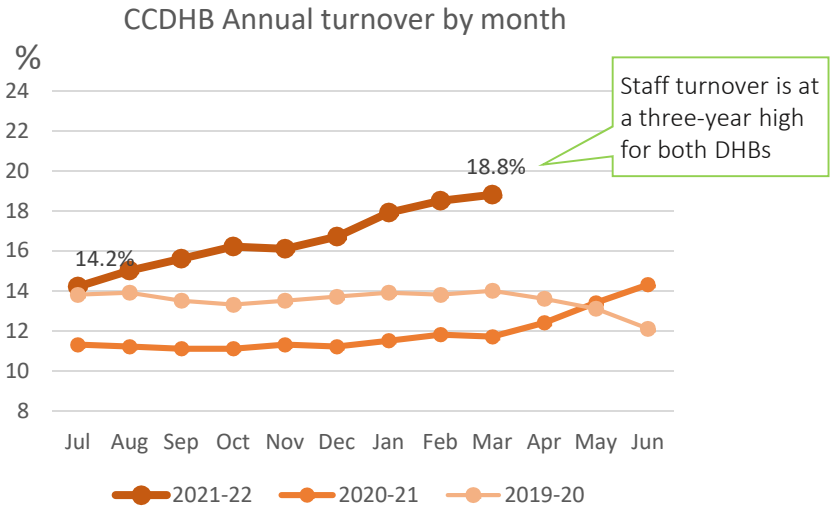
The single employer Collective Agreement covering our Pharmacy, Stores & Trades workforce at Hutt Valley DHB recently ratified and the single employer Collective Agreement covering our Drivers & Stores workforce at Capital & Coast DHB is also about to be renegotiated.

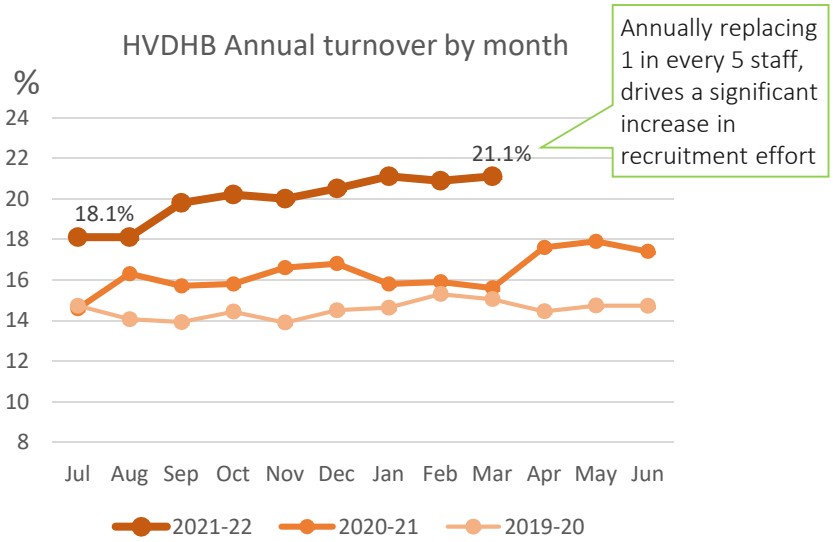
A number of national pay equity claims covering the work undertaken by our Administration, Nursing, Midwifery and Allied Health staff continue to be negotiated.

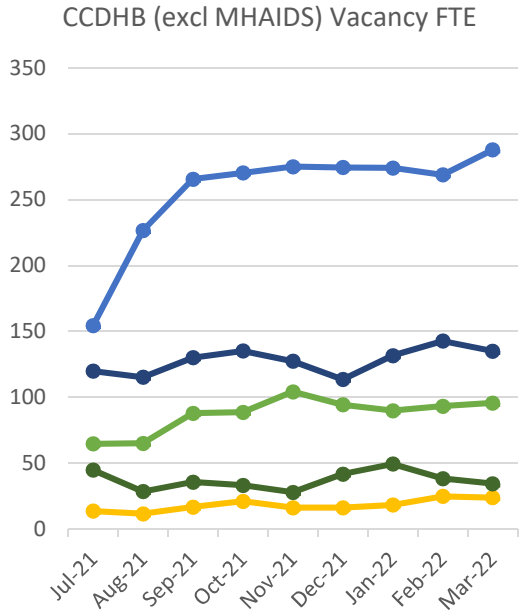
PSA Administration and Clerical Pay Equity Claim: The proposed settlement has gone to members for ratification. Voting on the proposed settlement is from 26 April to 16 May 2022.

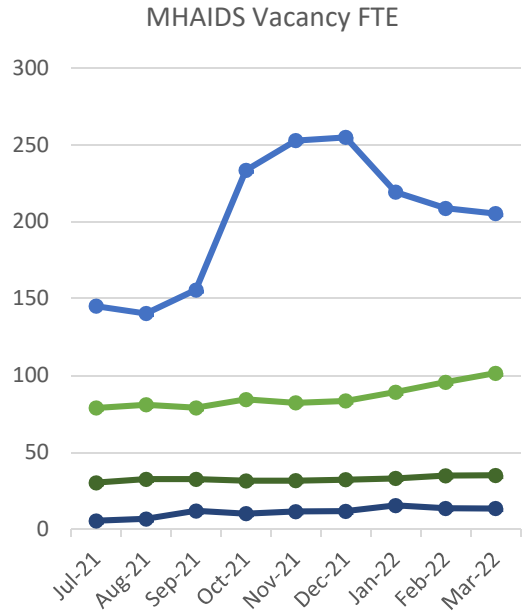
NZNO and PSA Nurses Pay Equity Claim: NZNO are consulting with members for a mandate to either approach the Employment Relations Authority to have pay equity rates determined and deal with the back pay issue or proceed to ratification of the proposed settlement agreement despite that, in the union's view, it breaches earlier agreements and conflicts with the Equal Pay Act. Voting on the options is from 1 to 8 May 2022.

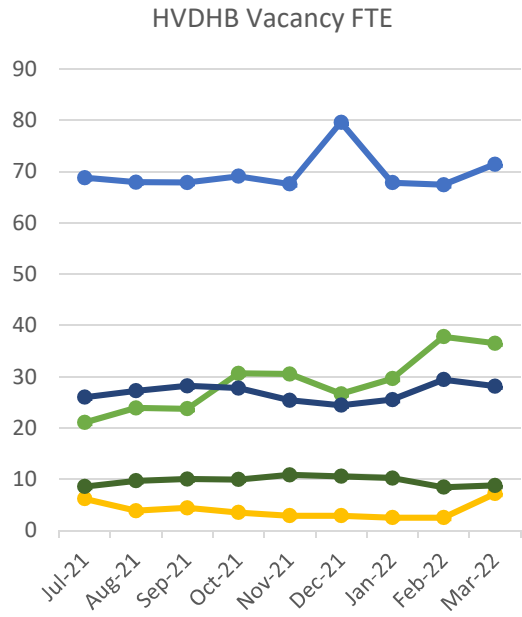
Turnover and vacancy









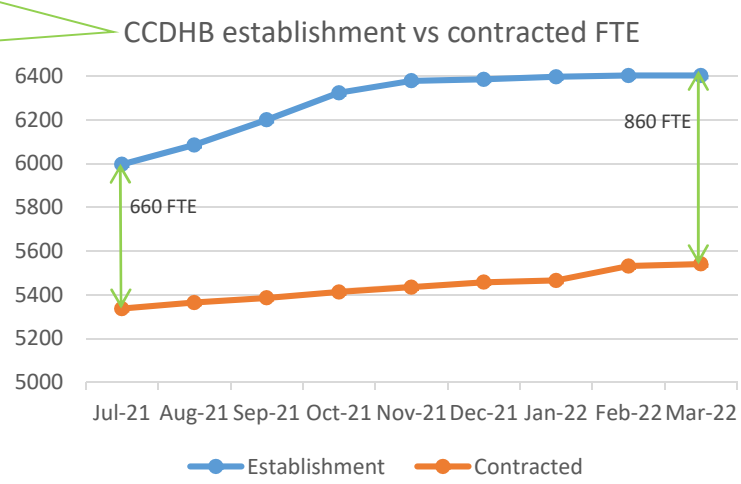


Turnover and vacancy

Staff turnover and shortages across the 2DHB has been identified as a risk to delivery of services and safety of patients and staff.

- Turnover rates across both DHBs are at three-year highs (see previous page)
- Contributing to turnover:
  - Local competition for resource from state sector and Health New Zealand transition
  - A workforce that is tired, experiencing burnout, and in some cases dissatisfied with their reward or recognition
  - Uncertainty from transition and change programmes
  - The opening boarders allowing existing staff to commence delayed travel or look abroad for job opportunities

Implementing Qlik for HVDHB would enable reporting consistency



CCDHB Vacancy levels	Mar 2022		Jul 2021
CCDHB whole	14.6%	⇧	11.4%
Registered midwives	51.6%	⇧	37.6%
Psychologists	31.8%	⇧	23.3%
Social workers	22.7%	⇧	20.4%
MH nurses	22.9%	⇧	18.0%
ICT professionals	12.1%	⇧	19.3%

Vacancy rates continue to grow across the professions that have been tracked in recent issues of this report

Vacancy levels

- 2DHB mean vacancy rates have risen during the current financial year, driven by increases to establishment
- The growing turnover rate has prevented recruitment efforts from significantly reducing the gap
- Global and domestic workforce shortages continue to challenge our ability to attract new staff
- Shortages and historical underinvestment in domestic workforce pipelines (tertiary education for health sector) are becoming evident, partially due to the reduced access to overseas recruitment

Campaigns

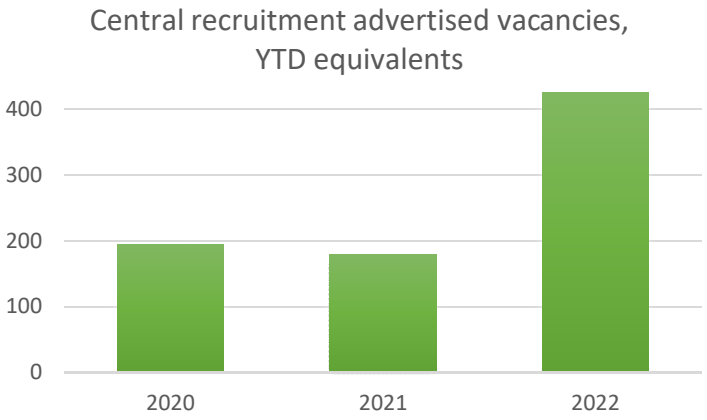
In response to persistent vacancy levels and tightening domestic market, we have invested in international attraction campaigns.

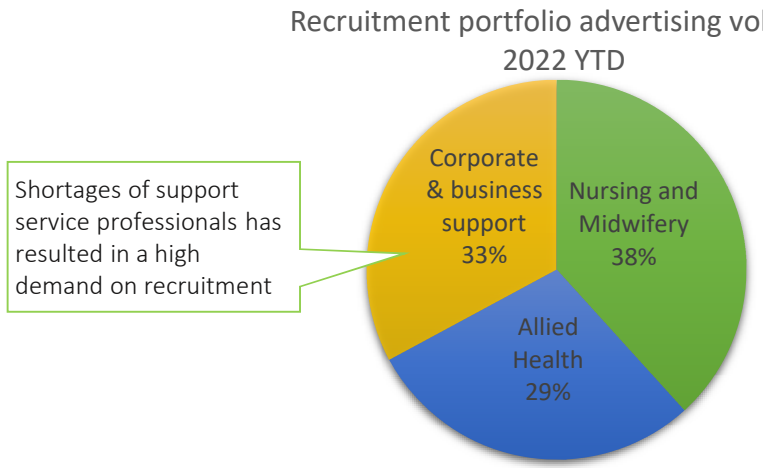
- We have collaborated with lower North Island DHBs to participate in the Dublin, London and Manchester online career expos. These have delivered 370 expressions of interest from potential candidates. From these the 2DHB has 55 active nursing and 44 allied health professions candidates.
- Our 2DHB Midwifery campaign has build strong interest and to date delivered 36 applications. So far 5 have been employed and a further 16 have contacted the Midwifery Council to commence registration.
- We continue to maintain our online presence through improved web content for nursing, mental health, and midwifery, supported by programmatic (targeted) advertising.
- The significant challenges to international recruitment continue to dampen the market, including travel and border closures, increased competition from other countries, source countries restricting the departure of clinical workers, and domestic increases to cost of living and housing. It is unlikely we will return soon to previous levels of international recruitment.

Recruitment

Growing turnover and vacancy levels has resulted in significantly higher recruitment activity than for previous years.

- Centralising of MHAIDS and HVDHB recruitment advisors into the 2DHB recruitment team increased the resource by 50%.
- At the same time job advertising demand has increased 140% from last year.
- The shift to a fully centralised recruitment function has allowed the standardisation of processes and service levels.
- Addition of administration resource has supported the increased work volumes however the 2DHB recruitment function continues to be resourced well below sustainable and industry standards, especially given the manual workarounds required with no automation/recruitment tool.
- Setup of the new recruitment cloud software is underway, with user testing planned for this June and introduction from July. The system will introduce simplify and increase automation from the initial authorisation to recruit stage, through to on-boarding of new staff. It will also enable reporting across 2DHB sites, on-boarding support for candidates and a better user experience for hiring managers and new starters.





Current recruitment activity

- Multiple stalls are booked for the upcoming Careers expo in Wellington.
- Campaigns are underway for encouraging interest in health careers with secondary school students.
- Job advert structure, graphics and content have been refreshed across both DHBs.
- Hot-lists and continuous recruitment panels for nursing continue to be tested, to improve selection quality and speed both for hiring managers and candidate experience.

Covid-19 Response

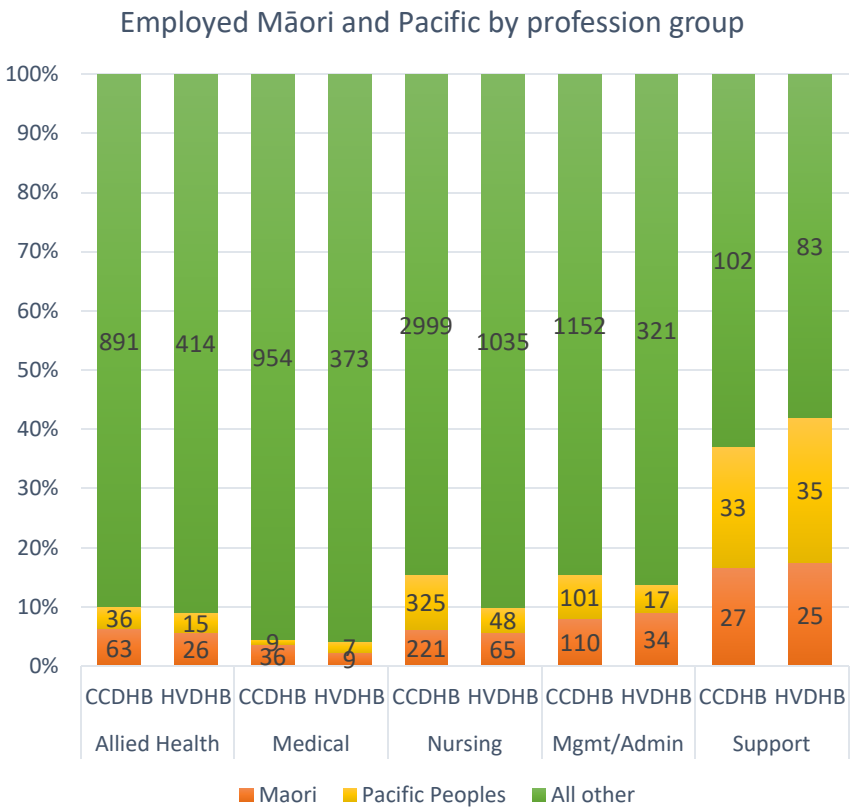
- Based on the model used by Northern Region Health Care Collaborative, an external recruitment agency was engaged to manage sourcing, on-boarding, and remuneration for a surge workforce.
- This successfully enabled Regional Public Health to increase their workforce in time with the recent Omicron surge.
- An Expressions of Interest process was designed with IOC to allow staff to register their availability to work additional shifts and outside their service. The process and resources are now recorded as a standard operating procedure.

Equity and diversity

The ethnicity profile of 2DHB has remained largely unchanged. In line with the health outcome priorities, 2DHB focus is on achieving parity of staff representation for Māori and Pacific Peoples.

The graph below shows percentages for Māori and Pacific Peoples across the profession groups:

- 2018 NZ census recorded Māori at 16.5% and Pacific Peoples at 8.1% of the population.
- Support personnel has the highest representation of both group. However this is generally the least qualified and lowest remunerated profession group within the DHBs.
- The next highest repetition for Māori is within Management/Administration roles at HVDHB, at 9.1%



The implementation of a new recruitment system will improve initial gathering of ethnicity and disability data by improving the ease for submitting this information.

New roles continue to be introduced with a focus on improving our equity outcomes, such as the 2DHB Director Hauora Māori.

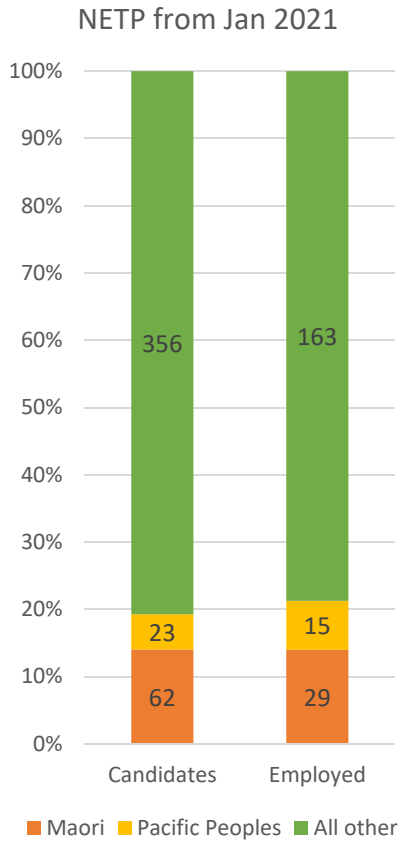
Efforts will focus on improving our attraction as a culturally safe employer, and our ability to retain existing staff.

Nursing at CCDHB has the highest representation for Pacific Peoples (outside Support), at 9.2%. This is not consistent across the 2DHB, with nursing in HVDHB only 4.2% Pacific Peoples.

The main opportunity to increase representation is through recruitment, in particular new to the workforce staff.

The graph to the right compares the representation of Māori and Pacific Peoples in candidates applying for the Nurse Entry to Practice at CCDHB with those we hired.

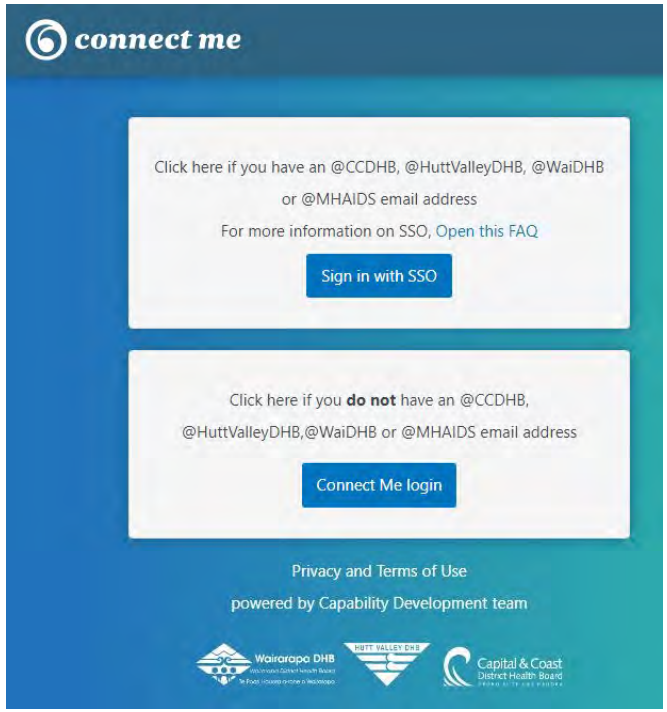
- We achieved a higher rate of recruitment given the available candidates.
- Even if 2DHB were able to recruit 100% of Māori and Pacific candidates available, it would not enable us to reach our representation goals.
- There is insufficient supply from the workforce tertiary education pipelines. This is recognised and 2DHB Nursing are investing in programmes working with secondary schools to attract students into health career education.
- HVDHB NETP employment rate was less than 2% for Maori and 8% for Pacific, maintaining HVDHB's lower representation rates in Nursing.



Organisational and capability development

A range of initiatives have and are being delivered to maintain and support our culture and capability.

- **Flexiwork** guidelines were released in April and the supporting policy is scheduled to be available in May. The guidelines are in line with the Public Services Commission (Te Kawa Mataaho) 'flexible-by-default' approach and the rights of all employees to request consideration of flexible working arrangements.
- Alignment continues of the 2DHB **learning management systems** to enable better access for staff learning, and provide improved reporting and tools for managers. This is linked with 20DHB work underway to propose and test a transition approach for all DHBs to a single learning environment.
- **Single sign-on** was implemented for the CCDHB-hosted learning management system, Connect Me. This makes it the first and only LMS across the 20 authentication process. All staff across the 3DHB group can access the system and broad range of learning programmes. The anticipated outcome is increased engagement from profession groups such as medical. Helpdesk requests for support from staff has reduced 80% since implementing single sign-on.
- **Te Wao Nui** – in collaboration with paediatric consultants, Capability Development are developing both an **online staff orientation** to the new building and **an interactive child safety information package**. The child safety resources will be accessed through a kiosk funded by the Hospital Foundation, located in the main entry foyer. Using the touch screen whānau and tamariki coming into Te Wao Nui will be able to quickly access information such as street safety, meningococcal disease, safe sleeping, button batteries, car seats, appliance and furniture safety.
- A **Māori Crown Relations Survey** will be launched in the coming month to assess staff confidence and capability in Māori Crown relations skills across 2DHB. The survey is based on the Te Arawhiti Maori Crown Relations Cultural Capability framework and contextualised to the 2DHB operating environment.
- All 2DHB **position descriptions are being reviewed** to ensure they reflect **the principles of Te Tiriti o Waitangi** and support the 2DHB Equity and Diversity priorities identified in the Strategic plan. This will include updating the competencies, as the foundation to our expectations of how we work.
- A **COVID Learning Framework** was developed to provide easy access to related learning for all staff. It combines eLearning, videos, practical learning and navigation to resources on the intranet for topics such as PPE and hand hygiene, respiratory anatomy and physiology, non-invasive ventilation indicators and 'how to' guidance. It also supports cultural competence and practice with access to translated patient resources and guides, disability awareness, as well as staff wellbeing and resilience.
- Training to support our health, safety, and wellness culture has been reintroduced for **de-escalation** (e.g. Keeping Everyone Safe and My Safety Workshops) for ED, Orderlies and other Frontline security staff.



Leadership Development

- All face-to-face Leadership Development programmes (including Emerging Leaders, Frontline Leadership and Clinical Leaders Development) have been on hold during Hospital level 1 response and above. These are scheduled to resume May/June.
- A review of the Frontline Leaders individual coaching programme was undertaken last month with recipients reporting an increased ability to build productive relationships, better cope with ambiguity, and increased confidence in leading their teams. Recipients also felt it helped them develop strategies to build personal resilience and manage staff under significant pressures.

COVID vaccination mandate

The Health Order mandating COVID-19 vaccinations added a significant workload to the People & Culture directorate with particular regard to supporting managers with reports, consultation, stand downs and protracted termination and legal challenges.

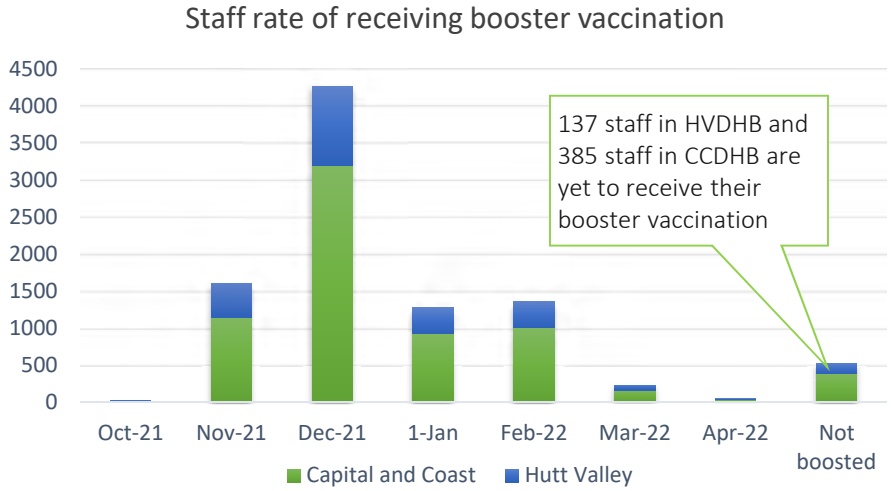
Staff who did not complete their initial full vaccination course (2-3 doses) were stood down in November 2021 and 1 January 2022. In line with other DHBs, considerable effort has been expended meeting our obligations as employers through the process of terminating staff who do not comply with the Health Order.

The following numbers represent the 2DHB, as at 26 April 2022:

Total stood down 2DHB	116
Subsequently vaccinated and returned to work	51
Resigned due to mandate	12
Terminated	53
Still contested	23
Subsequent grievance	6

The addition to the Health Order requiring staff to have received their booster vaccination has continued the pressure on HR advisory teams. The deadline for boosters has been extended several times, requiring continuous reporting. As each extension has been approved on or just after the stand down date, managers have been repeatedly briefed and supplied with stand down letters.

The current booster deadline is 27 April and for the first time, staff who have previously been granted an extension have now been declined. At time of writing there are 20 staff across the 2DHB who may be stood down unless they receive their booster.



Employee Wellbeing continues to be a key priority as we transition from Pandemic Response to creating our "new normal". This includes:

- **Implementation of a new 0800 Speak-up line and email**, to provide staff with independent counsel and information on 2DHB policies and procedures that support the development of positive healthy interpersonal relations.
- Establishment of a pilot group of **Wellbeing Champions**. These champions will lead the building of a holistic approach to staff Wellbeing. They will help increase engagement with our current Wellbeing resources and help to reduce Covid psychosocial fatigue. This pilot is integrated with our 2DHB leadership development framework and provides opportunities for on-going leadership development for our Frontline leadership graduates and other up-coming potential leaders.
- Continuation of **EAP service on site** for general staff wellbeing and to provide expertise and advice on Debriefing for Critical Incident Management.

Board Information – Public

13 May 2022

2DHB Māori Health Strategies (Taurite Ora and Te Pae Amorangi) Report	
Action Required **Board note:** (a) The progress and performance of the 2DHBs against the 2DHB Strategic Priorities and the two Māori Health strategies.	
Strategic Alignment	Ministry of Health, Whakamaua: the Māori Health Action Plan 2020-2025 CCDHB Health System Plan 2030 (the 2030 Plan) CCDHB, Taurite Ora Māori Health Strategy 2019-2030 HVDHB, Te Pae Amorangi, Māori Health Strategy 2018-2027
Author	Arawhetu Gray, Director Māori Health Services Jeanette Harris, GM System Change Jane Patterson, GM Māori Provider Services
Endorsed by	John Tait, Acting Chief Executive
Presented by	Arawhetu Gray, Director Māori Health Services
Purpose	Provide an update on the progress and performance of the 2DHBs against the two Māori Health strategies.
Contributors	Māori Health Services across the two DHBs
Consultation	Not applicable

Executive Summary

To support the planned changes to Aotearoa New Zealand's health and disability system, we continue to implement Te Pae Amorangi and Taurite Ora and embed our activities within the 2DHB Strategic Priorities agreed by the Board. Coordination across 2DHB promotes better outcomes across all measures of wellbeing, inparticular for Māori, Pacific and the diabled community. A summary of the progress and performance of the 2DHBs against the two Māori Health strategies.

Strategic Considerations

Service	Continued delivery of the tailored programmes of work highlighted in Te Pae Amorangi and Taurite Ora to address the impact of inequity on Māori health outcomes.
Financial	Baseline funding remains, Taurite Ora - $500k and Te Pae Amorangi $350k.
Governance	The upcoming Māori Health Authority an interim Iwi Māori Partnership Board

Attachments

1. Attachment 1: Progress and performance against the 2DHB Strategic Priorities and Māori Health strategies.

Attachment 1: Progress and performance against the 2DHB Strategic Priorities and Māori Health strategies.

Our Hospitals: provide safe, quality complex and specialist care that achieves equity of access and outcomes				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
Acute Hospital Flow	Pro-equity Prioritisation Policy	• Provide a Māori centred overview of the proposed policy for ambulatory services. • Support the development for a hospital wide pro-equity prioritisation policy	Draft policy specific for ambulatory services under review. Governance group to raise hospital wide proposal with Hospital Health and Safety Committee.	• Approval for hospital wide policy • Revised policy with appendices for specific services as required
Planned Specialist Care	Engaging Māori in Eye Clinic Services	• Reduce the DNA rate for Māori patient • Improve access to eye clinic services • Prevent avoidable eye health degeneration	Second pilot proposal is being drafted for a dedicated shuttle bus to support Māori patients. Cost benefit analysis is in development and potential providers have been assessed.	• Completed proposal and business case. • Approved funding. • Contracting to be underway.
	Supporting Māori and Pacific Tissue and Organ Donation	• Increase the number of Māori and Pacific donors • Identify key concerns for Māori and Pacific people in around donation • Enable better donor matching and prevent frequent eye surgery	Established connection with Organ Donation NZ who identified other DHBs with similar projects of work. Working to arranging meetings with those staff to understand their projects, lessons learned and whether their changes could be implemented at CCDHB.	• Met with other DHB contacts. • Proposal and approval for change based on other DHB projects or proposal for project work programme.
Maternity and Women's Health	New Model of Care for Community Midwifery Team	• Establish well aligned and resourced Maternity continuity-of-care for those unable to access community LMC	Workshops are underway with both Community Midwifery Teams to develop new models of care.	• Finalising a new community of care model to be implemented • Facilitate workshops with CMT team at both Hutt and CCDHB.

Attachment 1: Progress and performance against the 2DHB Strategic Priorities and Māori Health strategies.

Our Hospitals: provide safe, quality complex and specialist care that achieves equity of access and outcomes				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
			Continue to provide Māori Health leadership, insight, guidance that will lead to improved access, quality care and health outcomes for our hapū whānau.	
	Uplift Policy	• Develop and publish a CCDHB Uplift Policy • Educate staff on the new policy • Implement BAU training for all new staff	Policy is complete and published in Capital Docs. Development of training is underway with the approach to be one off presentations and a potential online course as part of required on-boarding.	• Complete one off training sessions. • Complete ConnectMe online module • Lessons Learned and project closure
	Uplift Guidelines	• Develop and publish guidelines to support the Uplift Policy • Implement BAU training	Guidelines are being drafted.	• Completed first draft. • Plan for consultation, review and feedback with subject matter experts and required agencies, e.g. OT and Police.
	Vulnerable Pregnant Person Guidelines	• Develop and publish guidelines to support women who require wraparound support • Clarify the referral pathway to Maternal Wellbeing and Care group	On hold due to review of group and focus in that area.	• Completion of dependencies and project restarted.
	Culturally Responsive Care Principles	• Develop, with consumers, principles to enable discussion	Early development stage.	• Met with consumer partners • Met with clinical partners

Attachment 1: Progress and performance against the 2DHB Strategic Priorities and Māori Health strategies.

Our Hospitals: provide safe, quality complex and specialist care that achieves equity of access and outcomes				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
		around culturally responsive care • Identify how best to support clinicians in being culturally responsive	Meetings will be arranged with consumer partners to develop direction.	• Developed initial draft principles for wider consultation
	Consumer Feedback Process	• Review consumer feedback survey • Implement new feedback pathway • Proposal for Consumer Feedback subcommittee under MQSP Governance • Establish how feedback informs improvement projects	Early development stage. Feedback survey through Breastfeeding Peer Support workers on hold due to COVID-19 settings. Will restart when able. Proposed subcommittee was verbally agreed in principle by the Governance Group. Terms of Reference and feedback pathways into and out of the group are to be developed.	• First surveys completed through the Breastfeeding Peer support workers. • Draft Terms of Reference and proposed feedback pathways completed for wider consultation.
	Hapū whānau Hubs	• Commission and develop 'hubs' that provide a continuum of Service for hapū whānau	Seeking guidance on engagement Synthesise insights and data enabling due diligence and inform next steps	• Working with iwi to develop and implement hapū whānau hubs • Supporting synthesis and ideation of hapū whānau hubs
	Maternal Wellbeing and Care Group	• Review group for Māori Health outcomes • Revise Terms of Reference as needed	Draft proposal for additional resourcing is complete and will be taken to management for feedback and approval.	• Revision and approval of the additional resource proposal.

Attachment 1: Progress and performance against the 2DHB Strategic Priorities and Māori Health strategies.

Our Hospitals: provide safe, quality complex and specialist care that achieves equity of access and outcomes				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
		• Proposal for additional resourcing	Significant change is required to align with the new Schedule 5 expectations under the MOU between MOH, OT and Police.	• Established change plan for revisions to the group pending MOH feedback on local iwi engagement per Schedule 5. • NOTE: Any change is dependent on the Iwi Māori Partnership Board and the Māori Health Authority. Thus further work is on hold.
	Culturally Responsive Education HVDHB	• People working within maternity are given the education and support to gain skills and confidence in providing culturally responsive care	Engaged with Hukatai Consultants to provide education sessions through 2022 to maternity staff	• Cultural education continues through 2022
		• Provide Social Workers to support Hapū Mama	• High Risk Mama are supported through pregnancy	• A social worker has been appointed at each DHB • Service development at CCDHB is on hold due to a resignation. A replacement begins in June • Social worker at the Hutt in orientation phase building relationships

Commissioning and Community: develop strong networks of primary and community care that will support whānau and achieve equity

Priority	Work Programme / Projects	Objectives	Current Status	Target achievements by 30 June
Porirua and Wainuiomata Service Integration	Wainuiomata Service	• Area based health provision that meets our obligations of Te Tiriti o Waitangi to achieve equitable health outcomes for all	Interviewed community providers on strength and opportunities for Māori health improvement.	• Development of a localities plan for the Hutt Valley
	Porirua		Porirua has been confirmed as one of nine communities where a locality approach will operate in partnership with mana whenua to improve health and wellbeing.	• A detailed localities plan is being co-designed with mana whenua
Complex Care and Long Term Conditions	Whare ki te whare	• To reduce avoidable admission rates for whānau • provide wrap around services for whānau with chronic conditions	Workforce personnel in place Service now includes sleep clinics and considering other services that may be suitable.	• Outcome measures in place
Inter-Sectoral Priorities	Specialist advice & Ambulatory care	• Develop guidance and tools enabling good co-design process to facilitate equitable outcomes	Currently engaged with external consultancy group TātouTātou to develop guidance and tools Engaged with Māori leadership in codesign across other sectors	• Finalise and commence implementation of guidance and tools
	Strengthening 2DHB Family Violence Response	• Strengthen our response to Family Violence (FV) • Reduce the impact of FV and improve FV outcomes and support safer communities • Ensure culturally responsive and equitable FV Health response.	Have undertaken prototyping work with Thinkplace. Facilitating workshops with external providers and with 2DHB staff to test prototype	• Finalise report and recommendation • Gain approval of recommendations • Implementation plan in place and underway

Mental Health and Addiction Commissioning: a whole of population, equitable, mental health and addiction system of care				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
Kaupapa Māori Mental Health Development	Te Waka Whaiora - Kaupapa Māori Forensic Step Down Unit	• To strengthen our relationship and ensure the successful implementation of the new Kaupapa Māori Forensic Step Down service. • To support Te Waka Whaiora develop its workforce with Hauora Māori training funding. • To support co-ordination between agencies, provider and community for the successful integration of the Forensic Step Down Unit into the community. • Hauora Māori training funding has been approved by MoH we are working closely with our Māori providers to ensure the fund is fully expended. • We are developing communications material to promote the fund to 2DHB staff	Kāinga Ora is working with Te Waka Whaiora to complete refurbishment work on the property that will house the forensic unit. The work has been impacted by Covid, and shortages of labour and building materials Applications from Te Waka Whaiora for funding support to complete NCEA L6 Māori Dip in Māori Public Health are currently being processed. 85% of HVDHB funding is committed 75% of CCDHB funding remains uncommitted	• Building is on track to be completed by early July, with a first intake of 6 tangata motuhake soon after. • Funding for Wānanga travel, resources and accommodation will be finalised. • On track to be fully expensed by end of January 2023

Enablers: co-ordinating and enhancing to achieve our priorities.				
Priority	**Work Programme / Projects**	**Objectives**	**Current Status**	**Target achievements by 30 June**
Data and Digital	Māori Digital Sovereignty	• To work with the Chief Digital Officer to understand and engage meaningfully with Māori, particularly with mana whenua about their expectations of 2 DHB regarding data gathering, management and sharing	Develop scope and approach. Engage with mana whenua regarding a co-design approach to a Māori data governance model.	• Work with mana whenua to develop a data governance model
Workforce	Kia Ora Hauora 2DHB Career Pipeline	• The *Kia Ora Hauora / 2DHB Career Pathway Programme* is a partnership between the 2DHBs (Hutt Valley and Capital & Coast, District Health Boards) and Kia Ora Hauora (KOH) Central Region, to promote, support and implement a pipeline for rangatahi Māori into health careers.	Has commenced and delivering its first initiative on 28/04/22	• The Working group established with a TOR • An engagement plan formulated • Regional hui with kura and their staff to inform them on this programme • Mahi exposure Day delivered and completed • Māori engagement training resource for hospital staff, drafted for review
	Overarching Allied Professions Māori Workforce Strategy	• To reframe our current recruitment strategy to recognise how we increase Māori workforce and to embed a Te Tiriti centric working environment	Currently in first draft	• Final draft completed • Peer reviewed and consultation process completed with General health and MHAIDS • CoCE reviewed and approved • Submitted to Document Control

	Te Pae Amorangi Tuatahi – Increasing our Māori Workforce across the System	• Supporting redirection of recruitment systems to be more culturally responsive • Developing a Māori Health Workforce Plan for nurses and midwives • Working with KOH to strengthen the pipeline for Rangatahi to progress toward health careers • Supporting Nursing and Midwifery Schools with programme design and governance • Support Māori nursing and midwifery staff across 2DHB	This is a new work programme being developed.	
Ethnicity Data	All research to include ethnicity data as standard. To answer the question. What impact are we having on health inequities	Working with Clinical excellence to develop project plan including communications to clinical staff • Identifying strategies to improve accuracy of ethnicity data	Work across 2DHB to bring together the	• Project plan to improve ethnicity collection has been signed off • Communication tools to improve understanding of the importance of ethnicity data is developed and ready for dissemination

Board Information – Public

13 May 2022

2DHB Pacific Health Strategy: Progress & Performance Report 2021/2022 – April 2022	
Action Required **The Boards note:** (a) that a number of initiatives have occurred to meet the actions of the Strategic Plan. (b) The Covid-19 response for Pacific people.	
Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Junior Ulu, 2DHB Director Pacific People's Health
Endorsed by	John Tait, Acting 2DHB Chief Executive Officer
Purpose	Update the Boards in relation to the implementation of initiatives related to the Pacific Strategic Plan.
Contributors	Merivi Tia'i, Principal Advisor Pacific Sam McLean – Principal Analyst & Team leader - Analytics
Consultation	2DHB Strategy, Planning & Performance

Executive Summary

This report provides an overview of the progress made in relation to the key outcomes defined in the Pacific Strategic Plan and includes:

- A detailed report on the collaborative effort of Pacific providers who received funding for the Delta Variant.
- An update on funding allocations for equity and Omicron.
- A high-level dashboard and explanation of indicators that have been developed to measure progress in relation to Pacific health equity.

Strategic Considerations

Service	NA
People	NA
Financial	Investment to implement the Pacific Health Strategy
Governance	Pacific Health Strategy to be jointly owned by the DHBs and the Pacific community DHBs listen to the voice of the Pacific community in the transformation of our health system to improve health outcomes and ability to achieve equity for Pacific communities.

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
Insert risk #	Limited additional investment to implement the Plan	Junior Ulu Peter Guthrie	Ensure approval of funding investment for out years are sought	3	Medium risk

Attachment/s

1. 2DHB Pacific Progress and Indicators Report
2. Report 3: Tranche 4 – Delta variant & vaccine support

Attachment 1: 2DHB Pacific Health Strategy: Progress & Performance Report 2021/2022 – April 2022

This report provides an overview of progress made on the key outcomes of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region, and includes:

- A report outlining the outputs and outcomes by the Pacific community on MoH Delta Funding
- An update on the distribution of Pacific Equity Funding
- An update on Pacific Covid-19 Omicron Funding.

Contents

1. Background

This report covers the period from November 2021 – April 2022. While the previous report covered a similar period until February this year, there are additional updates on the work of the 2DHB Pacific Directorate that provides a summary of the activities undertaken by the Directorate throughout this timeframe.

Given this is the final report for the Boards, we have used this opportunity to provide a series of updates on funding arrangements commissioned by the 2DHB Pacific Directorate to support not only Covid-19 related work, but also equity funding that will help to meet the six priorities outlined in the 3DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 – 2025. Appendix 1 provides the latest dashboard of progress against the six priorities of the Strategic Plan.

There has also been a number of staffing changes within the Directorate, while people have moved on to other roles it has created opportunities for other Pacific people to support the communities we serve. The next few months will be unsettling for the Health sector in general, however the work to strengthen positive health outcomes for Pacific will continue. Learning over the past year will help to drive equitable outcomes for Pacific and will not be lost due to the health reform.

2. Tranche 4 – Delta Variant & Vaccine Support Report

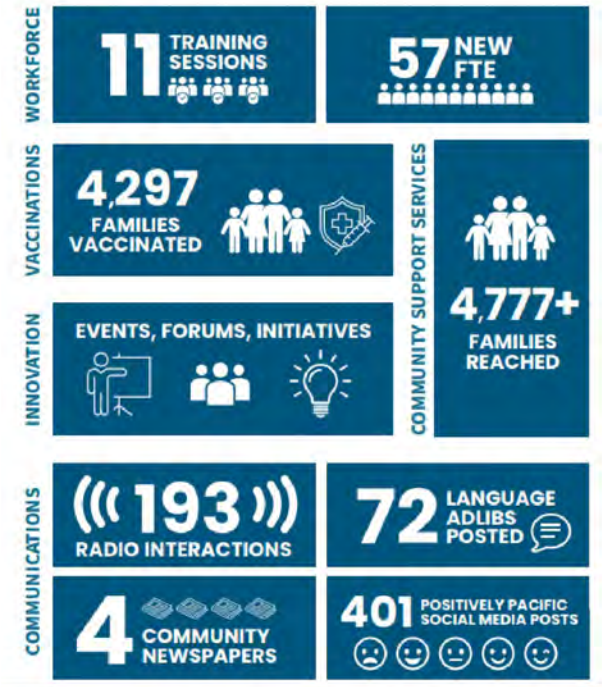
In late 2021 the 2DHB Pacific Directorate received funding from the Ministry of Health (MoH) for Pacific COVID-19 response services in relation to the Delta outbreak. As part of the reporting requirements to the MoH Moana Pacific – a Pacific research company, were commissioned to capture the outputs and outcomes carried out by Pacific stakeholders in relation to Pacific COVID-19 response services to the Delta Variant for the period 1 November 2021 to 28 February 2022.

The resurgence of COVID-19, particularly the Delta variant, disproportionately affected Pacific communities and as a result, Pacific communities needed to scale up their response activities well beyond the initially planned parameters. Funding received from the Ministry has enabled providers to deliver an equitable response to this outbreak by sustaining community-led response activities and maintaining capability to support post-lockdown recovery and the vaccination rollout.

Appendix 2 outlines the full report and emphasises the findings of a rapid evaluation undertaken to explore the effectiveness of how Primary Health and Pacific providers contributed to the Pacific COVID-19 delta variant response and COVID-19 vaccination rollout to protect Pacific peoples from the resurgence of COVID-19, particularly the Delta variant and the newly introduced Omicron variant.

New providers were added to the Pacific COVID-19 response and include along with existing providers: Vaka Atafaga, Pacific Health Services Hutt Valley, Pacific Health Plus, Taeaomanino Trust (Uso bike rides), NET Pacific, Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific radio stations), Vaka Tautua, Eastern Bay Medical, Te Awakairangi Health Network, The Family Centre and Regional Public Health. Diagram 1 demonstrates the collaborative effort carried out by Pacific providers throughout the period of the report.

Diagram 1: Evaluation results summary by activities



3. Pacific Equity Funding Allocation Budget 2021/22 and Beyond

Learnings from the Pacific COVID-19 response highlight that appropriate resourcing of approaches, which are culturally responsive, enables different ways of working and overall supports achieving equitable health outcomes. There are persistent equity gaps and unmet needs we need to address.

CCDHB has allocated funding as part of the 2021/22 budget process to target equity approaches to lift Māori and Pacific health outcomes. An allocation of $1,625,000 over 2.5 years (from 1 January 2021 until 30 June 2023) has been appropriated for Pacific equity approaches across CCDHB.

Focus area	Unmet need for Pacific populations	Pacific Health Strategy Solution
1	Currently there is no Pacific health provider located within the Wellington CBD area. There is also a high population of Pacific peoples in low socio economic areas within the Wellington CBD and Eastern suburbs. Not having a specific Pacific health provider in the region, presents barriers to accessing health services for Pacific peoples.	Reflecting the success of the Porirua Pacific nursing service, commission a similar Pacific community nursing service in Wellington. This solution will support Pacific families in areas not currently served by Pacific specific services, to receive culturally responsive and more convenient health care access that will support improved health and wellbeing outcomes.
2	Learnings from COVID-19 has highlighted that for effective Pacific engagement in vaccinations, health promotion efforts needed to have: Pacific tailored communications, community mobilisation and empowerment. There is a need to increase capacity for community-level health promotion opportunities and overall lift Pacific vaccination rates across CCDHB.	Support more health promotion efforts, and dissemination of health and wellbeing service information, to Pacific communities – via radio and media platforms, through community organizations.
3	Pacific people's access to health care is limited by traditional, operational servicing hours. Being time poor and over-represented in lower socioeconomic employment and deprivation, further creates barriers for Pacific peoples to access health care services.	Enabling services to extend their service hours to support working class Pacific peoples to access affordable after hour's health care.
4	Pacific peoples experience inequitable cardiovascular health outcomes and have persistently high ASH rates for stroke. Stroke is New Zealand's second biggest killer and 75% of strokes are preventable. Currently Pacific peoples are not adequately prioritised in services for prevention and treatment of stroke. There is also a real need to diversify the workforce to support more culturally appropriate care.	Fund specific FTE to ensure culturally responsive workforces in services which serve Pacific peoples who have been impacted by stroke.
5	Pacific disability services are under-represented in disability support services. There is also a lack of Pacific disability services which meet the holistic needs of disabled Pacific peoples and their families.	Enhance the capacity building of Pacific disability services to provide culturally safe support to Pacific peoples.

Five providers have been identified for the services outlined in the table below. Rationale for procuring these services is discussed specifically in relation to the unmet needs and solutions above. The key objective of these procurements is to improve health service access and outcomes for Pacific peoples.

The Pacific Directorate has good understanding of the market and direct source procurements are required as the providers selected are the only providers specialized in their field of expertise for the particular service required within the CCDHB catchment. The Pacific Directorate also has close working relationships with the recommended providers. We have undertaken extensive discussions to determine their level of capacity and capability to deliver on the proposed services, and have no concerns.

The investment strategies is aligned to the Government's planning priorities for health and the Minister's Letters of Expectations. As we transition to the new health and disability system, the Government has prioritised the development of a strong and equitable public health system that delivers better health outcomes for populations who have long-standing health inequities. The investments proposed also aligns strongly with the Pacific Health and Wellbeing Strategic Plan and 2DHB Pro-Equity Commissioning plan, which mandates equitable approaches for underserved communities.

The following funding allocation will be applied per contract with each recommended provider.

	CCDHB 2021/22 Pro rata $300k	CCDHB 2022/23	CCDHB 2023/24	2.5 year contract value
Vaka Atafaga	$100,000	$200,000	$200,000	$500,000
Catalyst Pacific	$50,000	$50,000	$50,000	$150,000
Pacific Health Plus	$100,000	$200,000	$200,000	$500,000
Stroke Central New Zealand	$50,000	$100,000	$100,000	$250,000
Vaka Tautua (contract holder)	$65,000	$80,000	$80,000	$225,000
Total	**$365,000**	**$630,000**	**$630,000**	**$1,625,000**

4. Pacific COVID-19 Omicron Funding

The 2DHB Pacific Directorate received $815,000 of Pacific Covid-19 Omicron Funding on the 15 February 2022 targeted to support Pacific providers and communities to adapt to the new COVID-19 protection framework and provide services suitable to meet demands as a result of the Omicron outbreak. The scope of services will:

- Address provider capacity pressures
- Accelerate ongoing protection measures, including vaccination
- Support provider business models to adapt to Omicron infections and provide care in the community
- Encourage innovative Pacific models of care including different health settings but with a focus on the immediate Omicron response
- Recommunicate culturally appropriate key messages.

The 2DHB Pacific Directorate have responsibility to commission the funding to Pacific providers and community as per the planned approach and support capacity and capability building of providers by enabling system level responses. As per previous funding the Directorate will also coordinate and facilitate reporting responsibilities to the Ministry on behalf of funded providers.

The following allocation was made to each listed provider to support and sustain their response to the Omicron outbreak. The majority of the listed activities were already operational prior to the 2DHB receiving confirmation of Omicron funding, established through previous COVID-19 tranche funding. Therefore, the intent of this specific Omicron funding is to support ongoing sustainability of these services.

Provider	Allocation	Funding support for	Funding activities allowance	Areas of operation funded
Taeaomanino Trust	$245,000	• Distribution of (2DHB Pacific Directorate) approved spending to support Pacific specific vaccination events, community groups and disability specific support • Provision of hygiene products for isolating families • Delivering mental health support in line with COVID-19 restrictions • Secure capacity of provider workforce in delivering manaaki and clinical services • Culturally appropriate community approaches for using rapid antigen testing (RATs) • Outreach care in the community services for Pacific families across the Wellington region	• Resources and supplies for isolation packs • Venue and equipment hiring • Volunteer costs • FTE and backfilling roles	• Regional
Pacific Health Plus	$200,000	• Enhance operations of afterhours vaccination clinics • Support collaborative service delivery approaches with other Pacific providers across the Wellington region • Secure capacity of provider workforces (currently stretched across delivering both manaaki and clinical support in the Kāpiti and Porirua regions)	• FTE and backfilling roles • Resources and supplies for isolation packs	• Regional and Porirua-Kāpiti specific
Pacific Health Services Hutt Valley	$200,000	• Enhance operations of newly accredited vaccination site and mobile vaccination service • Support collaborative service delivery approaches with other Pacific providers across the Wellington region • Outreach care in the community services for Pacific families across the Wellington region • Secure capacity of provider workforces (currently delivering manaaki and clinical support at Hutt Spoke level)	• FTE and backfilling roles • Resources and supplies for isolation packs	• Regional and Hutt Valley specific
Vaka Atafaga	$75,000	• Enhance and sustain outreach vaccination service	• FTE and backfilling roles	• Porirua region

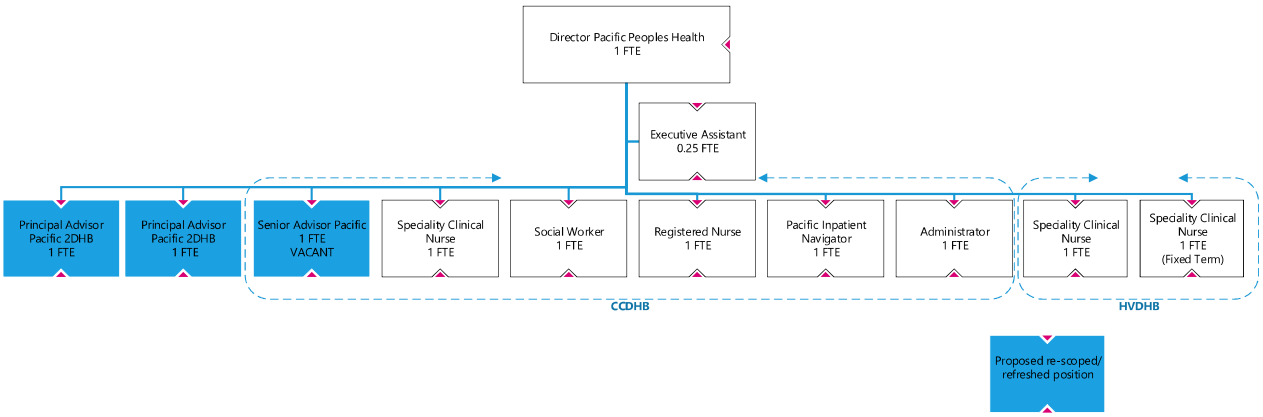
		• Support delivery of in-home education services around COVID-19 messages • Secure capacity of provider workforces • Support outreach vaccination services into local schools and education settings	• Resources and supplies for isolation packs	

Catalyst Pacific	$50,000	• Sustain COVID-19 messages through social media platform (Positively Pacific Facebook, Instagram and Youtube)
		• Sustain radio messaging through
		  ○ Samoa Capital Radio
		  ○ Wellington Access Radio
		  ○ Mai FM
		  ○ PMN platforms
		• Support strategic level communications planning and development
			• FTE and backfilling roles
			• Resources and IT equipment
				• Regional

Naku Enei Tamariki Pacific (NET)	$25,000	• Secure capacity of provider workforces (currently operating at Hutt Spoke level) • Community outreach support • Support hygiene and kid's packs for families	• Resources and supplies for isolation packs	• Hutt Valley region
Eastern Bays Health Centre	$20,000	• Support vaccination clinics • Secure capacity of provider workforces (currently impacted by staff shortages and stretched capacity delivering manaaki support for families) • Support hygiene and clinical packs for families	• Resources and supplies for isolation packs	• Wellington CBD region
Total	**815,000**			

5. Pacific Directorate Staffing Changes

The 2DHB Pacific Directorate has seen significant changes in personnel throughout the period of this report. While some staff have moved on to other opportunities it has made way for new staff who will continue to build on the work of their predecessors. The diagram below highlights the current structure of the 2DHB Pacific team.



Principal Advisor changes:

- **Sipaia Kupa** who has been with the Pacific Directorate for over 15 years has taken a new role as the MHAIDS Principal Advisor Pacific for a 12 month secondment. **Luke Laban** will be seconded from Regional Public Health to act in this role while Sipaia is away.
- **Candice Apelu-Mariner** has taken six months leave without pay to support the work of Pacific Health Services Hutt Valley. **Merivi Tia'i** is acting in this role for six months.

Senior Advisor changes:

- As **Merivi Tia'i** has moved into the Acting Principal Advisor position, **Ivana Pereira** has accepted an acting role for six months.

Dotted line position changes:

- **Vanessa Masoe** has accepted a fixed term role as the Pacific Network Lead to support the Porirua Locality Prototype work.
- **Alfred Soakai** (Covid Equity Lead Pacific) has resigned from his position to take up a role with Polynesian Health Corridors at the Ministry of Health. Alfred will be replaced by **Christina Hunt** who starts in early May.

6. Next Steps

The Pacific team across Hutt Valley and Capital & Coast DHBs will:

- Work is underway on a Full Report to Health New Zealand capturing the work of the 2DHB Pacific Directorate and Pacific Health Unit that can be fed into the Health New Zealand Pacific Strategy once developed.
- Work has also begun on a 2DHB Pacific Workforce Strategy that will help provide a framework for future Pacific employment.

7. Appendix One: 2DHB Pacific Health Dashboard

Pacific child health and wellbeing

To give Pacific children and their families the best possible start in life

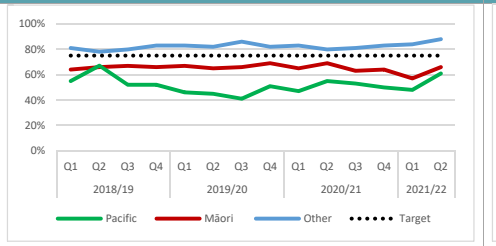
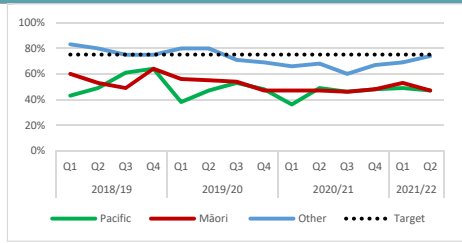
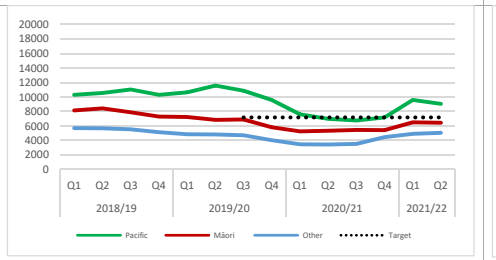
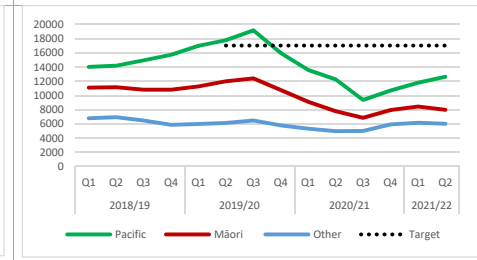
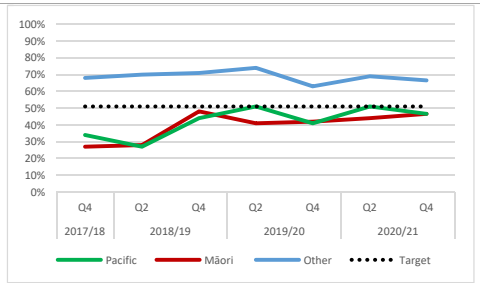
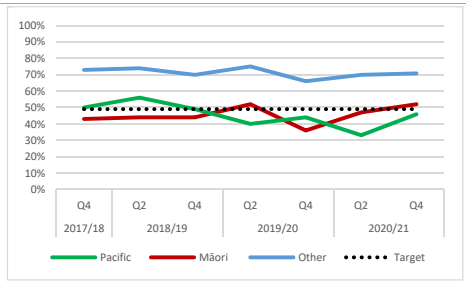
Ensure Pacific Children meet key childhood developmental milestones through culturally responsive and quality services and support

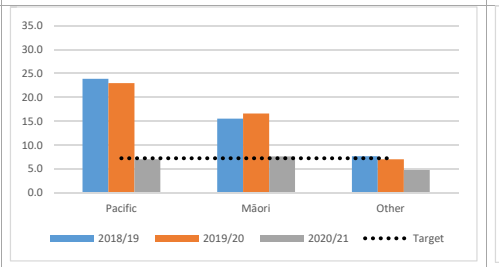
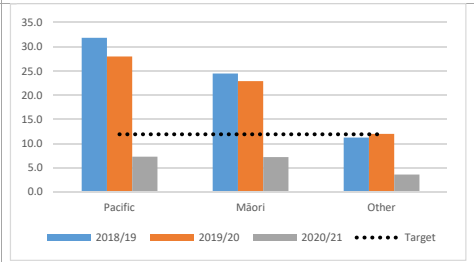
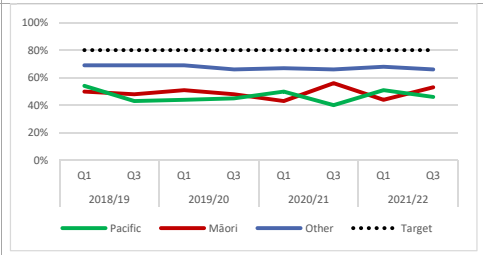
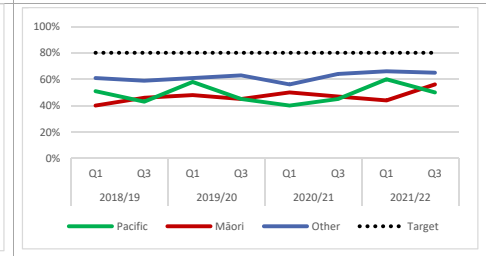
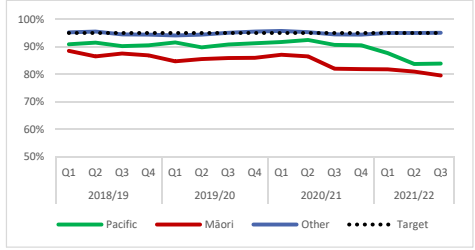
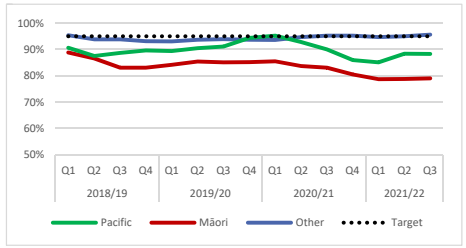
Areas of focus for next 12 months

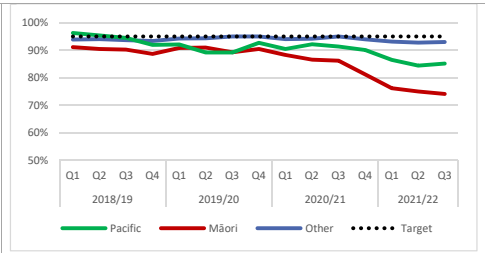
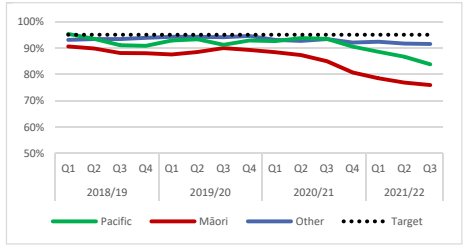
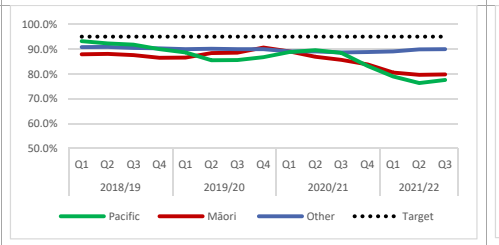
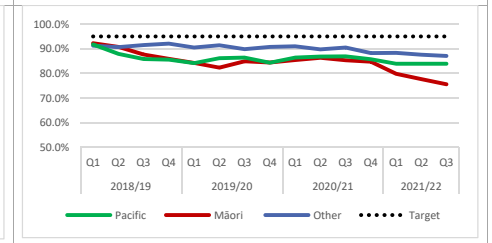
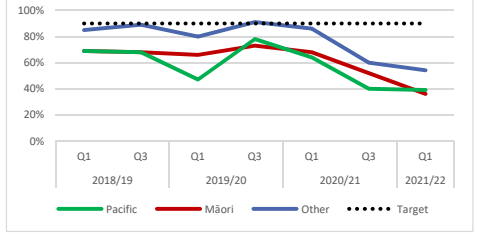
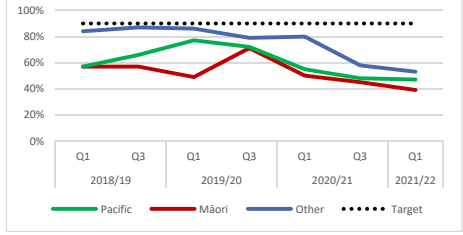
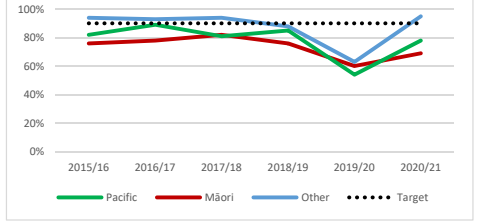
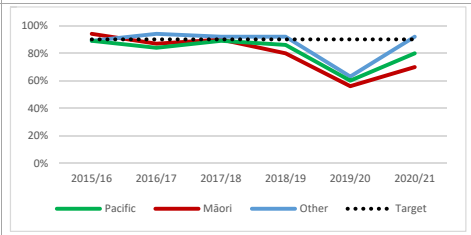
- More accessible and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.
- Increase the number of Pacific children living in healthy homes that are warm and smokefree

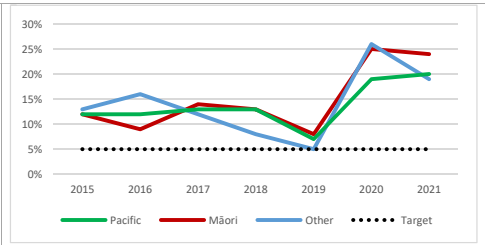
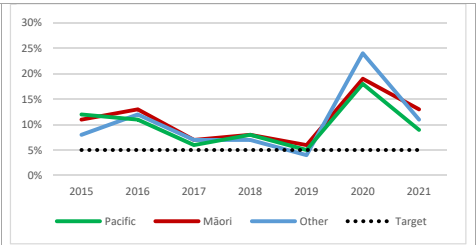
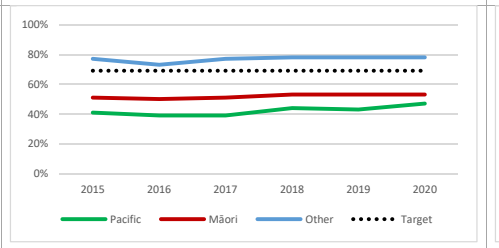
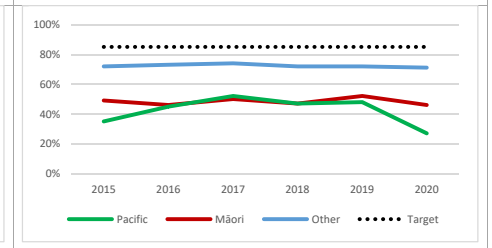
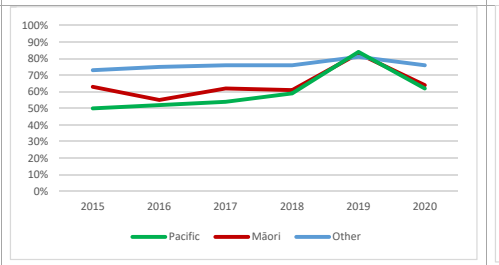
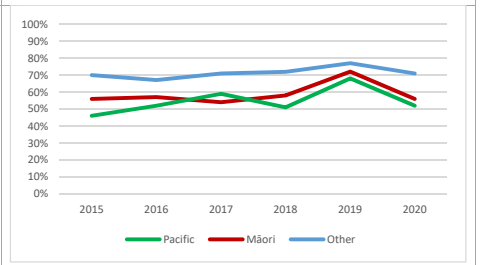
Sub-regional initiatives (2DHB)

- Child Health Network
- Developing and committing to an Equitable Commissioning Policy
- Regional Rheumatic Fever leadership Group
- Pacific workforce plan and recruitment strategy
- Cultural competency workforce plan
- Community Localities, Neighbourhoods work.

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
% of Pacific pregnant women registered with a Lead Maternity Carer within the first trimester of pregnancy	Early engagement with an LMC enables opportunity for screening, education and referral, and begins the primary maternity continuity of care relationship between a woman and her LMC.	≥75%			In 2020/21 CCDHB has invested in a new Māori and Pacific midwifery collective in Porirua, which we expect will continue to improve access to antenatal care in Porirua and across the DHB catchment. In 2020/21 we will commence our 2DHB maternal health system plan, which will deliver models of care that improve access and engagement in early antenatal care and education.
Rate of Ambulatory Sensitive Hospitalisations for children aged 0-4 years (per 100,000 people)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care interventions. This indicator also highlights variation between different population groups. ASH rates can be reduced by shifting care closer to home, providing coordinated primary and secondary care services, and improving timely access to high-quality and culturally safe primary care services.	CCDHB: ↓6% (≤7,162) HVDHB: ≤17,021			Actions to improve ASH rates, particularly for Māori and Pacific children, are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. We continue to actively monitor performance in this area and identify actions to improve performance. ASH rates across the 2DHB fell during the first COVID19 lockdown and have begun to increase at the start of 2021/22.
% of Pacific babies living in smoke-free households at 6 weeks	This measure is important because it aims to reduce the rate of infant exposure to tobacco smoke by focusing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to - from pregnancy, to birth, to the home environment	CCDHB: 51% HVDHB: 49%			Actions to improve babies living in smoke free homes are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. From April 2021, the CCDHB Hapū Ora service will be able to offer nicotine replacement therapy directly to their clients as an additional support tool. HVDHB continues to progress work promoting the relationship between the Hapū Māmā smoking cessation service and maternal and child services provided in secondary care.

	within which they will initially be raised.				
Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15	Housing related hospitalisations are related to the quality of housing. This indicator highlights variation between different population groups. Rates can be reduced by ensuring that homes are safe, warm and dry.	CCDHB: ≤7.2 HVDHB: ≤11.9			Actions to improve performance are related to ASH rates, particularly for Pacific children. These are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. We continue to actively monitor performance in this area and identify actions to improve performance. The declining rates are driven by decreased respiratory illness in 2020.
% of Pacific infants fully or exclusively breastfed at 3 months	The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of life long physical and psychological benefits for babies.	≥80%			CCDHB is supporting the training of five Māori and Pacific lactation consultants. It is expected that the first LC will complete the qualification in April 2022 so it will take time to see the benefits of this investment. In HVDHB a three-stage breastfeeding improvement project is currently being scoped to strengthen the level of breastfeeding support services available to mothers.
% of Pacific children fully vaccinated at eight months old	Immunisation rates at age eight months are a measure of timely protection against whooping cough, among other vaccine-preventable diseases. Timely protection is important because whooping cough is particularly dangerous to babies aged under 1 year; around half of babies who catch whooping cough when they are aged under one year will need hospital treatment.	≥95%			Work is underway to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register and how both primary care and the OIS provider can be supported to reach families with children still needing vaccinations. 12 month immunisation coverage for all ethnicities was at 95% or above which shows that some children are delayed in

% of Pacific children fully vaccinated at two years old		≥95%			completing the full schedule of vaccines but do 'catch up'. We are focused on developing a pro-equity commissioning approach adopting the learnings of our COVID vaccine programme. What we know from our COVID Vaccine programme is that commissioning vaccination, with our priority populations (Māori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but will be developed as the equity gains may be worth a small investment.
% of Pacific children fully vaccinated at five years old		≥95%			
% of Pacific children accessing Well Child Tamariki Ora services and completing Core Checks (all checks by 1yrs)	The early years of life set the foundation for lifelong health and wellbeing. The WCTO programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to 5 years. The programme includes 12 Core Contacts.	≥90%			COVID restrictions had a significant impact on the ability to deliver the core checks and services have worked hard to catch up on core checks that were missed. HVDHB has recently reviewed its investment in its WCTO providers (Te Rūnanganui o Te Atiawa and the Pacific Health Service), with a view to validate or correct the level of WCTO activity the DHB purchases from our providers.
% of eligible Pacific children receiving and completing a B4 School Checks	The purpose of the B4 School Check is to promote health and wellbeing in four year olds, and to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school. This measure particularly monitors and promotes quality improvement across WCTO providers	≥90%			The B4SC programme was interrupted in 2019/20 due to COVID restrictions and the service has been working hard to catch up. We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Pacific.

% of Pacific children (0-12) enrolled in Community and DHB oral health services overdue for their scheduled examinations	By providing effective publicly funded child oral health programmes (health promotion, prevention and treatment) that reduce the prevalence of oral disease in children of primary school age, the DHB will contribute to the outcome of protecting and promoting good health and independence through decreasing the prevalence and severity of dental decay experienced by children in school Year 8 (12/13-year olds).	≤5%			As a result of the COVID-19 lockdowns we lost 20% capacity in 2020 and (to date) 10% capacity in 2021. This means it is harder to catch up children who missed their appointments and maintain service for children already booked or due. The impacts of this lost capacity on caries is cumulative. For example, preventative work that wasn't done in 2020 may result in more caries in both 2020 and 2021. We continue to work closely with the Bee Healthy Service to improve health outcomes and achieve equity for Pacific children. We are working to ensure that our pathway for follow-up is integrated with other services including WCTO, Public Health Nurses, Pacific Providers and other relevant stakeholders.
% of Pacific children caries free at 5 years		CCDHB: ≥69% HVDHB: ≥85%			
% of Pacific children caries free at 12 years old		TBC			

Pacific Young People

Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives

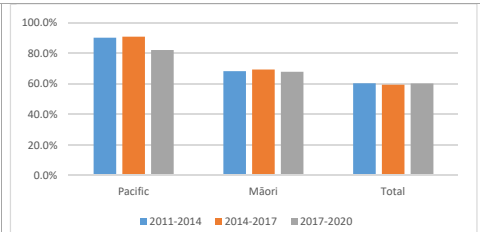
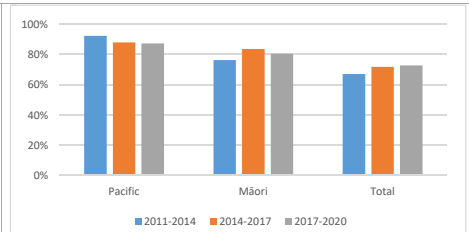
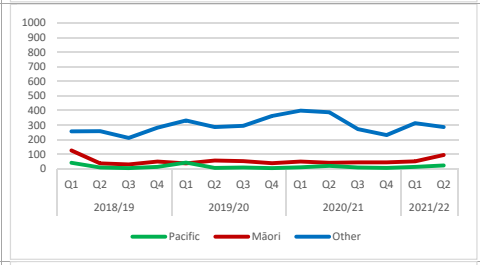
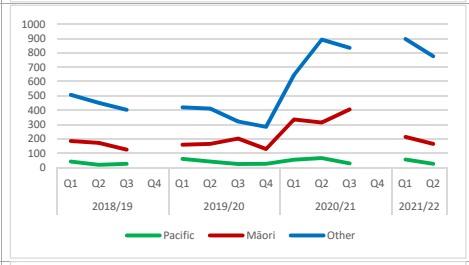
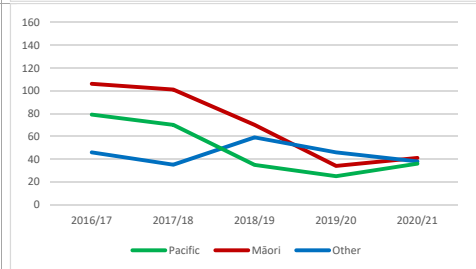
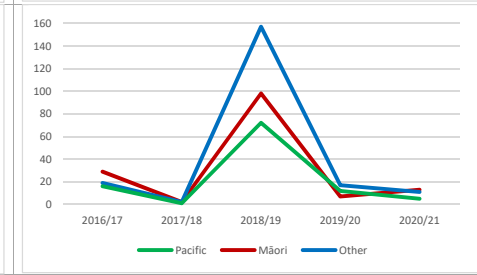
Areas of focus

- Mental Health services engagement and support
- Obesity Prevention & Healthy Lifestyles Programmes
- Measles & Rheumatic Fever

Sub-regional initiatives (2DHB)

- Piki Youth Mental Health Services
- YouthQuake
- Re-ignite Rheumatic Fever Campaign for Pacific
- Measles Vaccinations Campaign

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments

% of age-standardised rate of overweight and obesity in Pacific aged 15+ years	By supporting Pacific youth identified as obese DHBs will support Government's priority to make New Zealand the best place in the world to be a child and our health system outcome that we have health equity for Māori and other groups.	TBC			CCDHB and HVDHB are implementing improvements to identify and manage obesity earlier in a young persons' life. We are re-engaging with Pacific and community provider to find more accessible premises for clinics; introducing evening clinics to provide families with more choice; and closer coordination with primary care, including delivery of immunisations.
Number of eligible Pacific young people's accessing Community Youth mental health services (primary services)	This measure focuses on improving and strengthening youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve: early identification of mental health and/or addiction issues; better access to timely and appropriate treatment and follow up; equitable access for Māori, Pacific and low decile youth populations.	TBC			The procurement for the Porirua YOSS was an incredibly successful process which disrupted traditional commissioning of services and looked to rangatahi from Porirua to be the decision makers with the DHB in a supporting role. We look forward to working with Ora Toa and Partners Porirua to improve outcomes for Pacific youth. Integration of health services is critical and we will work to ensure youth services can meet all the care requirements of Pacific people and connect with existing services such as the Piki Pathway. There will be significant work done to bring youth functions together across the 2DHBs.
Number of Pacific students seen by School based health services – routine health assessment		TBC			

Pacific adults and ageing well

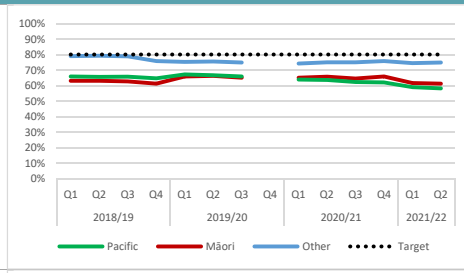
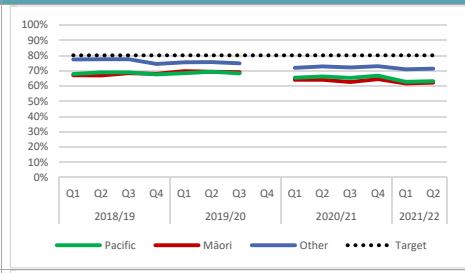
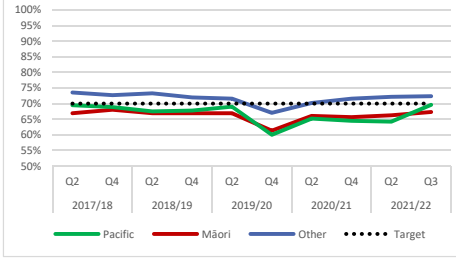
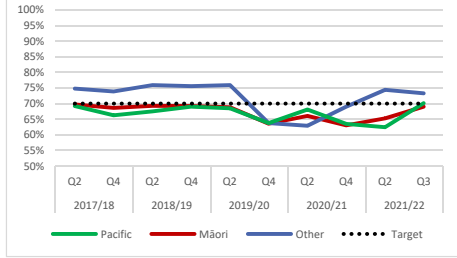
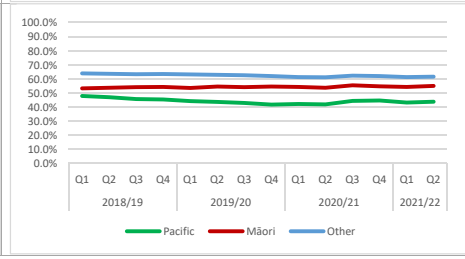
Pacific adults and elderly are actively engaged in their health care, live productive, active, culturally secure and quality long lives.

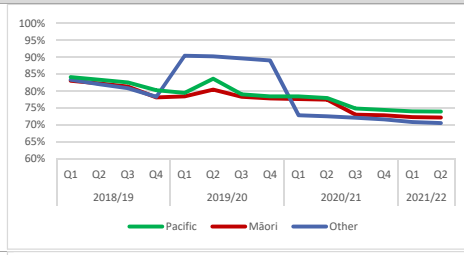
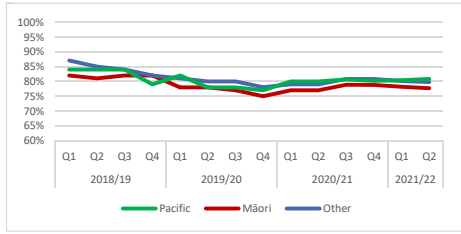
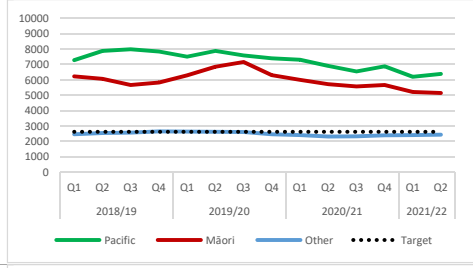
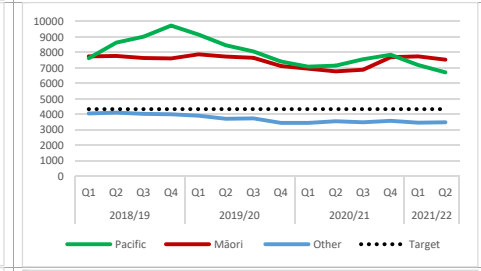
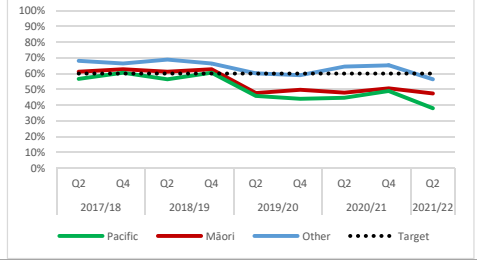
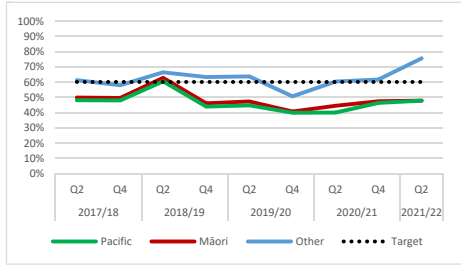
Areas of focus

- Work in partnership with key stakeholders to increase and encourage participation in screening programs (cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).
- Increased timely access to medications and pharmaceuticals by decreasing the number of prescriptions unfilled due to cost

Sub-regional initiatives (2DHB)

- Developing and committing to an Equitable Commissioning Policy
- Pacific workforce plan and recruitment strategy
- Cultural competency Training Package
- Community Localities, Neighbourhoods work.
- Regional Screening Services
- Mental Health Projects

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
% of eligible Pacific women (25-69 years old) completing cervical screening	By improving cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health. Cervical, Breast and Bowel screening reduce Pacific morbidity and mortality via improved access to early identification.	≥80%			Regional Screening Services continue to provide additional supports for Pacific women who are overdue or unscreened to attend a breast screening clinic. Same day biopsies and first specialist appointments are now more common in our symptomatic imaging clinic which runs concurrently alongside the breast clinic. We continue to work with Pacific Navigation Services to improve our referral pathways, booking and rescheduling appointments.
% of eligible Pacific women (50-69 years old) completing breast screening		≥70%			
% of eligible Pacific population (60+) completing bowel screening testing			-		TBC

% of Pacific patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	Faster cancer treatment takes a pathway approach to care to ensure resources are used effectively, efficiently and equitably.	≥90%	Indicator to be developed to provide ethnicity.	Indicator to be developed to provide ethnicity.	We are exploring the quality of the ethnicity data reported in our cancer systems.
% of the eligible Pacific population assessed for CVD risk	Improve equity for high risk populations to have CVD risk assessment and management. Improve early risk assessment and risk factor management efforts for people with high and moderate cardiovascular disease risk by supporting the spread of best practice from those producing the best and most equitable health outcomes.				Across the 2DHBs we are strengthening nurse-led clinics and nurse capacity, including increases in the CVDRA nursing hours to deliver checks every quarter. Opportunistic screening is undertaken outside of general practice, At the Bunnings Trade Breakfast our PHOs checked workers blood pressures (this activity further identified and advised people to follow up with their GP due to high blood pressure)
Ambulatory sensitive hospitalisation rate for Pacific adults aged 45-64 (per 100,000 people)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care interventions. This indicator also highlights variation between different population groups. ASH rates can be reduced by shifting care closer to home, providing coordinated primary and secondary care services, and improving timely access to high-quality and culturally safe primary care services.	CCDHB: ≤2,623 HVDHB: ≤4,340			We have a number of initiatives underway to improve performance, including implementing the Health Care Home model in HVDHB and Community Health Networks in CCDHB. Improved self-management of long term conditions and earlier identification of risk factors is being prioritised as part of the Long Term Conditions priority for our Boards.
% of Pacific people with diabetes aged 15-74 years enrolled with a PHO whose latest HbA1c in the last 12 months was <=64 mmol/mol	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control. The expectation is to continue to improve diabetes services and implement actions in the Diabetes plan "Living Well with Diabetes" the Quality Standards for Diabetes Care	>60% and no inequity			Due to COVID and staff shortages our Diabetes Clinical Network resumed meetings in December 2020. We are refreshing our focus on activity to address equity gaps with a particular focus on Pacific and young people who live with diabetes for longer and experience complications earlier.

CCDHB & HVDHB
PACIFIC COVID-19 RESPONSE

Report 3:
Tranche 4 – Delta variant & vaccine support

COMMISSIONED BY CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS, MARCH 2022

HUTT VALLEY DHB
Capital & Coast District Health Board
MOANA RESEARCH

CONTENTS

GLOSSARY OF TERMS & ACRONYMS

TERMS	ABBREVIATIONS
AOG	Assembly of God
BAU	Business as usual
CCDHB	Capital & Coast District Health Board
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CIR	Covid Immunisation Register
DHB	District Health Board
Dr	Doctor
FAN	Facilitated Attuned Interaction
FCPRU	Family Centre Social Policy Research Unit
FTE	Full-time Equivalent
HVDHB	Hutt Valley District Health Board
IMAC	Immunisation Advisory Centre
IT	Information Technology
M&E	Monitoring & Evaluation
MoH	Ministry of Health
MSD	Ministry of Social Development
NIBS	National Immunisation Booking System
NET	Naku Enei Tamariki
PCR	Polymerase Chain Reaction Test
PHN	Pacific Health Navigator
PHO	Primary Health Organisation
PHP	Pacific Health Plus
PHSHV	Pacific Health Service Hutt Valley Incorporated
PIPC	Pacific Island Presbyterian Church
PPD	Per patient day
PPE	Personal Protective Equipment
PUCHS	Porirua Union and Community Health Service
RN	Registered Nurse
SCR	Samoa Capitol Radio
Talanoa	To discuss or to have a conversation
TE AHN	Te Awakairangi Health Network
TT	Taeaomanino Trust
VA	Vaka Atafaga
VT	Vaka Tautua

ABOUT THIS REPORT

This interim report, commissioned by the Capital & Coast and Hutt Valley District Health Boards (2 DHBs), follows on from the two Wellington Region Pacific Response – Pacific Specific Outreach and Integrated services report (Moana Research, 2021) and the Monitoring and Evaluation Framework (M&E framework) document which was developed for the Wellington Pacific COVID-19 Response work supported through COVID-19 funding received from the Ministry of Health (the Ministry). The M&E framework provides a basis for demonstrating progress and success from immediate to long-term outcomes. This document is to be read in conjunction with the M&E Framework document. These documents emphasise the findings of a rapid evaluation undertaken to explore the effectiveness of how Primary Health and Pacific providers contributed to the Pacific COVID-19 delta variant response and COVID-19 vaccination rollout to protect Pacific peoples from the resurgence of COVID-19, particularly the Delta variant and the newly introduced Omicron variant.

New providers have been added to the Pacific COVID-19 response since reports 1 and 2. Provider progress included in this report are: Vaka Atafaga, Pacific Health Services Hutt Valley, Pacific Health Plus, Taeaomanino Trust (Uso bike rides), NET Pacific, Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific radio stations), Vaka Tautua, Eastern Bay Medical, Te Awakairangi Health Network, The Family Centre and Regional Public Health.

This report continues to align with the evaluation framework presented which will help to inform and guide future commissioning of COVID-19 Pacific responses.

It is important to note that due to the rapid turnaround of this report, there were limitations in capturing the views of the funders and the views of the families however plans to evaluate impact on clients and families are ongoing and will be made available in the June 2022 report.

BACKGROUND

The purpose of this report is to meet the reporting requirements on behalf of the 2 DHBs and relevant stakeholders, in relation to Tranche 4 funding received from the Ministry for Pacific COVID-19 response services in relation to the Delta outbreak. This reporting period covers from 1 November 2021 to 28 February 2022.

Pacific COVID-19 response services in relation to the Delta Variant

The resurgence of COVID-19, particularly the Delta variant, disproportionately affected Pacific communities. As a result, Pacific health providers needed to scale up their response activities well beyond the initially planned parameters.

Funding received from the Ministry has enabled providers to deliver an equitable response to this outbreak by sustaining community-led response activities and maintaining capability to support post-lockdown recovery and the vaccination roll out.

Funding will:

I. Sustain the service capacity of priority Pacific health and disability providers to continue leading the response

II. Allow DHBs to rapidly scale-up mobile outreach and community vaccination services for Pacific families

III. Undertake Pacific ethnic-specific engagement and communication across specific Pacific communities to maintain an elevated level of compliance within public health guidance.

PACIFIC COVID-19 TRANCHES

This report is the third of a series of evaluation reports documenting how investments of the Pacific COVID-19 Response funds for Tranches 2-4 has been implemented. Report 3 describes provider progress for key deliverables such as vaccine support and delivery, engagement with communities and promotions and communications, all strategies needed to be continued through the Delta outbreak to maintain heightened preparedness and protection for Pacific communities. Some providers are also engaged to provide wraparound health and social support services for families impacted by COVID-19.

TRANCHE	DELIVERABLES	TIMEFRAME	PROVIDERS	EVALUATION
Tranche 2	1. Outreach 2. Communications 3. Workforce	Dec 2020 – June 2021	- Vaka Atafaga - Pacific Health Services Hutt Valley - Pacific Health Plus - Net Pacific - Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific)	Report 1 (baseline) (submitted)
Tranche 3	Vaccine support • Support to carry out requirements to prepare for vaccination. This may include data entry, and training for staff on data entry software. • Purchase of capital items to support vaccination process, and to ensure robust information collection during vaccination. Capital items may, for example, include purchase of tablets and connectivity-related items. • To support providers to adapt to and evolve with the ability to respond to unforeseen disruption and long-term challenges. • Localised vaccine support should be implemented in a way that supports Pacific health providers with their efforts in increasing uptake of the vaccine for Pacific peoples and their families.	1 June 2021 – 30 June 2022	- Vaka Atafaga - Pacific Health Services Hutt Valley - Pacific Health Plus - Net Pacific - Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific)	Report 2 – November 2021 (submitted) **Report 3 – 20 March 2022** Report 4 – 20 June 2022
Tranche 4	Delta variant • Multiple additional pop-up testing sites across their region. • Provision of ethnic specific support services. • Wraparound health and social support for cases and close contracts, especially the large number of families self-isolating in the community. • Alert Level 3 and 4 compliant business as usual (BAU) services, with a priority on families with complex needs. • Mental health and disability specific support to Pacific families.	13 Sept 2021 – 31 March 2022	- Vaka Atafaga - Pacific Health Services Hutt Valley - Pacific Health Plus - Taeaomanino Trust - Net Pacific - Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific) - Vaka Tautua - Eastern Bay Medical - Te Awakairangi Health Network - The Family Centre - Regional Public Health	

Table 2 - Tranche Deliverables And Evaluation Reports

PROGRESS EVALUATION APPROACH

Vaccination data was provided by the 2 DHBs while progress against deliverables were supplied by each provider as part of their routine administrative data collection. Specific information requested of providers included:

THEME	PROVIDER RESPONSE
Vaccine Support: delivery of vaccinations.	• Number of any new staff employed for Delta Response – specify whether community/mental health etc. • Any vaccination training undertaken
Uptake Support: facilitate and promote vaccinations	• Types/number of promotions/ campaigns per provider and/or Positively Pacific
Service Capacity: secure sustainability of the provider	• Any additional examples of new or extended services since your November reporting. (e.g. extended operation hours for vaccinations/establishing standalone vaccination site/ community work/mobile clinics etc.) • Approximated total care packages delivered (if applicable) • Approximated number of hours of COVID-19 related mental health support provided since November reporting (if applicable)

Descriptions of provider progress are described in Table 5 with a Summary of all indicators compiled in Table 6.

LOGIC FRAMEWORK

The overarching programme logic provides an overview of the objectives, activities and the outcomes for the eleven Pacific providers and Primary healthcare providers. As this was a rapid formative and process evaluation, the focus was on evaluating the existing support.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
COVID-19 VACCINE NAVIGATOR OR COORDINATOR ROLES	Coordination of culturally appropriate COVID-19 vaccination information and services to families and communities.	Trusted relationships established with families and communities.	More Pacific families confident to access COVID-19 vaccination services.
LOCALISED VACCINE SUPPORT	Providers are well supported and resourced to deliver COVID-19 vaccination services to communities. Pacific peoples and their families are supported through their journey in getting their COVID-19 vaccinations, which includes wrap-around support. Dissemination of culturally appropriate and relevant COVID-19 vaccination messages targeting Pacific families. Families have increased awareness of mental health and wellbeing services available to them.	Providers sharing resources when delivering vaccination events in the community. Delivery of innovative approaches, which engage with Pacific peoples and community. Increased number of Pacific clinicians and non-clinicians involved in the delivery of localised vaccine programmes. Ethnic-specific COVID-19 vaccination messaging and COVID-19 safety messages delivered to different ethnic audiences. Families are supported throughout their mental and emotional wellbeing journey during COVID-19. Increased capacity and capability of Pacific mental health experts within Pacific providers and primary healthcare organisations.	Services have co-ordinated models of delivery to respond to the COVID-19 response. Highly skilled and credentialed staff equipped to deliver COVID-19 related services. Services continue to be fully funded to provide wraparound services. COVID-19 vaccination services are well known to Pacific peoples and communities across the Wellington region. Cultural localised vaccine services for Pacific families.
MAINTENANCE AND SCALE-UP OF RESPONSE SERVICE	Ongoing accessibility of services	More Pacific families continue to access Pacific providers and primary healthcare services.	Pacific providers and primary healthcare services are fully funded and have long-term contracts.

Table 3 - High Level Programme Logic

PROVIDER DELIVERABLES

Table 4 outlines proposed activities by Provider organisations. The funding column provides an indication of the proportion of the budget that each provider receives to undertake their proposed activities.

PROVIDER	ACTIVITY	DETAILS	FUNDING %
Vaka Atafaga	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• New FTE • Workforce Training • Innovation • Community Support	16%
Pacific Health Services Hutt Valley (PHSHV)	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• New FTE • Workforce Training • Innovation • Community Support • Vaccinations • Resources • Strategic	11%
Pacific Health Plus	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• New FTE • Backfill • Workforce Training • Innovation • Community Support • Vaccinations	11%
Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific)	Localised vaccine support	• Community Support • Innovation	16%
Net Pacific	COVID-19 vaccine navigator or coordinator roles Localised vaccine support	• New FTE • Innovation • Community Support	3%
Taeaomanino Trust	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Funding distributor for Pacific festival days	• New FTE • Backfill • Workforce Training • Innovation • Community Support	25%
Vaka Tautua	Localised vaccine support	• Innovation • Community Support	3%
Eastern Bay Medical	COVID-19 vaccine navigator or coordinator roles Localised vaccine support	• New FTE • Backfill • Workforce Training • Innovation • Community Support • Vaccinations	3%
Te Awakairangi Health Network (TEAHN)	COVID-19 vaccine navigator or coordinator roles Localised vaccine support	• Innovation • Community Support • Vaccinations	25%
The Family Centre	Maintenance and scale-up of response services	• Community support • Innovation • Resources	3%
Regional Public Health	Coordinator role Localised vaccine support Maintenance and scale-up of response services	• New FTE • Workforce Training • Innovation • Community Support • Resources	5%

Table 4: Contract Deliverables And Funding Proportions By Providers Who Received Tranche 4 Funding

*Please note Taemamanino Trust acts a funding holder to disseminate funding to other groups such as Uso Bike Rides.

PROGRESS SUMMARY BY PROVIDER

This section provides a summary of the evaluation findings across all nine providers within a logic framework that is affiliated with key high-level activities commissioned by the Ministry of Health, including:

- COVID-19 vaccine navigator or coordinator roles
- Localised vaccine support
- Maintain and scale-up of response services

PROVIDER	ACTIVITY	COMPLETED TO DATE						
		NEW FTE / BACKFILL	WORKFORCE TRAINING	INNOVATION	COMMUNITY SUPPORT	VACCINATIONS	COMMUNICATIONS	RESOURCES & STRATEGIC DEVELOPMENT
Pacific Health Services Hutt Valley (PHSHV)	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	20 x Youth Ambassadors employed on fixed term contracts for 6 months at 20 hours each, to support the festivals and COVID-19 promotion work in the Community.	6 x training sessions which include: • Refresher training for COVID-19 Administrators on CIR in conjunction with Unichem Pharmacy Clinical Team for December 4 Pacific Vaccination Festival • IMAC training for site set up as PHSHV office is now registered as a Vaccination site • Indici, NIBs and CIR training for PHSHV Administrators and Clinical Lead • Paediatric Vaccinator Training completed by 5 of the PHSHV nurses in January 2022.	• Involvement in 6 of the 22 Pacific Vaccination Festivals delivered (partnership with TE AHN) • 12 x weekly meetings held with TE AHN, NET Pacific to plan and organise Pacific Vaccination Festivals as well as support the Testing/Swabbing. • 10 x online planning Zoom sessions with a) Combined Catholic Church Groups, b) Mafutaga Faifeau Wellington Committee c) Niue Community Group, d) Viti Wellington Fijian Community, e) LDS Youth Group.	5 x Pacific Community groups contracted to support the Vaccination drive including ethnic specific vaccination events delivered in • Community Vaccination Centre • Pelorus Sports Trust House in Lower Hutt. These groups included: • Hutt Valley Catholic combined congregations • Viti Fiji Wellington group • Mafutaga Faifeau Wellington Network • Tongan Leaders Council • Niuean Community Network. Support provided to Whaioranga Medical Centre in Wainuiomata, Stokes Valley Medical Centre and Naenae Medical Centres to engage with Pacific families who had not received their first dose. This resulted in approximately 600 x Pacific families being contacted. PHSHV Clinical Nurse Lead supported Te Awakairangi Health Network mobile vaccination team with home visits to Pacific families in the Lower Hutt who were unable to get to a clinic for vaccinations.	Please refer to table 5.	Weekly promotional work on Samoa Capital Radio via the 1-hour health interview. CEO and nurses have promoted the Festivals and the COVID-19 support provided by PHSHV. Daily updates on PHSHV social media platforms of COVID-19 key messages.	Pacific Health Services Hutt Valley became an official standalone vaccination site in February 2022. Cold Chain accreditation was granted in beginning of February. The first vaccination clinic for boosters, 1st/2nd doses and paediatric vaccinations held on the 26th of February 2022.
Vaka Atafaga	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	2 x Pacific Registered Nurses (RN) • 1x Samoan RN • 1x Tokelauan RN	Much of November and December 2021 revolved around ensuring new staff were provided with appropriate orientation experiences.	The staff have developed a reputation for being a reliable, professional and a compassionate source of support. Their ability to focus on what works best for the client/household is a solutions-based approach that underpins the work they do.	The ability to provide an Outreach Vaccination Service has been very successful at reaching people who were hesitant and/or reluctant to be vaccinated. These households took considerable time and many visits before they consented. Once they had experienced the service provided, many of these households became active recruiters for other members of their extended families.	Please refer to table 5.	Staff provide ongoing and up to date COVID-19 related information with every home visit and outreach engagement with Pacific clients and families.	The addition of new experienced staff has allowed for an extension of an effective model of care premised on outreach and going to where our families live.

Table 5 - Table Of Progress Summary By Providers Who Received Tranche 4 Funding

PROVIDER	ACTIVITY	COMPLETED TO DATE						
		NEW FTE / BACKFILL	WORKFORCE TRAINING	INNOVATION	COMMUNITY SUPPORT	VACCINATIONS	COMMUNICATIONS	RESOURCES & STRATEGIC DEVELOPMENT
Pacific Health Plus	Localised vaccine support Maintenance and scale-up of response services	• 1 x Full time Doctor (clinical) • Increased Locum GP sessions (clinical) • 2 x Part Time Nurses (clinical) • 1 x Full time administrator (both community and clinical support) • 2 x Part time administrators (both community and clinical support) • 1 x Full time Community worker (Community)	• 2 x Training sessions All staff CIR trained • 3 x RNs Paediatric COVID-19 vaccinations trained	• 1 x Afterhours clinic Late night hours at Cannons Creek site 5.00pm - 10.00pm Wednesday and Thursday nights to increase vaccinations • Opened up a new site at Kapiti – initially a vaccination site but now also a Rapid Antigen Testing (RAT) and PCR testing site and GP practice full time. Located at Kapiti - 9 Milne Drive Paraparaumu.	• Over 100 x care packages delivered to COVID-19 households • 100 x Telephone consults with families for mental health wellbeing related issues	Please refer to table 5.	• Facebook promotion/ Website promotion/ monthly on Samoa Capital Radio - Senior Practice Manager • Word of mouth and constant contact with patients with phone calls	We have been providing anxiety assisted support through phone conversations when doing assessment conversations with positive patients, this is in the vicinity of 100 patients and their families.
Net Pacific	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• 0.38 FTE COVID-19 Project Lead (Contractor hours), Project Coordinator, FTE resource • 0.75 FTE COVID-19 Project Administrator • 0.38 FTE COVID-19 Pacific children's book illustrator (fixed term to 15 December 2022) • Temporary redeployment of staff to support the production of children's packs and care packs	COMPLETED – 5 DECEMBER 2021 COVID-19 Resilience Leaders Workshop Part two – NET Pacific partnered with the Wellington Regional Emergency Management Office (WREMO). ON TRACK – COVID-19 Project Lead provides weekly updates used for COVID training for all NET staff to support conversations with families on NET programs.	Working with Pacific Health Services Hutt Valley, and Positively Pacific at the Hutt Pacific COVID-19 Vax Festival on Saturday 4 Dec 2021 to make sure our tamariki have a kids activity tent. NET Pacific - In house design of Pasifika cares campaign. Colouring activity packs; uniform shirts and gift prizes, banners.	Wellington Niue Cultural Officers Work Group – supported by NET Pacific and Dr Alvin Mitikulena there were 17 Niue community individuals who were called to action and were stood up to provide trusted faces trusted places for the Niue Festival Vaccination Clinics, representing Niue High Commission, Niue Presbyterian Church Kilbirnie, Niueans in Levin, Porirua, Hutt, Wellington, and Niue youth. The Wellington Niue Cultural Officers Working Group members are now forming the Wellington Niue Health Network to continue raising awareness and support Niue vaccination clinics for Niue people in the wider Wellington region and establish Niuean COVID-19 Care Teams – led by Dr Alvin Mitikulena.	N/A	Age-appropriate campaigns • Production underway of Pacific children's storybook about COVID-19 vaccinations to launch end of March 2022 • NET Pacific has supplied 550 GIVEAWAY kids activity packs to Pacific vaccination clinics (in Porirua, Hutt, Newtown) • NET Pacific children's superhero stickers.	On average each field staff (home visiting) provide up to 15 hours per week of psycho social support to families registered with NET – and utilize Facilitated Attuned Interaction reflective practice. There are 14 NET field staff social work/infant mental health practitioners.

PROVIDER	ACTIVITY	COMPLETED TO DATE						
		NEW FTE / BACKFILL	WORKFORCE TRAINING	INNOVATION	COMMUNITY SUPPORT	VACCINATIONS	COMMUNICATIONS	RESOURCES & STRATEGIC DEVELOPMENT
Catalyst Pacific (Samoa Capital Radio/ Ethnic Specific)	Localised vaccine support Maintenance and scale-up of response services	• 2x social media contractors used during Oct-Feb for 3 months & 1 month. *(The project team are in the process of recruiting/ contracting a social media specialist).*	**SCR continue to build its relationship** with the Malaghan Institute of Medical Research, and well-known figures in the scientific community such as Professor Graham Le Gros, and his team of specialists, providing invaluable information relating to COVID-19, vaccinations, and other health related topics, to better inform the community. Pacific Health Service Hutt Valley's CEO, continues to connect with Savelina Kasiano on a regular basis, providing information in the Samoan language relating to COVID-19 via Zoom.	Positively Pacific has been present at almost all festival events during Oct-Feb. Show reel of each event are produced and posted within 48 hours. • 194 = 97 images created; posted x2 • 160 = 80 videos produced; posted x2 • 24 = 12 links shared from other sources x2 • 15 = Live feeds from Vaccination events • 8 x videos on TikTok since Dec 2021 (Still being evaluated) • 22 x Festival, Booster, Paediatric events. Live reports from events by SCR staff reporting at vaccination events. During these events, SCR have 2 teams operating one from the location of each event, and another working from the studio providing regular messaging throughout the time of these events, to ensure people are informed of venue location, and other COVID-19 messaging. Held one live panel interview with MSD on accessing Welfare support. Coordinates regular slots for health clinicians and Pacific providers to present and be interviewed on Pacific radio stations.	**Community newspaper** Kapi Mana – 1 full page (Do-it-for-the EAST – Dec) Kapi Mana – 1 full page (Youth Vax Festival – Oct) Hutt News – 1 full page (Niue Festival – Oct) **Samoa Capital Radio: Oct 21 – Feb 2022** Regular programmes and online live feed in the Samoan Language, bi-lingual interviews in Samoan and English, Promotion/ Advertising Campaign re Pacific festival, Super Vaccination National event, Samoan Catholic Churches, Youth COVID-19 Vaccination: Oct-Dec 2021PIPC- Newtown (3) , Hutt City (5) and Porirua (5) on 106.1FM, SCR YouTube, Facebook & SCR Radionet via app. **During January - Feb 2022** promotion of the implementation of the Traffic Light system and Omicron Phase 3, Booster/ 5-11years paediatric events were promoted including live feeds from PIPC Newtown, and AOG Church Porirua. COVID-19 Alert Level 4/3/2 interviews & news as appropriate, including COVID-19 Alert messaging & ad-libs during all shows including interviews with DHB staff, promoting & reporting COVID-19 vaccine events in SCR news bulletin, Discussing vaccine with listeners on Ata o le Taeao, talkback and across different radio programmes including during prime time. **Also, engage leaders of Samoan church** denominations (14) to give messages of encouragement (between 10 mins to 30 minutes to the Samoan and Pacific communities to get tested and vaccinated. This included Tui Sopoaga for the Tokelauan community. The messages were replayed during the week including weekends over 24-hr period. **In addition to its work on COVID-19**, Samoa Capital Radio continues to stream the RNZ live feed of special Press Conferences by the Prime Minister, including Health updates with Dr. Ashley Bloomfield and other health officials. Often at 1pm in the afternoon, these live feeds allow our people to be up to date and informed with key messaging relating to COVID-19 from the Government. Following these press conferences and stand ups by health, our announcers translate key messages from these events, from English into Samoan for our listeners, often these include case numbers per day, new changes to the COVID-19 response, and alert changes. **Radio adlibs on 531pi** during language programmes – 20 adlibs – Porirua Youth Vax Festival (Oct 2021) 20 adlibs – Tonga Festival Day (Nov 2021) 20 adlibs – Hutt Park (Dec 2021) 12 adlibs - AOG vaccination clinic (Feb 2022) **Radio interviews on 531Pi** 10 interviews With Pacific health providers and Pacific youth. Once initial interview and introduction made 531Pi are able to make direct contact with the provider. **Radio items on RNZ Pacific** 2 news items – Porirua – Youth Vax (Oct 21 & Doitforthe East (Dec 21). **Mai FM** 4 month campaign to encourage young Pacific audience to follow Positive Pacific – for 60 spots per month, 40 prime time & 20 Anytime plus free filler ads – 108 adverts for February. **Positively Pacific** Oct – Feb (includes Facebook, Instagram, Facebook stories and Instagram stories. Each platform requires its own design concept, artwork and editing for posters, tiles and videos to meet the format required).			

PROVIDER	ACTIVITY	COMPLETED TO DATE						
		NEW FTE / BACKFILL	WORKFORCE TRAINING	INNOVATION	COMMUNITY SUPPORT	VACCINATIONS	COMMUNICATIONS	RESOURCES & STRATEGIC DEVELOPMENT
Taeaomanino Trust	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	We have not recruited new staff however our hours have extended to include weekend support to provide increased access for our individual clients and families.	No formal training has been undertaken during this period however our staff have had to tailor their standard practice for the COVID-19 response to discuss and encourage vaccinations and to provide extra care for families through welfare and wellbeing support.	While Taeaomanino does not directly vaccinate, we are supporting multiple events and schools in this area in a bid to provide collaborative vaccination support in our region. We also provide care packs (which are not funded by this contract or funder) through our vaccination support work.	Taeaomanino have attended numerous local events over the last 3 months to support vaccinations of our community by encouraging those in our networks to attend and supporting our vaccinator workforce in our engagement with clients and families who turn up to be vaccinated. Taeaomanino have distributed DHB approved funding for over 30 community groups who have worked in partnership with the 2 DHB on delivering vaccination events to their local community.	N/A	Opportunities to talk about and promote vaccinations into our community continues to be part of the roll out in our BAU with staff who engage with our clients or visiting homes including this in their health promotion to families.	We have provided (rough estimate) a minimum of 160 hours of COVID-19 mental health support since November.
Vaka Tautua	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	*Progress summary to be reported in the next report due to staff members being unwell*				N/A	*Progress summary to be reported in the next report due to staff members being unwell*	
Te Awakairangi Health Network (TE AHN)	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	N/A	Provided training and supervision to Pacific providers to increase vaccination credentials for running their own vaccination clinics.	Delivery of "Trust us" Campaign Involvement in the 22 Pacific Festival clinics delivered	Phone calls to Pacific patients of our medical practices to book them in for 1st, 2nd or booster doses or option of in-home. Having Pacific in-home vaccinations delivered by our Pacific vaccinator.	N/A	Trust us (COVID-19) Pacific communities campaign resources designed to build awareness amongst Pacific communities in the Hutt Valley about the importance and safety of the COVID-19 vaccine.	
Eastern Bay Medical	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• 4 x Nurses • 1 x Doctor	N/A	3 x Vaccination Clinics established	40 x Care packages to COVID-19 positive patients. Looking after high needs patients on a continual basis.	N/A	• Media Interview about Omicron variant of COVID-19 in the Niue language 25/1/22 • Media Interview about 5 to 11 year old vaccination roll out in the Niue language 27/1/22 • Media interview about mask use, types of masks and how to wear them during the pandemic in both English and Niue language 27/1/22 • Media Interview about red light phase of Omicron • Participation in Ministry of Pacific People zoom meeting to discuss red light phase 2.	

PROVIDER	ACTIVITY	COMPLETED TO DATE						
		NEW FTE / BACKFILL	WORKFORCE TRAINING	INNOVATION	COMMUNITY SUPPORT	VACCINATIONS	COMMUNICATIONS	RESOURCES & STRATEGIC DEVELOPMENT
Regional Public Health	COVID-19 vaccine navigator or coordinator roles Localised vaccine support Maintenance and scale-up of response services	• 1 x Pacific liaison officer	• 5 cultural workshops with RPH staff Pacific and non-Pacific over 35 participants reached	Creation of a pilot programme (Tiakina Te Ira Tangata) based around culturally responsive contract tracing engagement approaches to engage Maori and Pacific families. Learnings from the pilot are being implemented within the RPH operations.	Supported 3 vaccination clinics and supported access to digital vaccine passports (email and copies). Support organisation with over 180 requests from non-Pacific staff for support to engage Pacific peoples and groups. Provided outreach cultural and spiritual support to 1 Pacific case isolating at community isolation facility.	N/A	Provision of language interpretation service for over 10 Pacific cases requesting language support.	Created resources for non-Pacific staff to reinforce cultural workshop content and complement eLearning courses. Developing cultural booklet covering language, Pacific providers and Pacific cultural values as a resource for staff. Established Governance group to hold organisation accountable to performance and equity response for Pacific and other underserved communities.

VACCINATION EVENTS

The below figure provides an overview of the Pacific specific vaccination events delivered by the 2 DHB, Pacific health providers in partnership with various Pacific community groups. The 20th November 2021 clinic delivered at Porirua, Tu Ora Outreach Waitangirua saw the highest numbers of Pacific peoples (214) receiving their vaccines. This was followed by the clinic held at PUCHS Clinic at Cannons Creek on 29th January 2022 having the second highest numbers of people receiving their vaccine.

Festival Outreach Clinics

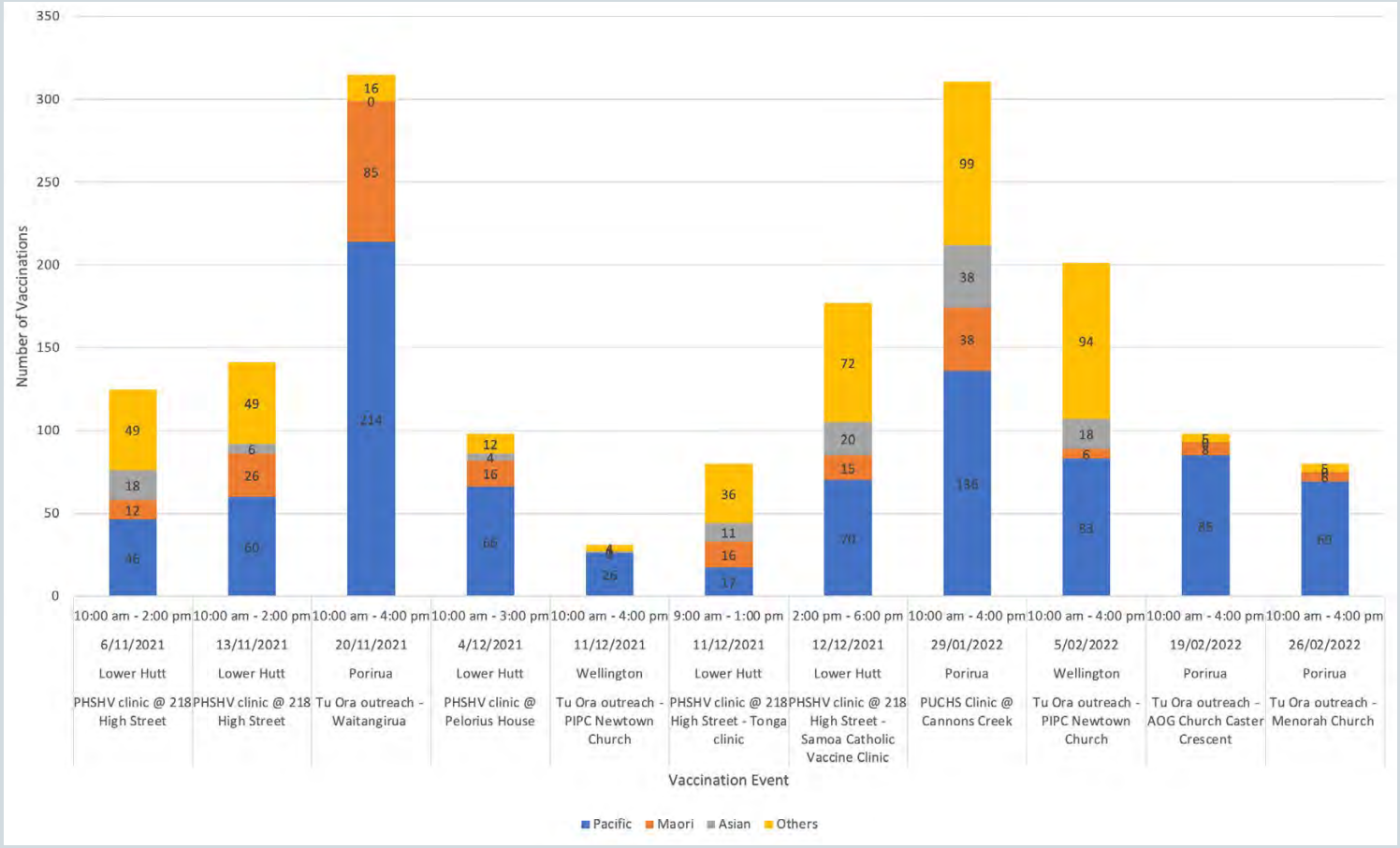


Figure 1: Festival Outreach Clinics Events Vaccination Rates

VACCINATIONS BY PROVIDERS

The below Table (5) and figures (2 & 3) presents an overview of vaccinations delivered to the different ethnic groups by some of the Pacific Providers. Table 5 highlights Pacific having the highest vaccination rates (1830), followed by Maori (656), then Asian (389).

Just over half of families who were vaccinated (54%) received these from PHP, followed by Tu Ora Outreach (17%) and PHSV Clinic (14%). The remaining families who were vaccinated (14%) received their vaccines from Vaka Atafaga (7%) and PUCHS Clinic (7%).

- Tu Ora and PUCHS have not receieved funding through this contract however we have drawn on their staff to deliver vaccine clinics.

PROVIDER	PACIFIC	MĀORI	ASIAN	OTHERS	TOTAL	col %
PHP	813	314	265	937	2,329	54%
TU ORA OUTREACH	477	105	19	124	725	17%
PHSV CLINIC	259	85	59	218	621	14%
VAKA ATAFAGA	145	114	8	44	311	7%
PUCHS CLINIC	136	38	38	99	311	7%
TOTAL	1,830	656	389	1,422	4,297	100%

Table 6 - Vaccinations by Provider and Ethnicity from November 2021-March 2022

Vaccinations (%) by Provider from Nov 2021 – Mar 2022

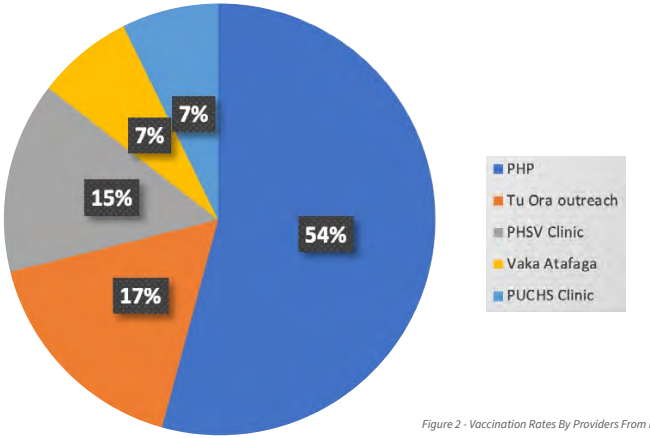


Figure 2 - Vaccination Rates By Providers From Nov 2021 To Mar 2022

Vaccinations by Provider & Ethnicity from Nov 2021 – Mar 2022

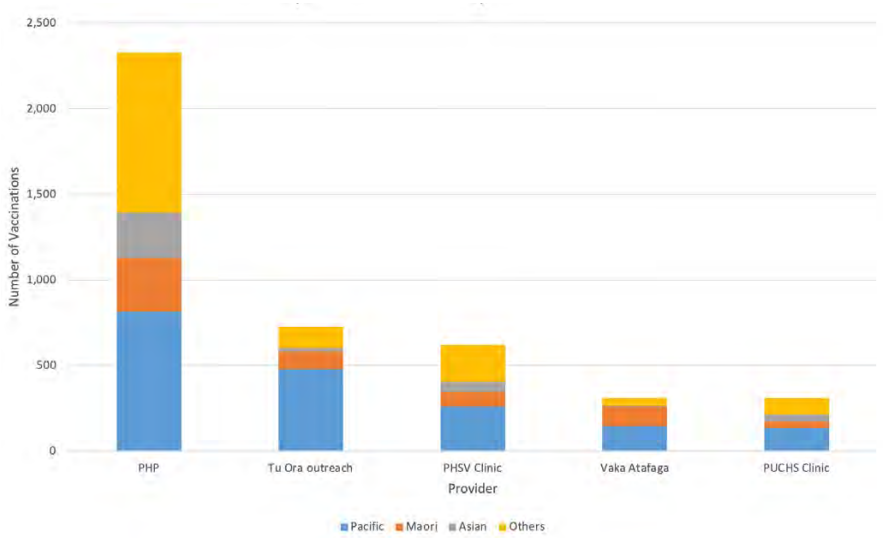


Figure 3 - Vaccinations By Provider And Ethnicity From Nov 2022 - Mar 2022

EVALUATION RESULTS SUMMARY BY ACTIVITIES

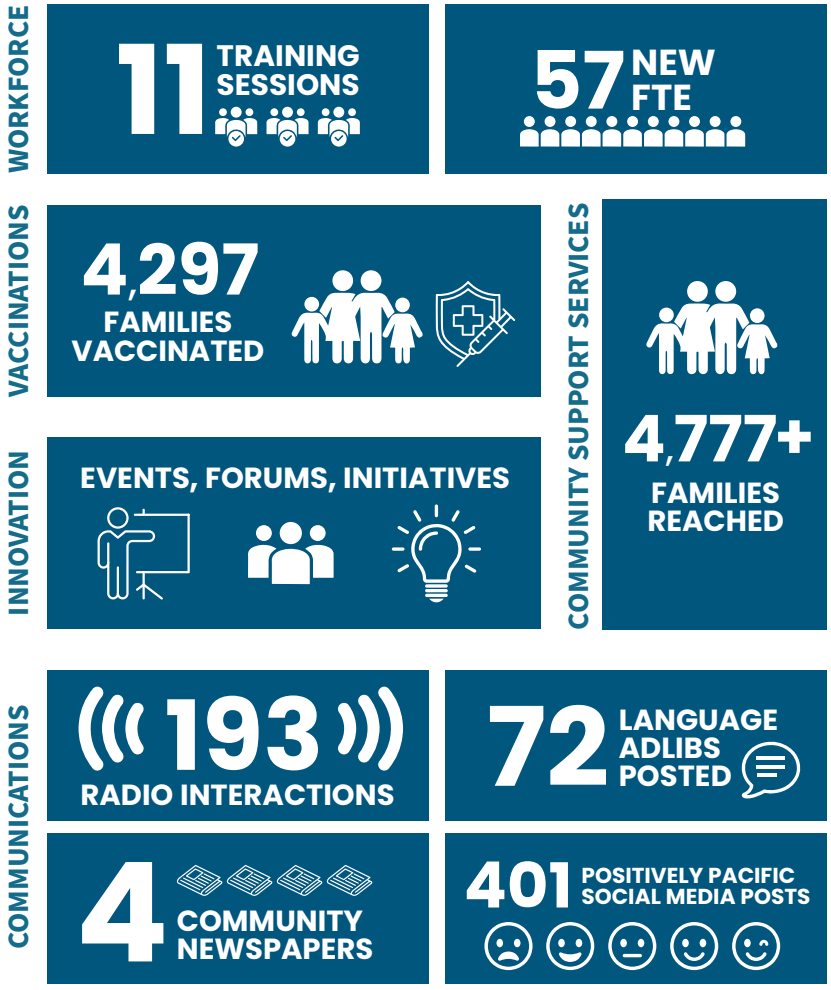


Table 7 - Summary of all Indicators

KEY HIGHLIGHTS

- Collaborative partnerships established for Wellington vaccination events with more providers working together to promote, attend and deliver vaccinations to Pacific peoples across the Wellington region.
- Expansion of services through recruitment of new staff to accommodate for the increased demand for vaccinations, health services and care during COVID-19; leveraging of existing models of care (e.g., increased outreach services) and establishment of new clinics (e.g. Kapiti vaccination clinic).
- Increased involvement of Pacific community groups in vaccination events including ethnic-specific groups to help engage with and mobilise Pacific families.
- Increased visibility of COVID-19 information and events including information available in Pacific languages across radio and social media platforms.
- Coordination of care that responds to other health needs (e.g., mental health) and provides wellbeing care (e.g. provision of care packs partially funded by MSD) through engagement pathways made possible through this contract.

NEXT STEPS...

- Plan and undertake outcome evaluation with consumers and families of the Pacific COVID-19 response to date since the submission of Report 1 against each provider's logic model of outcomes. This approach will include talanoa approaches and surveys with Pacific peoples across the Wellington region. It will also acknowledge the views and experiences of providers and staff.
- Continue to compile routine administrative data that reflects progress against key deliverables.
- Identify how best to incorporate and evaluate the Pacific COVID-19 Omicron response funds recently distributed to provide care for families during the Omicron outbreak.

APPENDIX 1: PROVIDER LOGIC MODELS

Evaluation logic models were drafted for each provider following interviews with a provider representative. These frameworks provide the basis for ongoing review and development of process and outcomes evaluations for the June 2022 report. We note that there are new providers recently added to the Pacific COVID-19 response.

Pacific Health Service Hutt Valley Inc

The Pacific Health Service Hutt Valley (PHSHV) is an independent health service that has been in operation since 1999. Driven by the 'by Pacific for Pacific' principle, PHSHV provides services to over 12,000 Pacific people residing in the Hutt Valley region. Service provisions include Family Wellbeing Services, Well Child Tamariki Ora service, Antenatal Classes, Mental Health services, Primary Nursing Outreach, and Nursing Support Service, Faith lead Wellness programme. PHSHV identified the need to deliver services that included a mobile clinic.

Using a Pacific family-centred approach, the service looks at socio-cultural evidence as the basis for engaging and working with Pacific families. The service has established community networks and collaborates with Hutt Valley DHB, Te Awakairangi PHO, Ministry of Health, Ministry of Social Development, Oranga Tamariki, Hutt City Council and New Zealand Institute of Sport (NZIS).

The service is governed by a Board, and the team is led by Nanai Mua'au (Director) and Joy Sipeli, who is the Project Manager for the service. Joy is also the Executive Director for Naku Enei Tamariki Incorporated (NET) and manages services delivered.

Table 8 provides a logic framework for Pacific Health Service highlighting the inputs, outputs, and short-, medium-, and long-term outcomes.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
One mobile clinic	Ongoing accessibility of services.	More Pacific families in Hutt Valley are accessing mobile clinic. Strong relationships established with churches and ethnic community groups.	Over 80% of Pacific families in Hutt Valley region who have limited access, are now accessing mobile clinics.
Communications Strategy	Dissemination of culturally appropriate and relevant health promotion and education messages targeting Pacific families/clusters. Contract Tracing Resources and Information developed for Pacific audiences (churches, ethnic- specific gatherings, sports clubs, clusters etc). Delivery of Radio Programme, promoting mobile service and activities happening across cluster areas.	More Pacific families are aware of the outreach programmes and accessing the services. Messages delivered in different Pacific languages and promoted through different media, including radio, social media, and online posts.	Outreach Programme is well known across Wellington region, and surrounding areas. Communication Strategy updated and current.
Community Partnership with key stakeholders (e.g., Cluster Groups)	Pacific families across three cluster areas have access to services and community initiatives. Three Cluster Groups • Hutt Valley • Central Valley • Upper Hutt.	All cluster groups have infrastructure systems in place and are receiving appropriate support and training, i.e., emergency response, funding applications. Strong relationships established with key stakeholders such as community providers, Regional Public Health, DHBs, Whanau Ora providers (Pasifika Futures).	Cluster groups are autonomous, and fully funded to deliver programmes for their respective communities (long- term funding).
Service Development – Pacific Mental Health Service	Data collation of Pacific families in Hutt Valley region affected by mental health issues. Database of health professionals (clinical, non-clinical and volunteers) to be trained in mental health (infant, youth, elderly). Build relationship with existing mental health providers with high Pacific client numbers.	Increased awareness and knowledge of mental health issues (infant and maternal) affecting Pacific families. Pacific cultural service framework developed for proposed service. A pool of highly skilled Pacific workers registered to deliver services in Mental Health and gain Level 5 Certification.	Establishment of a Cultural Response Counselling Service for Pacific families (sustainable psycho-social support) High number of qualified Pacific female mental health specialists employed to work in infant and maternal mental health area. Service is fully funded – long-term contract.
COVID-19 vaccine navigator or coordinator roles	1 x Vaccination Coordinator for Coordination of culturally appropriate COVID-19 vaccination information and services to families and communities.	Vaccination events in place and resourced appropriately.	COVID-19 vaccination rates of 90% reached for the Wellington region.
Localised vaccine support	Partnerships developed with Te Awakairangi Health Network (TE AHN) planned, organised, facilitated, and implemented. Establishment of youth leaders' forum to drive vaccination promotion to Pacific youth. Wrap-around service available for families, which includes food parcels, transportation and food vouchers.	Trusting relationships developed to ensure families including youth can make fully informed decisions with regards to the COVID-19 vaccinations. Families are fully supported through their vaccination journey.	
Maintenance and scale-up of response services	Clinical and non-clinical staff credentialled to respond and deliver COVID-19 vaccination clinics.	Staff are confident in delivering COVID-19 vaccinations safely.	Highly skilled and credentialled staff equipped to deliver COVID-19 related services.

Table 8 - Phshv Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Vaka Atafaga Pacific Nursing Service

Vaka Atafaga Pacific Nursing Service is a nurse-led service of experienced Registered Nurses, who provide home-based services to Pacific families in Porirua city. The Team are led by Margaret Southwick (Clinical Team Leader). The values of the team are based on the Tokelau concepts, 'Inati' and 'Alofa ki te tamanu.' These are understood as values of:

- The fair and equitable sharing of resources.
- Compassion, and transparency.
- Respectfulness, integrity, openness and honesty because the notion of Vā/ relationship matters.
- Taking an intelligent approach to actively innovate primary health nursing for Pacific fanau.

Self-referrals are acceptable although many of the referrals are provided by Health Services, Social Services, Education Providers and Mental Health Services. Hours of business are from Monday to Friday, from 9am-6pm

The logic framework in Table 9 emphasises the inputs and outputs of the Vaka Atafaga Pacific Nursing Service providing short-, medium-, and long-term outcomes.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
Extra Nurse	Maintaining interactions/visits with families. Linking families with food parcels.	Families meet basic needs. Families receive primary health care. Ease unrealistic workloads for staff.	More families are healthier and happier. Nurses are equipped and able to provide better service and care to families.
Admin – 3 months	Administrative support.	All patient family records are current, filed, and accessible for nurses.	A fulltime or 0.5 FTE position established. An efficient administrative system is in place (record keeping, data collation, finances).
Website	Service profile and information. Website maintenance.	Greater awareness of current service provisions and activities. Increasing number of followers, quarterly.	Website is recognised and followed regionally, nationally, and internationally.
Family support	Family relief.	More families receiving the right support – addressing social determinants. Increased awareness of COVID-19 hygiene practices.	Less families requiring help due to support mechanisms in place that empower families to become more independent. COVID-19 practices are part of normal everyday lives.
Holistic Model of Care	Nurses engaging with Pacific families – genuine interactions. Nurses are connected to primary care services and providers working with Pacific families.	Better relationships with families, built on trust and understanding. Home service is used by more Pacific families, who have limited access to primary care services.	More families are accessing services and have a good relationship with nurses. Home service fully funded and well resourced.
COVID-19 vaccine navigator or coordinator roles	Employment of Authorised Vaccinator Registered Nurse.	More families receiving vaccinations.	Wellington vaccination rates reach 90%.
Localised vaccine support	More support services for families.		
Maintenance and scale-up of response services	5 x Staff are Credentialled as Provisional COVID-19 vaccinators. 1 x Outreach immunisation services.	Staff are confident in delivering COVID-19 vaccinations safely.	Highly skilled and credentialled staff equipped to deliver COVID-19 - related services.

Table 9 - Vaka Atafaga Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Pacific Health Plus

Formerly known as Porirua Health Services (PHS), Pacific Health Plus (PHP) was set up as a primary care provider in January 2019, funded by the Fiso Investment Group. After 10 years in operation, PHS was faced with severe financial pressures and made the decision to conduct a formal bid process for new owner(s). In December 2018, the Fiso Investment Group was notified as the successful bidder, and established the new entity, Pacific Health Plus (PHP). The company is owned and led by Director, John Fiso, who also chairs the Proprietor's Board.

Today, PHP provides general medical care to over 2000 residents, many who are primarily of Pacific descent. Service provisions include Well Health Checks, Immigration Medicals, Immunisations, Nutritional Advice, Blood Pressure Checks, Family Planning, Sexual Health, Minor Surgery, Asthma and Diabetes, Mental Health Support, Health Education and Promotion, and Interpreter services. The service is governed by a Board of six members with backgrounds in Education, Finance, Council and Health. In recent times, PHP has been able to deliver mobile healthcare services, Whanau Ora and has expandedits services to include After Hours care.

Table 10 lists the outputs and outcomes from the mobile clinic, communications strategy, Pacific models of care and the workforce.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
One mobile clinic	Ongoing accessibility of services.	More Pacific families in Porirua are accessing mobile clinics.	Over 80% of Pacific families in Porirua region with limited access are now accessing mobile clinics.
Communications Strategy - Public Health	Dissemination of culturally appropriate and relevant health promotion and education messages targeting Pacific families. Contract Tracing Resources and Information developed for Pacific communities of practice (including churches, ethnic-specific gatherings, and sports clubs).	More Pacific families are aware of outreach programmes and accessing the services. Messages delivered in different Pacific languages and promoted through different media, including radio, social media, and online posts.	Outreach Programme is well known across Wellington region, and surrounding areas. More Pacific families with increased knowledge of medication and greater health literacy levels. Communication Strategy updated and current.
Pacific models of care – Holistic wrap-around services	Pacific families in Porirua are well supported through their health journey (extended service hours).	Better integration with other services working with Pacific families, using cultural model of care approaches i.e., Kenepuru Health Services, Whanau Ora services in Wellington, hospitals.	MOU with other providers/ services and DHBs for ongoing service integration and delivery of Pacific model of care framework. Services are fully funded to provide wrap-around services - long-term contracts.
Workforce	A database of health professionals for service implementation and training. Training provided for interns and nurse trainees.	Increase in Pacific health professionals, with more nurses and interns involved in the Outreach programme i.e., Whitireia Polytechnic.	A pool of highly skilled workers available to deliver services. Increased funding made available for workforce training and wages.
COVID-19 vaccine navigator or coordinator roles	Current FTE coordinating COVID-19 vaccine activities.	More families receiving vaccinations	Wellington vaccination rates reach 90%.
Localised vaccine support	Staff trained to support COVID-19 vaccinations.	Staff are confident in delivering COVID-19 vaccinations safely.	Highly skilled and credentialled staff equipped to deliver COVID-19 related services.

Table 10 - Pacific Health Plus Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Net Naku Enei Tamariki Incorporated

NET is a not-for-profit agency with three community teams that focuses on specific service provision to Māori, Pacific, Pakeha, and all other communities. Service provisions include:

- Early Intervention home visiting service in the Hutt Valley established in 1993.
- Oranga Tamariki Family Start programme, established in 2005, and is the only service provider in the Hutt area.
- Parenting programmes and support groups that are culturally appropriate, with specialised ECE programmes tailored for Māori and Pacific.

All services are family-focused, relational, and strengths-based. Programmes are complementary and designed to improve outcomes for families and children.

Joy Sipeli is the Executive Director for Pacific and Pakeha Sections of the Home visiting and Social Support services. She also delivers the parenting courses to Pacific families.

The logic framework (Table 11) demonstrates outputs and outcomes for the communications strategy and community development.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
Communications Strategy	Dissemination of culturally appropriate and relevant health promotion and education messages targeting Pacific families. Contract Tracing Resources and Information developed for Pacific communities (clusters, training and workshop facilities, churches).	More Pacific families, across three cluster regions, are aware of outreach programmes and are accessing the services. Messages delivered in different Pacific languages and promoted through different media, including radio, social media and online posts .	Outreach Programme is well known across Wellington region, and surrounding areas. Communication Strategy updated and current.
Community Development: Pandemic or Emergency response Wellington Regional Emergency Management Office (WREMO)	Emergency Response Trainings delivered across three cluster areas. A database of community individuals identified to participate in Emergency Response Trainings and represent Pacific in emergency response forums and advisory groups.	A pool of highly skilled, trained 'essential workers' on hand to facilitate and lead any emergency outbreaks affecting Pacific communities. Sufficient funding allocated to deliver training across Cluster areas.	Pacific communities are well prepared and responsive to any pandemic or emergency outbreaks. Pacific peoples are well represented in forums or advisory groups relating to pandemic or emergency responses. Ongoing funding made available for training and wages (community facilitators).
COVID-19 vaccine navigator or coordinator roles	1 x FTE COVID-19 Response Lead for Coordination of culturally appropriate COVID-19 vaccination information and services to families and communities.	Strengthened relationships with community, providers and key stakeholders in relation to COVID-19 activities.	Wellington vaccination rates reach 90%.
Localised vaccine support	Wrap-around services, which consist of multidisciplinary professionals.	Families are well supported during their vaccination journey.	Continued funding for wrap-around services.
Maintenance and scale-up of response services	2 x FTE Mental Health capability.	Increased awareness of mental health support.	Continued funding to support those suffering mental and emotional distress.

Table 11 - Net Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Catalyst Pacific Limited And Samoa Capital Radio

CATALYST Pacific Limited

CATALYST Pacific Limited is based in Lower Hutt. The service provides training in the following areas:

- Coaching and facilitation expertise
- Leadership and management development
- Mentoring
- Team building for high performance.
- Facilitation.

The service is delivered by husband and wife, Holona and Trish Lui. Holona is the Project Manager, Communication with Pacific Communities (radio).

Samoa Capital Radio 106.1 FM

Samoa Capital Radio is governed by a Board of Trustees. SCR was established in 1992, to broadcast radio programmes to audiences across the Wellington region. The programmes are delivered mainly in the Samoan language; however, government sector programmes are broadcast in the Samoan language or bilingually (English and Samoan). Podcasts are delivered daily.

The station has up to 40 volunteer programme makers and announcers on hand, including Church Ministers of the Mafutaga Faifeau Samoa Ueligitone. The group is led by Afamasaga Tealu Moresi (CEO).

The partnership with CATALYST Pacific Limited and Samoa Capital Radio has permitted community groups, Pacific providers, and Key stakeholders to engage with and inform Pacific families and communities about services available to meet their needs. This has been a particularly useful platform during COVID-19. Table 12 highlights the inputs, outputs and outcomes that will support the communication strategy and partnerships.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
Communications Strategy	'Positively Pacific' Website. COVID-19 messages delivered to different ethnic groups. Expansion of platforms to Facebook, Youtube and Instagram.	Consistent messages reaching out to a wide range of listeners, (including non-Pacific audiences).	Website has national and international followers/callers.
Translations	Pool of translators – database developed.	Various Pacific messages delivered to different ethnic audiences. Translators compensated for their contribution and time.	Increased funding available for translators and translations.
Funding	More Radio programmes. Workforce training and professional development (youth focus).	New funding available for innovative activities.	Long-term funding.
Partnerships	Support from key stakeholders for programmes.	Good working relationships with key stakeholders such as Regional Public Health, DHBs, Churches, community groups, and funders.	MOU with key stakeholders to continue delivering quality radio programmes that are well resourced.

Table 12 - Communications Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Taeaomanino Trust

Taeaomanino Trust is a Pacific social service and health provider based in Porirua. It is a non-governmental organisation that provides social and mental health services as well as counselling support to Pacific families and people, mainly in the Porirua and greater Wellington Region. Its service also provides a reach to Manawatu, Wairarapa and Hutt Valley.

The Trust is led by Chief Executive Theresa Nimarota and offers a variety of services that include:

- Alcohol & other drug counselling
- Child & Adolescent mental health services
- Family & individual counselling
- Family-centred services
- Family Start
- Family violence prevention
- Home-based services
- Problem gambling service
- Social workers in schools
- Whanau Ora.

Taeaomanino Trust's effectiveness and the differences it is making; it is important that its service has the evidence available to support this.

Taeaomanino has supported the 2 DHBs to actively engage with Pacific communities through mobilizing our funding streams for targeted community vaccination events.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
COVID-19 vaccine navigator or coordinator roles	New FTE COVID-19 Role (Pacific response service vaccine support admin role).	Consistent messages reaching out to a wide range of listeners, (including non-Pacific audiences) More Pacific families are aware of the COVID-19 vaccines and are accessing the services.	Increased COVID-19 Vaccination Rates for Pacific receiving 1st and 2nd doses of the COVID-19 vaccine.
Localised vaccine support	Provision of wrap-around Social Worker support for Pacific peoples and their families while they their journey in getting their COVID-19 vaccinations, which includes wrap- around support.	Families are happy and feel supported.	Services continue to be fully funded to provide wraparound services.
Maintenance and scale-up of response services	Continue to support community group initiatives.	Strengthened relationships to connect families and increase awareness. Families are connected and happy.	Increased awareness of community initiatives that focus on health and mental wellbeing.

Table 13 - Taeoamanino: Delta Variant And Vaccine Support Logic Framework

Vaka Tautua

Vaka Tautua is a national "by Pacific, for Pacific" health, disability, and social services provider in Aotearoa, with a strong presence in the Auckland, Wellington and Canterbury regions.

Vaka Tautua delivers multiple services nationally, with the following services delivered in Wellington:

- Aiga Fifia
- Community Connector Service
- Ola Fiafia
- Community Services
- Access and Choice
- Pacific Navigation Services
- Toa Disability Services
- Pacific Disability Information Advisory Service
- Tofa Mamao: Valuing Lived Experience Project
- Tupe Wise
- Pacific Helpline – 0800 OLA LELEI

Dr Amanda-Lanuola Dunlop is the Chief Executive Officer for Vaka Tautua. Her team is committed to improving the health and wellbeing of our Pacific peoples, families and communities.

Vaka Tautua staff bring their diverse knowledge, cultures, skills and experience to their work, collaboratively working with other non-government organisations, community organisations, district health boards and government agencies.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
Localised vaccine support	Wrap-around support provided to families.	Families' wellbeing and health are supported during their vaccination journey.	Services continue to be fully funded to provide wrap-around services.
Maintenance and scale-up of response services	0800 service to support families.	Families are well informed about COVID-19 and the vaccine.	Increased awareness regionally of access to the 0800 OLA LELEI line.

Table 14 - Vaka Tautua Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Table 15 - Vaka Tautua Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Te Awakairangi Health Network

Te Awakairangi Health Network is led by Chief Executive Bridget Allen, with the purpose of making a positive difference to the health and wellbeing of everyone in the Hutt Valley, with a clear focus on achieving equity.

Established in 2012, Te Awakairangi Health Network is a primary care network that provides quality primary care services across the Hutt Valley. Its services support general practices and a wide range of healthcare providers and community organisations, empowering and enabling communities to receive the care they need. Its services include:

- General Practices
- Community Programmes
- Te Awa Living
- Whakapakari Tinana
- Te Awa Active
- Good Food
- Hauora WoF
- Wellbeing Services
- Health and Wellbeing Support
- Mental Health and Addictions
- Community Health and Social Workers
- Outreach Nursing
- Healthy Families Lifestyle Support

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
COVID-19 vaccine navigator or coordinator roles	Current FTE COVID-19 Navigator working closely with PHS.	Strengthened relationships and vaccination support provided for PHS.	Successful delivery of culturally appropriate vaccination clinics.
Localised vaccine support	Support for unvaccinated Pacific communities.	Pacific families have improved access to culturally responsive vaccination services.	Increased COVID-19 Vaccination Rates for Pacific people receiving 1st and 2nd doses of the COVID-19 vaccine.
Maintenance and scale-up of response services	Training support for Pacific clinical and non-clinical staff.	Staff are confident in delivering COVID-19 vaccinations safely.	Highly skilled and credentialled staff equipped to deliver COVID-19-related services.

Table 15 - Te Awakairangi Health Network Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Eastern Bay Medical

Eastern Bay Medical is a local general practice service that provides a wide range of services to families, including:

- ACC Consultations
- Blood Tests
- Minor Surgery
- Pipelle Biopsy
- Family planning
- Immunisations & Flu Vaccinations
- Liquid Nitrogen cryotherapy
- Men's Wellness Checks
- Skin Checks
- Long-Term Conditions Management
- Free sexual health checks for young adults and adolescents 19 years and under
- Home Visits
- Travel Medicine
- Cervical Smears
- Asthma Reviews
- Cardiovascular Disease Risk Assessment
- IUDs
- Medicals
- Women's Health
- Smoking Cessation
- Free annual diabetic reviews

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
COVID-19 vaccine navigator or coordinator roles	New FTE Health coach role to support COVID-19 response team.	Families are well and happy.	Highly skilled and credentialled staff equipped to deliver holistic services to families.
Localised vaccine support	Establishment of an integrated health model approach to include mental wellbeing, health coaching, nursing, and GP care. Development of partnerships with local community organisations and Pacific providers.	Families are well supported during their vaccination journey. Partnerships and relationships are strengthened to support vaccination events when required.	A model that is an effective approach to engaging with and improving family's whole wellbeing. Increased COVID-19 Vaccination Rates for Pacific people receiving 1st and 2nd doses of the COVID-19 vaccine.
Maintenance and scale-up of response services	4 x Nurses Authorised Vaccinators.	More Pacific families are aware of the COVID-19 vaccines and are accessing the services.	Highly skilled and credentialled staff equipped to deliver COVID-19 related services.

Table 16 - Eastern Bay Medical Pacific COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

THE FAMILY CENTRE

The Family Centre is a leading cultural and social policy research agency based in Lower Hutt, Wellington, New Zealand. It is made up of a three tikanga (cultural) organisational structure of Māori, Pacific Island and Pākehā (European) sections who work independently but share resources inter-dependently.

The key area of their work is social policy research. They are a community-based NGO (Non-Government Organisation) located in the community where they also carry out family therapy services and community development work. They are also an international organisation involved in substantial research collaborations and education and teaching.

INPUTS	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM- TO LONG-TERM OUTCOMES
COVID-19 vaccine navigator or coordinator roles	New FTE Health coach role to support COVID-19 response team. Community education sessions delivered with local Pacific community and church groups to create COVID-19 pandemic response plans.	Families are well and happy. Communities prepared for outbreak of COVID-19 within their families or church community and can respond immediately.	Highly skilled and credentialed staff equipped to deliver holistic services to families. Increased community literacy relating to pandemic response activities and community preparedness.
Localised vaccine support	Establishment of an integrated health model approach to include mental wellbeing, health coaching, nursing, and GP care. Development of partnerships with local community organisations and Pacific providers.	Families are well supported during their vaccination journey. Partnerships and relationships are strengthened to support vaccination events when required.	A model that is an effective approach to engaging with and improving family's whole wellbeing. Increased COVID-19 Vaccination Rates for Pacific people receiving 1st and 2nd doses of the COVID-19 vaccine.
Maintenance and scale-up of response services	4 x Nurses Authorised Vaccinators.	More Pacific families are aware of the COVID-19 vaccines and are accessing the services.	Highly skilled and credentialed staff equipped to deliver COVID-19 related services.

Table 16 - The Family Centre COVID-19 Response: Delta Variant And Vaccine Support Logic Framework

Moana Research
PO Box 59244
Māngere Bridge
Auckland 2151

moanaresearch.co.nz

Board Information – Public

13 May 2022

3DHB Data and Digital update – Q3 and Q4 FY2022

Action Required

The Boards note:

(a) The content of the attached Data and Digital update

(b) The deliverables completed by the ICT this financial year to date

(c) The planned workstreams which will continue in Q4

(d) The key initiatives which are planned for the 2022/2023 financial year

Strategic Alignment	Creating a sustainable and affordable health system
Author	Martin Catterall, Chief Digital Officer, Capital & Coast District Health Board
Endorsed by	John Tait, Acting Chief Executive, Capital & Coast and Hutt Valley District Health Boards
Purpose	The purpose of the paper is to inform the Board as to the work programmes completed during the 2021/2022 financial year to date and to highlight the remaining work which is planned or underway for Q4 and into the 2022/2023 financial year.
Contributors	n/a
Consultation	n/a

Executive Summary

1. ICT has played an integral part in the DHB's COVID response and has delivered a large number of key applications throughout this financial year.
2. A number of key initiatives are in-train for the next financial year including the 3DHB Single Clinical Workspace project, replacing our end of life backup capability and urgent risk mitigation for our vulnerable PABX telephony.

Strategic Considerations

Service	n/a
People	n/a
Financial	n/a
Governance	n/a

Attachments

1. 3DHB Data and Digital Quarterly Report – May 2022

3DHB DATA AND DIGITAL BOARD REPORT MAY 2022

Whakahohe ai i te whānau me ngā kaimahi te matihiko me ngā tūtuki pūtanga

Enabling patient and workforce outcomes with digital solutions

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

1. EXECUTIVE SUMMARY

As this is the last ICT Board Report to be issued under the current DHB system we are taking the opportunity to highlight some of the successes achieved this year and recognise the performance from the ICT team to get us there. This report covers the work until the end of this financial year and what is being planned for FY2023.

A major work commitment this year has been the focus on supporting the DHBs' COVID response. The team have delivered a number of key applications to support the new challenges, maintained our security infra-structure to keep us safe (especially in the current environment of war in Europe which heightens the risk of global cyber-attacks) and completed some key strategic work to make national systems available to local clinicians. Operational work has been focused on infrastructure and equipment provisioning to front line staff, along with the training and supporting of these staff in use of this technology.

A number of key initiatives are in-train for the next financial year. These include:

- 3DHB Single Clinical Workspace—continuation of the key project to upgrade from Concerto to the Clini-cal Portal platform
- Replacing our end of life backup capability with an outsourced modern solution
- Urgent risk mitigation for our vulnerable PABX telephony

Within the department we are consulting with staff on a proposed restructure of the ICT Department. This has evolved from the increased demand for modern integrated technology, the consolidation of services and the transition to Health NZ.

Our operating environment is challenging with the uncertainty of the transition to Health NZ, COVID-19, re-muneration pressures and a strong candidate centred employment market. We maintain our focus on supporting our clinical colleagues and their priorities which ensures that the work we do as an enabling function clearly contributes to the clinical success. This in turn supports all New Zealanders. Providing this focus means that staff are more able to link their hard work to the clinical and community services delivered by the DHBs - which improves job satisfaction and employment longevity.

We are looking forward to seeing the future shape of the health services and how ICT will contribute to the success of the new organisation.

2. ACHIEVEMENTS IN FY2022

COVID RESPONSE

We stood up a COVID Response Team to oversee the prioritisation of requests to ICT. This has included changes to applications and templates and management of device requests including

- Implementing a link between Concerto and the COVID Clinical Care Module (CCCM) being used across the sector to manage people with COVID. This is available in the three DHBs and allows clinical staff to directly access CCCM and the care-related details held in that system
- Updating electronic discharge summaries used in the three DHBs to include COVID Information
- Updating specific document templates to record COVID information and make these available to the three DHBs
- Working on electronically sending a copy of the discharge summary to CCCM
- Setting up mechanisms to record RAT results for staff and for patients, and to share COVID test results with ESR and MoH. Some of this data feeds into the CCCM record
- Setting up point of care testing in inpatient services for 2DHB
- Setting up access to shared email in-boxes so that clinicians can plan for admission and discharge of people with COVID. This includes Regional Public Health, inpatient services and the 2DHB COVID Response Team
- Setting up tablets in inpatient isolation rooms with Zoom Always On so that patients and staff can communicate safely without having to go into the patient's room. This has been set up for Masterton, Hutt and Wellington hospitals
- Reporting weekly to the 2DHB Emergency Operations Centre meeting, and liaising with the GM Hospital Flow who runs these meetings
- Liaising with the 2D COVID Response Team to support its operational requirements. This has included work on equipment set up and on setting up Teams to share vaccination information with other providers in the 2DHB sub-region
- Reporting weekly to the WrDHB Emergency Operations Centre meeting.
- Working the WrDHB COVID Community Response Team to ensure it has the equipment to do its work
- Setting up Microsoft Teams so that staff working on COVID-related activity can use Teams to communicate with colleagues in the wider health sector
- Working with the 2DHB Occupational Health Team to support its work managing staff with COVID
- Working with services and facility management on building changes in response to COVID—for example the changes to Wellington ED portacabins for ED screening, dialysis unit at Hutt for COVID patients, ability to set up inpatient beds in Wellington Main Outpatients if required for non-COVID patients
- Distributing equipment—hardware, devices, phones—where required to support staff who need to work from home or move around the workplace

We liaised with the Ministry of Health with regard to CCCM and the link to Concerto. This has included getting information about the security and privacy aspects of the CCCM link. We also worked on a Privacy Impact Assessment for the Teams Silver offering as this involves sharing personal information received from the Ministry of Health with other care providers such as general practitioners, community pharmacies, etc.

COVID work has a very high priority and we have made various work prioritisation decisions in conjunction with the services in response to COVID work requests.

CLINICAL WORKSPACE

The Clinical Workspace Programme has continued to deliver on existing commitments where they have been funded, and new items relating to the COVID response.

- CCDHB successfully moved to the Regional Radiology System (R.RIS) in April. This is the culmination of work over a number of years and has involved a number of people across the DHB, TAS and vendors. It paves the way for the planning migration of HV and Wr DHBs, which is currently planned for July 2022.
- ePrescribing for outpatient prescribing went live in mid-January. This initiative has allowed clinicians to prescribe medicines electronically, removing the need to print paper prescriptions. It uses the prescription broker that is also used for primary care prescribing. Work on supporting electronic prescribing for Mental Health Addiction Services has also started. A business case is being developed.
- We are supporting a number of strategic initiatives:
    - 2DHB Cardiology Network We are working with 2DHB Provider Services on the implementation of the 2DHB Cardiology Network. ICT is represented on the Governance Group. It is also working on the implementation of technology such as Synapse and Holter Monitors. Wr Synapse is due to go live by 30 June 2022
    - Front of Whare We are working with the project team, including review of the business case for these changes
    - Ophthalmology We are working with SPP on this initiative, which will include eReferrals and patient management processes
- Other initiatives/areas of work include
    - Regional breast screening—equipment replacement to improve equity of service access and delivery
    - Community nursing—investigating mobile working to support community-based nurses access core clinical systems from remote/mobile locations
    - Dictation/transcription—modernising processes and systems used for recording, transcribing and delivering clinical information across a range of environments
    - Replacement of the current radiation calculator—medical oncology
    - Implementing phase 2 of Scope, a clinical audit tool, at HVDHB
    - eReferrals—for the Central Region
    - Work on T-Docs for theatre/CSSD is planned to go-live in May for HV and June for CC
    - Upgrading of critical clinical applications to keep them in support
    - Verification of approach, including gathering business requirements for electronic patient observations

SERVICE DELIVERY

Service Delivery is focussed on optimising customer service and adding value.

There has been a significant increase in demand, and this has been exacerbated by the COVID pandemic. The team has made significant progress in reducing waiting times for call responses. The number of outstanding calls has been reduced by more than 73%, and is continuing to reduce.

Initiatives to avoid a recurrence of the ticket backlog include a focus on ticket management and the underlying processes that need attention in order to manage and prioritise tickets more effectively. This includes refining how action incidents and requests are prioritised to ensure the right priority is given to each ticket. Process and tool improvements include using trend analysis, business feedback and industry best practice as a guide. The focus is on adding the most value now, and benefit from continual service improvements through measurable and meaningful process, structure and data capture.

CORPORATE PORTFOLIO

We continue to work closely with corporate functions on their needs on significant programmes of work such as security for safety and FPIM migration.

STRATEGIES

This year we have focused on delivering the key enterprise technology strategies and roadmaps for the foundational capability upon which a modern health system is delivered. These strategies have been developed in consultation with all directorates and wider into the health sector. These are presented to the DDIG for consultation and signoff in the 3DHB environment.

Many of these approved local strategies have been adopted by the Central Region and nationally.

- Network
- Cloud/infrastructure
- Data
- Integration
- Future of patient administration systems—market landscape scan, including other DHBs and vendors
- Imaging
- Regional enterprise architecture charter—development of a framework for enterprise architecture across the Central Region (6 DHBs) due early May 2022
- Regional roadmap for R.RIS, PACS, Clinical Portal and webPAS— input to the TAS roadmap for the next 24 months. Primary focus on remedial work—eg stability, performance, disaster recovery as well as user experience
- Assurance and access management framework—development of an overarching strategy for service assurance, from resource to business service management

DIGITAL FOUNDATIONS

The Digital Foundations Programme has focussed on underlying infrastructure for our clinical and corporate systems.

While the infrastructure hardware cyclical replacement programme is continuing, we are experiencing some supply chain issues, resulting in delays in hardware delivery—some have now been pushed into FY2023. This applies to server, storage and network infrastructure.

Cybersecurity work has included:

- Rolling out CloudStrike EDR
- Transition to a new security operations centre
- Piloting the new user awareness and training solution
- Security patching—80% of all servers have been patched by the end of April 2022

We have successfully implemented Microsoft Exchange Online and Project Online. We are now rolling out Teams to staff to support the COVID response.

The HVDHB webPAS upgrade is nearing completion. The planned go-live is 21 May 2022. This work has been delayed by Omicron.

OTHER

We have increased the size of our Commercial Team. This is due to an increase in project work and the requirement to review existing contracts. The team has delivered some savings, which offset some unplanned support costs from legacy investment decisions. We are working with Finance to better document and forecast vendor costs.

We participated in the Public Records Act Audit of HVDHB which was carried out in April. 2022 The focus of the audit was on corporate systems.

3. CURRENTLY UNDER WAY—BY END OF FY2022

STRATEGIES

In Quarter Four we are focusing on creating enterprise strategies for:

- Analytics
- Corporate systems
- Identity and access management framework—foundational capability and enabler for digital strategy. Provides for modern authentication and role-based access control to digital services. Scope includes local, regional and national levels

CORPORATE PORTFOLIO

The following initiatives will be delivered in Quarter Four:

- Occupational Health PMS—CC and HV service amalgamation expected go-live June 2022
- Occupational Health Qualtrics tool for staff to record COVID data completed April 2022
- Payroll Leave Manager module implemented April 2022 to enable Holidays Act Remediation
- Exploring extension of Smartpage to HVDHB

CLINICAL WORKSPACE

- An action point in the 2DHB Maternity and Neonatal Services Plan is to develop a maternity clinical information system procurement and implementation plan by June 2022. We are working with the Women's Health Services in the three DHBs to achieve this.
- eReferrals design—a future phase of the eReferral solution

DIGITAL FOUNDATIONS

- FY2022 Security Improvement programme

HEALTH NZ

A number of initiatives have commenced involving 3DHB ICT as we start to transition to Health NZ. These include:

- Design and planning for implementation of Microsoft Defender Endpoint across 3DHB desktop fleet. This work is being done with co-operation with the Ministry of Health as part of a wider E5 deployment of security services
- Security team working with a number of Ministry of Health working groups to provide input across user awareness training, SIEM and E5 security

4. PLANNING FOR FY2023

STRATEGIES

Enterprise technology strategy work that is under way and will be completed in FY2023:

- Transcription—the current platform is end-of-life by December 2022
- Hospital digitisation strategy—by September 2022
- Business intelligence strategy—before the end of August 2022

INFRASTRUCTURE and SECURITY

- The urgent backup capacity remediation work is expected to be completed by August 2022.
- The Server Backup Capability Replacement Project, which will replace end-of-life backup capability with a managed service, will be completed by March 2023.
- We are exploring use of 'hybrid' cloud technologies. This work will be completed by December 2022
- Deployment of ICT infrastructure to Te Wao Nui, the new Children's Hospital.
- Security endpoint detection
- Implementation of Microsoft E3 and E5 capability.

CLINICAL WORKSPACE

- We are planning to implement BadgerNet Maternity in the three DHBs during FY2023. Timing is subject to vendor availability and planning in the respective Women's Health Services
- Extension of electronic prescribing to inpatient services and MH Addiction Services
- Work is continuing on the delivery of the 3DHB Single Clinical Workspace. The current plan is for Wairarapa DHB to go-live in July 2022, with Hutt Valley DHB in September 2022 and Capital & Coast DHB in February 2023. These dates may change
- Implementing Synapse into WrDHB and HVDHB which is currently planned to go-live in Sep 2022 as part of the 2DHB Cardiology Network
- Dental imaging for HV is planned to go-live in July 2022, and CC in Aug 2022
- The Medtech upgrade to Medtech Evolution for the Kenepuru Accident and Medical Service is planned to go-live in Aug 2022

CORPORATE PORTFOLIO

- Develop API platform, including interfaces with organisations such as ACC for claims lodgement
- Medical records scanning
- Roll-out video conferencing capability in meeting rooms
- Enterprise data warehouse upgrade
- WrDHB electronic meal ordering—business case approval April 2022, project scheduling to be confirmed
- Security for safety—business case presented in April 2022, multi-year programme of work
- Central Equipment Pool—business case to be approved. Three-month duration
- HVDHB electronic meal ordering—work to commence in FY2023
- 3DHB FPIM—Oracle financials to be complete Jan 2023
- 3DHB Microsoft 365 and Modern Desktop—complete June 2023
- Holidays Act payroll rectification—next steps being finalised; expect to complete June 2023
-

REGIONAL AND NATIONAL

- eReferrals—currently involved in the Central Region RFP being run by MidCentral DHB.
- Migration of Regional webPAS from TAS to Dedalus
- Submitting bids into the national ICT infrastructure fund
- Supporting the establishment of Health NZ by providing best practice advise to key work streams when invited.

5. GENERAL COMMENTS

Governance

Data and Digital Intelligence Governance Group (DDIGG) meetings have continued as a forum to provide updates on the delivery plan and approved technology strategies.

We have worked with the enterprise project management offices (EPMOs) to lift our project delivery governance competencies.

We have been working to lift governance of the regional clinical applications by ensuring they are business/ clinical-led rather than ICT-led.

Funding and other resourcing pressures and the extent of change in the health sector have contributed to ICT not being able to materialise the 2020 Digital Strategy. The 3DHB Digital Strategy has been used as the based for the Health NZ draft digital strategy. We have not reviewed or refreshed the 3DHB Digital Strategy.

Investment and financial performance

We will end FY2022 under budget for capital (85%) and slightly over budget for operating. The latter is due to increased vendor support costs and internal labour.

We have used our funding to advance end-of-life equipment replacement, commence a limited technology change programme and support urgent clinical initiatives.

Resourcing

We continue to compete in the market for talent which has driven up the cost of labour and places pressure on our personnel budget. Remuneration is a continuing challenge impacting on retention and this affects longer serving staff in particular.

We have increased our delivery headcount to ensure that we deliver to the DHBs' work programmes. The restructuring proposal currently being consulted on is intended to assist in addressing some of these issues.

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 13 May 2022

Resolution to exclude the Public

The Boards agree that the public be excluded from the following parts of the proceedings of this meeting, namely:

- for the Agenda items and general subject matter to be discussed as set out in the first column in the table below,
- on the grounds under clause 34 of Schedule 3 to the New Zealand Public Health and Disability Act 2000 as set out in the second column in the table below and
- for the reasons set out in the third column of the table below (including reference to the particular interests protected by the Official Information Act, where applicable).

TABLE

Agenda item and general subject of matter to be discussed	**Grounds under clause 34 on which the resolution is based**	**Reason for passing the resolution in relation to each matter, including reference to OIA where applicable**
Confirmation of minutes of previous meeting (public excluded session) and Matters Arising from those minutes.	paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982	i. OIA s 2(a) protect the privacy of natural persons, including that of deceased natural persons, section ii. OIA s 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied.

		iii. OIA s 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage negotiations
2DHB and MHAIDS Quality & Safety Report	As above	As above (i) and (ii)
2DHB Workplace Health and Safety Report	As above	As above (i) and (ii)
FRAC items for Board Approval from meeting dated 27/04/22	As above	As above (iii)
CCDHB Campus Link Building and Capital Works	As above	As above (iii)
MCPAC Update from meeting dated 27/04/2022	As above	As above (iii)
Chair's Report and Correspondence	As above	As above (i), (ii) and (iii)
Chief Executive's Report	As above	As above (i), (ii) and (iii)
General Business	As above	As above (i), (ii) and (iii)

NOTE
The Act provides that every resolution to exclude the public shall be put at a time when the meeting is open to the public, and the text of that resolution (or copies of it) must:

- be available to any member of the public who is present; and
- form part of the minutes of the board or committee.