PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 3 November 2021 Time: 9:30am Location: Zoom Zoom Meeting ID: 876 5068 1844

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Pg
1.	**PROCEDURAL BUSINESS**			
1.1.	Karakia		All members	2
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1.3.	Public Participation	**NOTE**	Chair	
1.4.	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair	3 8
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1.7.	Chair's Report and Correspondence	**NOTE**	Chair	
1.8.	Chief Executive's Report	**NOTE**	Chief Executive	18
1.9.	Board Work Plan 2021/2022	**NOTE**	Chair	34
2.	**DHB PERFORMANCE AND ACCOUNTABILITY**			
2.1.	HVDHB Financial and Operational Performance Report – August 2021 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	37
2.2.	CCDHB Financial and Operational Performance Report – August 2021 2.1.2 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance	88
3.	**UPDATES**			
3.1.	2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report – Quarter 1	**NOTE**	Director Māori Health	134
3.2.	2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report April – November 2021	**NOTE**	Director Pacific People's Health	154
3.3.	3DHB Data and Digital update – Quarter 1	**NOTE**	Chief Executive Chief Digital Officer	172
3.4.	Suicide Prevention and Postvention – Statistics on suicide and self-harm, and the 3DHB Action Plan update	**NOTE**	Director Strategy, Planning and Performance	181
3.5.	Hutt Valley Maternity progress update	**NOTE**	Chief Executive Director Provider Services	235
4.	**OTHER**			
4.1.	General Business	**NOTE**	Chair	
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Next concurrent Board meeting:
Date: Wednesday 3 November 2021, **Location:** Auditorium, Level 1 Clocktower Building, Hutt Hospital **Time:** 9.30am

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

03/11/2021

Name	Interest
Mr David Smol *Chair*	• Chair, New Zealand Growth Capital Partners • Chair, Wellington UniVentures • Director, Contact Energy • Board Member. Waka Kotahi (NZTA) • Director, Cooperative Bank • Chair, DIA External Advisory Committee • Chair, MSD Risk and Audit Committee • Director, Rimu Road Limited (consultancy) • Sister-in-law works for Capital and Coast DHB
Mr Wayne Guppy *Deputy Chair HVDHB*	• Mayor, Upper Hutt City Council • Director, MedicAlert • Chair, Wellington Regional Mayoral Forum • Chair, Wellington Regional Strategy Committee • Deputy Chair, Wellington Water Committee • Deputy Chair, Hutt Valley District Health Board • Trustee, Ōrongomai Marae • Wife is employed by various community pharmacies in the Hutt Valley
Stacey Shortall *Deputy Chair CCDHB*	• Partner, MinterElisonRuddWatts • Trustee, Who Did You Help Today charitable trust • Patron, Upper Hutt Women's Refuge • Patron, Cohort 55 Group of Department of Corrections officers • Ambassador, Centre for Women's Health at Victoria University
Dr Kathryn Adams	• Contracted Vaccinator, Kokiri Marae Hauora Clinic, Lower Hutt • Fellow, College of Nurses Aotearoa (NZ) • Reviewer, Editorial Board, Nursing Praxis in New Zealand • Member, Capital & Coast District Health Board • Member, National Party Health Policy Advisory Group • Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health • Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council

	• Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young • Staff seconded to Health and Disability System Review • Contact with Associate Minister for Health, Hon. Peeni Henare
Brendan Boyle	• Director, Brendan Boyle Limited • Director, Fairway Resolution Limited • Director, Fairway Holdings Limited • Member, NZ Treasury Budget Governance Group • Member, Future for Local Government Review. • Daughter is a Pharmacist at Unichem Petone
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd

Ria Earp	• Board Member, Wellington Free Ambulance
	• Board Member, Hospice NZ
	• Māori Health Advisor for:
	  ○ Health Quality Safety Commission
	  ○ Hospice NZ
	  ○ Nursing Council NZ
	  ○ School of Nursing, Midwifery & Health Practice
	• Former Chief Executive, Mary Potter Hospice 2006 -2017

Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board

	• Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Member - Te Hauora Runanga o Wairarapa • Member - Wairarapa Child and Youth Mortally Review Committee Member - He Kahui Wairarapa • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Senior Research Fellow, University of Otago Wellington (2001 – present) • Review Panel Member, PHARMAC Review (2021) • Board Member, Capital & Coast District Health Board (2019 – present) • Board Member, Health Quality & Safety Commission (2020 – present) • Chair- Muscular Dystrophy Assoc. (Tuaatara | Central Region) (2018 – present) • Director , Calls 4 Charity Limited (2021 – present) • Director, Miramar Enterprises Limited (2014 – present) • Chairperson, Foundation for Equity & Research New Zealand (2018 – present) • Co-Chair, My Life My Voice Charitable Trust (2019 – present) • Governance Representative, Disabled Persons Organisation Coalition (2018 – present) • Representative, Independent Monitoring Mechanism to the United Nations Convention on the Rights of Persons with a Disability (UNCRPD) (2018 – present) • Chair, Te Ao Mārama: Māori Disability Advisory Group, Ministry of Health (2018-2021) • Chair, Te Ao Mārama Aotearoa Trust: Māori Disability Advisory Group (2021) • Deputy Chairperson, Te Āparangi: Māori Advisory Group to HealthCERT, Ministry of Health (2019 – present) • Member, COVID-19 Immunisation Implementation Advisory Group, Ministry of Health (2021 – present) & Tātou Whakaha Disability Advisory Sub Committee • Member, Enabling Good Lives Governance Group, Ministry of Health (2020 – present) • Member, Machinery of Government Working Group, Ministry of Social Development (2020 – present) • Member, Māori Workforce Development Group, Ministry of Health (2021-present) • Member, Māori Monitoring Group, Ministry of Health (2021-present) • Professional Member, Royal Society of New Zealand • Member, Institute of Directors • Member,– Health Research Council College of Experts • Member, European Respiratory Society

	• Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Wife, Member 3DHB Disability Advisory Group & Tāngata Whaikaha Roopu
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Consumer New Zealand Board
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Member, E tū Union • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Member, Muscular Dystrophy New Zealand (Central Region) • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington

	• Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

HUTT VALLEY AND CAPITAL & COAST DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

3/NOVEMBER/2021

Fionnagh Dougan *Chief Executive Officer 2DHB*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Rosalie Percival *Chief Financial Officer 2DHB*	• Trustee, Wellington Hospital Foundation
Joy Farley *Director Provider Services 2DHB*	• Nil
Rachel Haggerty *Director, Strategy Planning & Performance 2DHB*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Arawhetu Gray *Director, Māori Health 2DHB*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Junior Ulu *Director, Pacific Peoples Health DHB*	• Member of Norman Kirk Memorial Trust Fund • Paid Member of Pasifika Medical Association
Helen Mexted *Director, Communications & Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
John Tait *Chief Medical Officer 2DHB*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC • Director, Istar • Member, Health Practitioners Disciplinary Tribunal
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Sarah Jackson *2DHB Acting Director Clinical Excellence*	• Nil
Rachel Gully *Director People, Culture & Capability 2DHB*	• NIL
Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington

Wednesday, 27 October 2021

Karla Bergquist *3DHB Executive Director MHAIDS*	• Former Executive Director, Emerge Aotearoa Ltd • Former Executive Director, Mind and Body Consultants *(organisations that CCDHB and HVDHB contract with)*
Sally Dossor *Director of the Chief Executive Office & Board Secretary*	• Partner is a Director of Magretiek, BioStrategy and Comrad
Paul Oxnam *Executive Clinical Director MHAIDS*	• Member, NZ College of Clinical Psychologists
Sue Gordon *Transformation Director*	• Board Member, Netball New Zealand
Martin Catterall *Chief Digital Officer 3DHB*	• NIL
Mathew Parr *Acting Chief Financial Officer 2DHB*	• Substantially employed by PWC • Partner's father works in the printing team at CCDHB

PUBLIC

	MINUTES Held on Wednesday 6 October 2021 Location: Zoom Zoom: 876 5068 1844 Time: 9:00am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

Due to Covid 19 alert level (level 2) only the Chair and limited staff attended in person (in person marked with * and all others on zoom).

PRESENT

*David Smol	Chair, Hutt Valley and Capital & Coast DHBs		
Dr Kathryn Adams	Board Member		Board Member
Dr Tristram Ingham	Board Member	Ria Earp	Board Member
Brendan Boyle	Board Member	Ken Laban	Board Member
Sue Kedgley	Board Member	Yvette Grace	Board Member
Roger Blakeley	Board Member	Prue Lamason	Board Member
Dr Chris Kalderimis	Board Member	Naomi Shaw	Board Member
Vanessa Simpson	Board Member	Dr Richard Stein	Board Member
Stacey Shortall	Deputy Chair	John Ryall	Board Member
		Josh Briggs	Board Member
		Wayne Guppy	Deputy Chair

APOLOGIES

'Ana Coffey
Hamiora Bowkett (for lateness – attended at 1.45pm)
Keri Brown
Roger Blakely (left at 1.30pm)
Vanessa Simpson (left at 2pm)

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

*Fionnagh Dougan	Chief Executive
Rosalie Percival	Chief Financial Officer
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Service
Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
Rachel Haggerty	Director Strategy, Planning and Performance
Sarah Jackson	Director of Clinical Excellence
Joy Farley	Director Provider Services
Rachel Gully	Director People and Culture
Sue Gordon	Director Transformation
Helen Mexted	Director of Communication and Engagement
*Sally Dossor	Director Office of the Chief Executive and Board Secretary
*Meila Wilkins	Board Liaison Officer

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1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

The Boards noted the attendance by the following:

- Bill Day, Chair Wellington Hospitals Foundation (WHF)
- Simon Williams, District Governor, Lions International, District 202m
- Rex Bullard, Past District Governor, Lions International, District 202m

Notes

- Bill Day introduced the representatives of Lions International which has made a donation of $500K to the Wellington Children's Hospital.
- The Children's Hospital covers three districts of Lions – and this was key to the Clubs' across the region embracing the project and undertaking significant fundraising in the last 12-14 months.
- Simon Williams noted the partnership with the WHF and working with Mark Dunajtschik.
- Lions have seen the project as a win-win and are pleased to be part of the legacy.
- Rex Bullard noted the Lions' involvement in fundraising for Ronald McDonald House and the natural continuity to become involved in the Children's Hospital project.
- The partnership with the WHF was acknowledged and the Clubs have enjoyed the opportunity to be involved
- The Chair thanked the WHF for its work and partnership with the Lions, and thanked the Lions for the phenomenal contribution, especially in the circumstances of Covid-19 presenting challenges for fundraising.

Acknowledgement

- The Chair and the Boards acknowledged the recent passing of Grant Corleison –and his contribution to the Children's Hospital project. Grant's contribution was also acknowledged by Bill Day on behalf of the WHF

1.4 INTEREST REGISTER

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** that any further changes were to be sent to the Board Liaison Officer via email.

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

It was **noted** as current and the Chief Executive will ensure the ELT will update as needed.

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Boards **approved** the minutes of the concurrent Board Meeting held on 1 September 2021 (public).

	Moved	**Seconded**	
HVDHB	Ria Earp	John Ryall	**CARRIED**
CCDHB	Roger Blakeley	Chris Kalderimis	**CARRIED**

PUBLIC

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

There were no updates or comments.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Board thanked the Chief Executive and team for the progress on the vaccination programme and the work preparing for Covid in the community.

Noted the milestone of Board appointments to Health New Zealand and Māori Health Authority.

1.8 CHIEF EXECUTIVE'S REPORT

*The paper was taken as **read** and the Chief Executive answered questions.*

Notes:

- The Chief Executive reflected on the value of Board members connecting with their communities and assistance with our vaccination programme.
- The data in the report was updated and the progress made since the Board reports were published was noted (1st dose Maori 64% to 66%, Pacific 70% to 72%)
- Trusted faces and trusted places is working well as a programme.
- Prime Minister visit noted and the positive outcomes of the visit
- It is about supporting individuals to come forward and working with community leaders, and interagency groups

1.9 BOARD WORK PLAN 2021/2022

The Board **noted** the work plan for 2021/2022.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB JULY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

*Paper was taken as **read** and the Chief Financial Officer answered questions.*

The HVDHB Board noted:

(a) the DHB had a ($3.3m) deficit for the month of July 2021, being ($0.5m) unfavourable to budget;

(b) the DHB year to date deficit excluding $0.1m net COVID-19 costs was ($3.2m);

(c) the Funder result for July was ($1.7m) unfavourable, Governance $0.1m favourable and Provider $1.1m favourable to budget;

(d) total Case Weighted Discharge (CWD) Activity was 12% ahead of plan.

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Ken Laban	**CARRIED**

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2.2 CCDHB JULY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

*Paper was taken as **read** and the Chief Financial Officer answered questions.*

The CCDHB Board notes:

(a) The DHB had a ($2.6m) deficit for the month of July 2021, being breakeven to budget before excluding COVID-19;

(b) In the one month we have incurred $441k additional net expenditure for COVID-19;

(c) The DHB has an overall YTD deficit of ($2.2m) from normal operations (excluding COVID-19) being $400k favourable to the underlying budget.

	Moved	**Seconded**	
CCDHB	Brendan Boyle	Sue Kedgley	**CARRIED**

3 UPDATES

3.1 HSC UPDATE FROM MEETING DATED 29/09/21

The Chair of HSC spoke to the paper.

The Boards noted:

(a) **The papers are in the Diligent Board book for the HSC meeting dated 29 September 2021.**

(b) **HSC received reports and noting recommendations on the following:**

Item 2.1: Planned Care Performance and Impact of COVID-19 Lockdown in 2021

(a) the increasing service delivery and financial risks within Planned Care services at both Capital & Coast and Hutt Valley DHBs

Item 3.1: Ministry of Health Non-Financial Performance Report – 2020/21 Quarter 4

(a) that this report provides a summary from two key reports:

i. CCDHB and HVDHB's Ministry of Health (MoH) Non-Financial Quarterly Monitoring Report for Q4 2020/21 (April to June 2021).

ii. CCDHB and HVDHB's Q4 2020/21 Health System Plan and Vision for Change dashboard.

(b) that for the 56 indicators rated by MoH this quarter, CCDHB received 1 'Outstanding' rating, 30 'Achieved' ratings, 18 'Partially Achieved' ratings and 7 'Not Achieved' ratings. This is an improvement on CCDHB's Q3 result.

(c) that for the 56 indicators rated by MoH this quarter, HVDHB received 1 'Outstanding' rating, 28 'Achieved' ratings, 19 'Partially Achieved' ratings and 8 'Not Achieved' ratings. This is similar to HVDHB's Q3 result.

(d) that specific action plans are in place to improve performance against the 'Not Achieved' performance measures, including strategies to improve our immunisation and smoking cessation advice results.

(e) that the recommissioning of immunisation services is now being considered, alongside quality improvement initiatives.

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(f) overall results for CCDHB and HVDHB demonstrate:

i. performance deterioration in immunisation targets reflecting the impact of a timing change in the age for MMR immunisations and a greater number of declines to vaccination offerings;

ii. a community health system delivering well for the majority of indicators with a persistent pressure points posing challenges; and,

iii. a hospital system working hard under the pressures of increased seasonal acute demand and bed pressures.

(g) that both CCDHB and HVDHB received 'Outstanding' ratings for the 'Engagement and obligations as a Treaty partner' indicator, which is recognition of our efforts in this area.

(h) that both CCDHB and HVDHB improved their performance rating for the 'Shorter Stays in Emergency Departments' indicator, which moved from a 'Not Achieved' rating in Q3 to a 'Partially Achieved' rating in Q4.

(i) that the recent Alert Level 3 and 4 lockdown period is likely to impact performance in the Q1 2021/22 results, as some activities cannot be performed during lockdown and resources have also been temporarily diverted into swabbing and vaccination efforts.

Item 4.2: Central Region Eating Disorder Service

(a) the contents of this report

Item 4:3: Homelessness, health and COVID-19

(a) This update on homelessness and how the 2DHBs contribute to addressing this important issue.

(b) Homelessness is part of a wider issue in a housing continuum that faces significant challenges. Working towards a solution requires coordinated cross agency collaboration.

(c) A strategic priority project around emergency housing is a priority this year. Emergency housing is considered a subset of homelessness.

Impact of primary care on acute demai

2DHB Covid programme - 29 Sep

Notes:

- The Chair summarised the reports considered by the Committee.
- The Chair noted ICU capacity and discussed staffing challenges and the impact of Covid on other hospital operations.
- Noted the contribution of our public health staff to contact tracing in Auckland.

	Moved	**Seconded**	
HVDHB	Josh Briggs	Wayne Guppy	**CARRIED**
CCDHB	Sue Kedgley	Kathryn Adams	**CARRIED**

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3.2 DSAC UPDATE FROM MEETING DATED 29/09/21

Board member (and DSAC member) Yvette Grace spoke to the paper.

The Boards noted:

(a) The papers are in the Diligent Board book for the HSC meeting dated 29 September 2021.

(b) DSAC received reports and noting recommendations on the following:

Item 2.1 Locality Community Mental Health Development (Strategic Priority: Community Mental Health Networks)

(a) the purpose of the Community Mental Health and Addiction (MHA) Change Programme (the Programme) is to design, and implement integrated, place-based, MHA services for the Hutt Valley, Wellington, Kāpiti and Porirua that are operational by 30 June 2022.

(b) the Programme is part-funded by Ministry of Health investment and is one of three MHA strategic priorities for delivery in the 2021/2022 financial year, as our DHBs transition to a new health and disability system.

(c) the first stage of the Programme is the MHAIDs-led 3-month Te Haika/Crisis Response project to address immediate pressures in our 24 hour call centre and intake/triage services and will consider our community mental health teams' structure.

(d) Te Rangapū Ahikaaroa, our memorandum of understanding with Ngāti Toa Rangatira and Te Āti Awa ki te Upoko o te Ika a Māui , is our platform for partnering to design and develop community MHA services for Māori, noting that staff are to ensure the same connections are made with other iwi in the sub region

(e) the Mental Health and Addiction Commissioning Forum will provide Programme governance and the design process will implement the Pro-Equity, People-based Commissioning Policy to understand and address inequities for our priority populations.

the enablers for the Programme design and implementation – our evolving partner, provider and stakeholder MHA networks, including the Lived Experience Advisory Group.

Item 3.1 - MHAIDS Service Performance Update

(a) the attached report from MHAIDS.

Item 3.2 – 3DHB Sub Regional Disability Strategy 2017 – 2022 Update

(a) This report provides DSAC with an update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

2DHB Covid programme DSAC 2{

Community MHA Networks presnetati

WrDHB Covid Programme.pptx

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Notes:

- Yvette Grace noted the DSAC papers and outlined the matters at the meeting
- On behalf of the committee, Yvette requested that item 2.1 (d) is amended from what was passed at the Committee – to include the additional wording in the resolution (shown in underlined text) to make it clear that the consultation will be with all iwi groups in the sub-region (and is not only the 2 groups in the MOU referred to). This addition to (d) was accepted by the leave of the meeting- and the motion accepted by the Boards (refer below)
- It was noted that the MHAIDS service report shows a system under distress, in particular the increase in demand for youth and staffing vacancies. Some are national and not just local. Noted there would be a report which includes mitigation measures at the DSAC meeting on 24 November 2021.

	Moved	**Seconded**	
HVDHB	Yvette Grace	John Ryall	**CARRIED**
CCDHB	Kathryn Adams	Sue Kedgley	**CARRIED**

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**	
HVDHB	Yvette Grace	Ria Earp	**CARRIED**
CCDHB	Brendan Boyle	Roger Blakeley	**CARRIED**

5 NEXT MEETING

Date: 3 November 2021, **Location:** Auditorium, Level 1 Clock Tower Building, Hutt Hospital
Time: 9.30am

The public meeting concluded at 10.05am

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2021

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 3 NOVEMBER 2021

Action Number	Date of meeting	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status
21-P03	7-Apr-21	Chief Digital Officer	In progress		Board - Public	3.2	Māori Health Strategy Reporting	Māori data sovereignty paper to be shared with Board when it is appropriate.	The issue is still a work in progress with all regional Directors Māori, Iwi, and the Ministry of Health continuing discussions. The Executive will advise on any developments.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 24 September 2021 to 21 October 2021.

2 COVID-19 Update

2.1 Current cases (as at 26/10/2021)

	2DHB	HVDHB	CCDHB
Number of active cases	0	0	0
Number of recovered cases	135	24	111
Number of cases deceased	2	0	2
Total number of cases	137	24	113

2.2 Testing – total tests and people served (from 18/08/2021 to end 25/10/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Total tests processed	5,492	4,316	43,323	1,267	867	6,898	4,225	3,450	36,425
Total people tested	4,582	3,538	36,267	1,175	785	6,457	3,447	2,773	30,012

2.3 Testing – 2DHB people served (from 18/08/2021 to end 25/10/2021)

	2DHB			HVDHB			CCDHB		
	Māori	Pacific	Other	Māori	Pacific	Other	Māori	Pacific	Other
Est. domiciled population tested	6.4%	9.5%	8.5%	5.1%	7.6%	6.6%	7.4%	10.6%	9.3%

2.4 Vaccination –2DHB providers delivery (from 22/02/2021 to end 25/10/2021)

	2DHB	HVDHB	CCDHB
Total doses administered	654,135	195,780	458,349
Total people served	364,403	112,295	258,213

2.5 Vaccination – 2DHB people coverage (from 22/02/2021 to end 25/10/2021)

	2DHB		2DHB	
	1st Dose Delivery	Est. 1st Dose Coverage	Complete Course Delivery	Est. Completed Course Coverage
Māori	34,622	75%	25,388	55%
Pacific	23,150	80%	18,034	62%
65+	62,702	96%	59,325	91%
Other	302,468	93%	253,353	78%
Total	360,240	90%	296,775	74%

2.6 Vaccination coverage of DHB workforce (from 22/02/2021 to end 25/10/2021)

	CCDHB	HVDHB
1st Dose	93%	95%
Complete course	90%	90%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

The main focus for the past month has been ongoing engagement, outreach and events for the COVID-19 vaccination programme.

For Super Saturday, held on 16 October, the 2DHB vaccination team ran briefing sessions for MPs and local government leaders, and arranged attendance at events across the region for the Prime Minister, Ministers, and MPs.

We also met with the region's Mayors at the Mayoral Forum on 15 October to discuss the vaccination rollout, COVID preparedness planning and provided an introduction to the 2DHB hospital network programme.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	Research/endocrine	Rare endocrine disorders research.
2DHB	COVID-19	Pitch – Super Saturday COVID-19 vaccination events and interviews.
2DHB	COVID-19	PR – Porirua youth-led COVID-19 vacination festival.
2DHB	COVID-19	PR – Super Saturday COVID-19 vaccination events.

3.3 Health promotion campaigns

COVID-19 vaccination programme

As at 18 October, the 2DHBs have now reached significant milestones with 88 per cent of people in the greater Wellington region having received at least their first dose of the vaccine, and at least 68 per cent of people fully vaccinated.

We continue to support the Ministry of Health's nationwide rollout with local and regional communication via digital channels, media, events, and targeted engagement for Māori, Pacific people, and the disabled community.

There are now around 60 clinics operating in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites. The vaccination programme to 18 October is delivering at 134 per cent against plan. The number of people fully vaccinated has increased significantly as the bubble of people who received their first dose during alert levels 3 and 4 returned for their second dose.

The focus has now turned towards reaching those who remain hesitant about getting vaccinated or who have not yet engaged with the programme at all. We are working with Māori and Pacific providers, PHOs, pharmacies and partners to create opportunities and events where people feel safe asking questions and seeking more information, as well as taking the vaccine into communities with larger numbers of unvaccinated people. We are also increasing engagement with local leaders who have the ability to reach into groups within their communities.

Super Saturday

Saturday 16 October – Super Saturday – was designated a national day of action for vaccination across the country and everyone involved in rolling out the vaccine pulled out all the stops to get people to get vaccinated or encourage their friends and whanau to consider getting vaccinated. Local businesses, sports teams and community organisations joined the effort, providing sausage sizzles, hangi, giveaways, entertainment and more to thank people for getting vaccinated.

Teams across the greater Wellington region administered more than 13,500 doses of the vaccine, smashing the previous daily record in the region of 5,666. Just over 20 per cent of these were first doses. Targeted follow-up events are now being organised based on the data we have around first doses, locations of unvaccinated people and the popularity of different kinds of events.

Considering slower vaccination rates in younger age groups, reaching young Maori and Pacific people is a key focus overall. On Super Saturday, the 'Do it 4 the East' event in Porirua proved particularly popular and showcased the role young people can and are taking in encouraging their peers to get vaccinated.

"It's about reaching the community in a way that's fit for purpose," said 22-year-old Jaistone Finau, one of the organisers. "The festival is a bit more fun and allows people to engage properly on the same level when it comes to having someone to talk to."

Kapiti's Ngapera Parata, 18, was also out and about.

"If people say why should I be vaccinated, or why are you vaccinated, I just say 'if you want our people to be heard, be present and be here forever, this is a place to start'. It's really helped, and that's kind of what changed my own mind."

Supporting our equity populations

Work continues with the vaccination programme's equity leads to provide supporting communications and engagement, including outreach and events, for Māori, Pacific, and disabled communities.

Māori-led clinics provide a kaupapa Māori approach to vaccinating, incorporating an all-of-whānau approach under the 'trusted faces in trusted places' model. As at 18 October 2021, at least 73 per cent of Māori in the greater Wellington region have received at least their first dose, while 50 per cent are fully vaccinated. These are highest figures of any of the DHBs across the country and ahead of the national figures of 66 per cent and 44 per cent.

Māori health partners and providers continue to operate community clinics across the region and are starting up mobile initiatives to target specific communities with large numbers of unvaccinated people. They are also running a series of hui focused on sharing accurate and persuasive information about COVID-19 and the vaccine, using local GPs, scientists and people who experienced COVID-19 to answer any questions people may have.

The Pacific Health team working alongside Pacific providers and PHOs are focusing on reaching young people. As at 18 October, 78 per cent of Pacific people in our region have received at least one dose of the vaccine and 58 per cent are fully vaccinated.

Feedback from the disability community has shown that the accessible and low sensory events have encouraged many people who would otherwise not have been vaccinated to do so.

One client said: "I couldn't be happier with the process we went through at the Autism Petone site to get our vaccinations. My son has never successfully had a vaccination and with a small wrestle we got it done and he was very calm afterwards. The attitude of the staff there was brilliant."

The same principles are being applied to engaging with the Rainbow community, providing pronoun cards to help foster more comfortable conversations when confirming their identity and working with organisations that are trusted within their communities.

Going mobile

As part of the next phase of the vaccination programme, we are focusing on people who are harder to persuade and reach. A great deal of effort is going into engagement with hesitant Maori and Pacific people, and going mobile allows the vaccination teams to go wherever there are low immunisation rates.

One of these initiatives is the 'Delta Buster'. Launched on Super Saturday, it is the Hutt Valley's first mobile vaccination service and is a collaboration between the Kōkiri Marae Keriana Olsen Trust and Te Awakairangi Health Network PHO in association with the Hutt Valley DHB and the Capital & Coast DHB COVID-19 Response, and supported by Metlink.

Teresea Olsen, General Kokiri Marae Keriana Olsen Trust said the Delta Buster will help raise the profile of vaccinations with whānau in the Hutt Valley.

"We know that it's hard for some whānau to get around and make appointments so we want to take the leg work out for them with this mobile based service. Having a uniquely Hutt-styled bus should help give us visibility in the community and encourage more people to get vaccinated."

The name was gifted by rangatahi Kimihia Tangianau. Kimihia was raised around the marae attending kohanga, kura kaupapa and is now working alongside the team at Wainuiomata Marae Clinic. She is also teaching Te Reo and has represented New Zealand in softball.

The location of the bus over the coming weeks will be determined by suburb data that shows where the highest numbers of unvaccinated Maori and Pacific people reside.

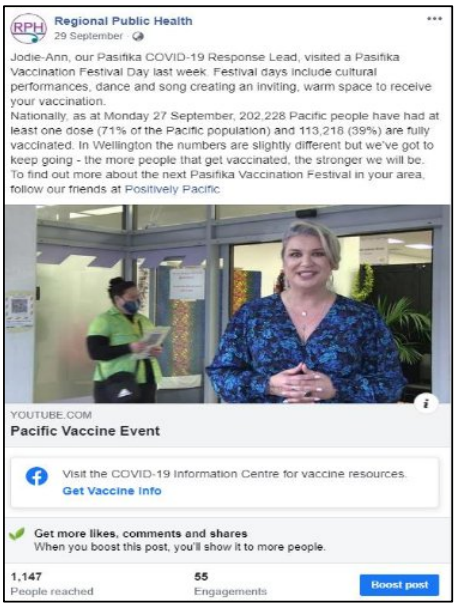
3.4 Social media views and stories

RPH Activity update

The last month has seen the RPH comms focus supporting vaccination activity in our region. This included profiling events in our communities alongside promoting the work of our contact tracing and case management teams. This was capped off with an interview by Dr Annette Nesdale, Medical Officer of Health on TVNZ Breakfast.

Our staff in our communities supporting vaccination initiatives

Jodie-Ann Webster and Sue Martin promoting vaccination events.

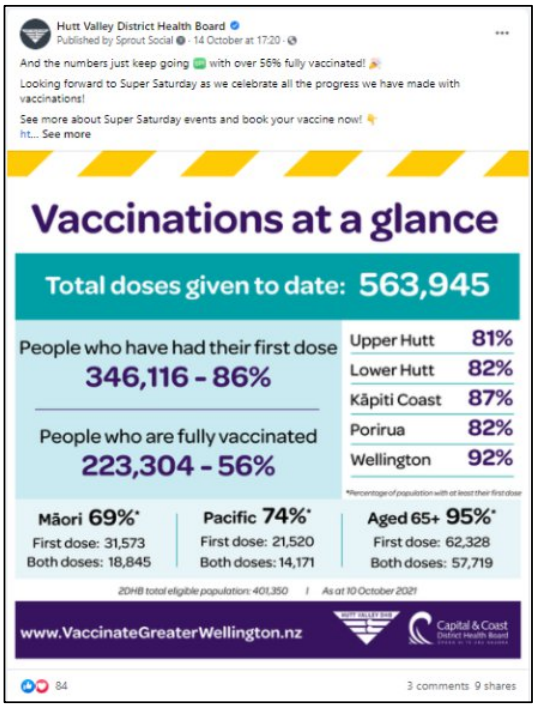


Dr Annette Nesdale Interview on TVNZ Breakfast

Annette was interviewed by John Campbell and did a fantastic job to cover off important RPH key messaging:

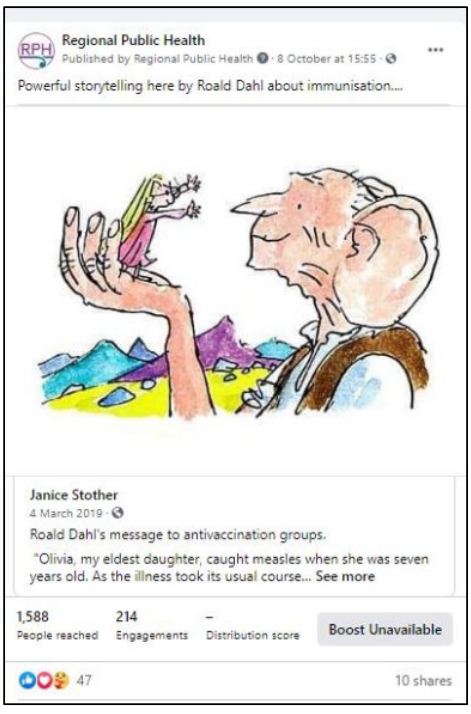
- how public health units across New Zealand have been supporting Auckland and Waikato with the Delta response
- the importance of using the NZ COVID and how it speeds up contact tracing efforts
- the intricacies and mystery solving involved in contact tracing
- being respectful to the complexities in individual's lives
- promotion of using the NZ COVID Tracer app and getting vaccinated.

Top social media posts



Other vaccination posts

One example of many posts support Super Saturday on the left. On the right – sharing a post about the story of author Roald Dahl (vaccination advocate) and his daughter's battle with measles – got a suprising amount of engagement.



CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 481,763 Twitter: 24,392 LinkedIn: 15,486	Facebook: 128,858 Hutt Maternity Facebook: Twitter: 3,160 Instagram: 5,565 LinkedIn: 12,030	Facebook: 17,777

3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
page views: 93,000	page views: 21,000	page views: 26,000	page views: 7,400

Our website continues to be a strong source of information to the public, with the pages most commonly visited shown below.

Top five webpages CCDHB

- Exemptions for face coverings (masks)
- Careers with CCDHB
- COVID-19 changes to our services
- COVID-19 CBACs
- CCDHB Postgraduate Nursing Funding Application 2022

Top five webpages HVDHB

- COVID-19 CBACs
- COVID-19 Visitor information
- Hutt Hospital Campus Map
- Careers with HVDHB
- Contact Us

Top five webpages RPH

- Super Satuday Vaccinations
- Getting vaccinated
- Coronavirus (COVID-19) frequently asked questions
- The COVID-19 Vaccine rollout in Greater Wellington
- Getting vaccinated in Wellington, porirua, the Hutt Valley, & Kāpiti

Top five webpages MHAIDS

- Do you, or does someone you know, need help now? Contact Te Haika
- Community Mental Health Teams (General Adult)
- Child and Adolescent Mental Health Services (CAMHS and ICAFS)
- How to contact our services
- Central Region Eating Disorder Services (CREDS)

3.5.1 Website stories and releases

Our People

Commissioning and Community

Community groups help get mask poverty sewn up

Local DHBs and community health providers have come together to make and distribute free cloth face masks to help tackle mask poverty.

Members of the Pomare Sewing Group, the Common Unity Project Aotearoa, plus local groups in Petone and Porirua, and in Rimutaka Prison, have sewn 4000 reusable masks so far as part of a project organised by Hutt Valley DHB and Capital & Coast DHB over recent weeks.

The project initially saw the distribution of 16000 disposable masks throughout Wellington, Hutt Valley and Porirua as a first phase response to the announcement of mandatory mask wearing as part of the recent lockdown.

Hutt Valley DHB and Capital & Coast DHB Māori Health Service Planning & Integration Managers Korena Wharepapa-Vulu & Anita Tagget helped co-ordinate the project. The aim was to get as many masks out in to the community by using local community provider as distribution and collection points for those in need and help alleviate any mask poverty.

Phase 2 was about finding a sustainable alternative solution by approaching local community groups to source materials and sew reusable ones.

“We wanted to be able to look after our whānau, and our whenua,” Korena said.

Established community groups, such as Kōkiri Marae Health Services, Te Rūnanganui o Te Āti Awa, Pacific Health Service, Nāku Ēnei Tamariki and many other local providers throughout the region, all contributing to the distribution of masks through their services with a focus on supporting Māori, Pacific and disabled peoples.

Day in the life of a vaccination clinic team

This year has seen primary healthcare providers swing into action to deliver the largest vaccination campaign in history.

When Rachel Dunn joined Primary Health Organisation (PHO) Te Awakairangi Health Network (Te AHN) as a project manager, she didn't imagine she would be setting up first testing facilities and then vaccination centres. Now she has oversight of two vaccination centres in the Hutt Valley, including a centre set up in May this year in a former Postie Plus on Hutt High Street.

"We had 11 days to turn it into a clinic – get the power on, clean the ventilation systems, and make it fit for purpose," explains Rachel. "We ran the first clinic for Group two for greater Wellington, so everyone learned from us."

The clinic runs seven days a week, and can vaccinate up to 800 people daily. Around 25 staff will be needed to operate the clinic on a busy day, working as greeters, administrators, receptionists, clinical and operations leads, and of course vaccinators, who also take turns 'drawing up' the vaccine and observing people for any potential side effects.

Working collaboratively with other PHOs and their medical practices, the two DHBs, Māori providers, Pacific providers, and pharmacies, different initiatives have been introduced to make it as easy as possible for people to be vaccinated. "Together, we run a wide variety of different clinics, from Pacific festival days to rainbow community clinics, various disability clinics, drive through clinics, and school holiday clinics offering prizes to teens," says Rachel.

"We've had great feedback from people who've come through our clinics. Staff are really accommodating and will do whatever it takes to help someone get vaccinated."

The best part of her job is "seeing people who are hesitant or worried about getting their vaccinations come in, being immediately looked after and welcomed, and leaving happy – and coming back for their second dose."

Like other PHOs and community healthcare providers, Te AHN also offers in-home vaccinations and, as the campaign progresses, plans to take mobile clinics into communities where vaccination rates are low. “We’ve found the majority of people who would come to a booked appointment have done so, and now it’s about going out and reaching those who can’t or won’t come to a clinic.”

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
page views: 217,284	page views: 76,000

Te Rerenga Ora Blood and Cancer Centre opening

Our People Commissioning and Community

The centre celebrated its official opening Friday after two years of construction.

The Te Rerenga Ora Blood and Cancer Centre celebrated its official opening Friday after two years of construction. The project has encompassed work on multiple wards including the Grace Neill Block Level 3 Day ward Matūtū and this centre. A special Whakanoa, a blessing of the new centre was given this morning.

Executive clinical director of Wellington Blood and Cancer, David Hamilton thanked all the various people involved and recognised staff who worked through the construction, clinicians, and contractors Naylor Love for their resilience in working in a clinical space.

The team would also like to extend thanks to Māori advisors Peter Jackson, Rawiri Hirini, and Arawhetu Gray for gifting the Te Reo Māori names and concept, lead architect Chow Hill, project managers Ann Boland and Paula van Raalte (Kensway) for the writing and delivery of this plan, and the ISS cleaners for their flexibility.

Special thanks to Jim Wiki for commissioning the artwork that will serve as a reminder of the journey and the challenges of a cancer patient and the beauty of the Wellington ecosystem.

Pacific-focused vaccination clinic builds trust

Dr Esela Natano talks about Pacific Health Plus' vaccination clinic and Tuvalu Language Week

Pacific Health Plus (PHP) is a primary care provider based in Porirua, supporting around 2000 local residents who are mainly of Pacific descent. It also runs a COVID-19 vaccination clinic out of Freedom Church Porirua, again mainly aimed at Pacific Peoples.

PHP is just one of the providers that the 2DHBs are working with to make sure that the communities we serve have access to information about the vaccine, and the chance to protect themselves against COVID-19.

A relationship of trust with the community meant that PHP was a natural choice to run a vaccination clinic that was local and easy to access for Pacific People, and could offer vaccinations in a culturally-appropriate setting. "Trust is a big thing – going to someone that you know and trust for your healthcare," says Dr Esela Natano (pictured left), who is one of the provider's general practitioners, as well as a clinical leader."Offering care in a familiar place means people are much more likely to attend their appointments, not only for vaccinations, but also for our diabetes and eczema clinics."

During the pandemic, PHP has also been supporting its community by offering COVID-19 swabbing and educational advice, as well as its primary healthcare services. Meanwhile its community arm has been providing food, and food vouchers, to the community, thanks to the financial help offered by Whānau Ora.

3.6.2 Staff posters

We produced a range of posters for staff to highlight key work programmes.

3.6.3 Top Intranet stories

2021 Ngā Tohu Angitu/Celebrating Success Awards

Our annual Ngā Tohu Angitu Celebrating Success Awards recognise and celebrate the work our people do to improve the health of our community.

Entries have now closed for both the Hutt Valley and Capital & Coast DHB awards, with judging of categories almost complete. 74 nominations were received at Hutt Valley and 160 at Capital & Coast. Judges once again commended the high quality of the nominations.

The team made a particular effort to invite nominations from and of a wide range of healthcare staff – those based in hospital services (including as a volunteer) and those based in the community (including those in primary care, NGOs or other partner organisations).

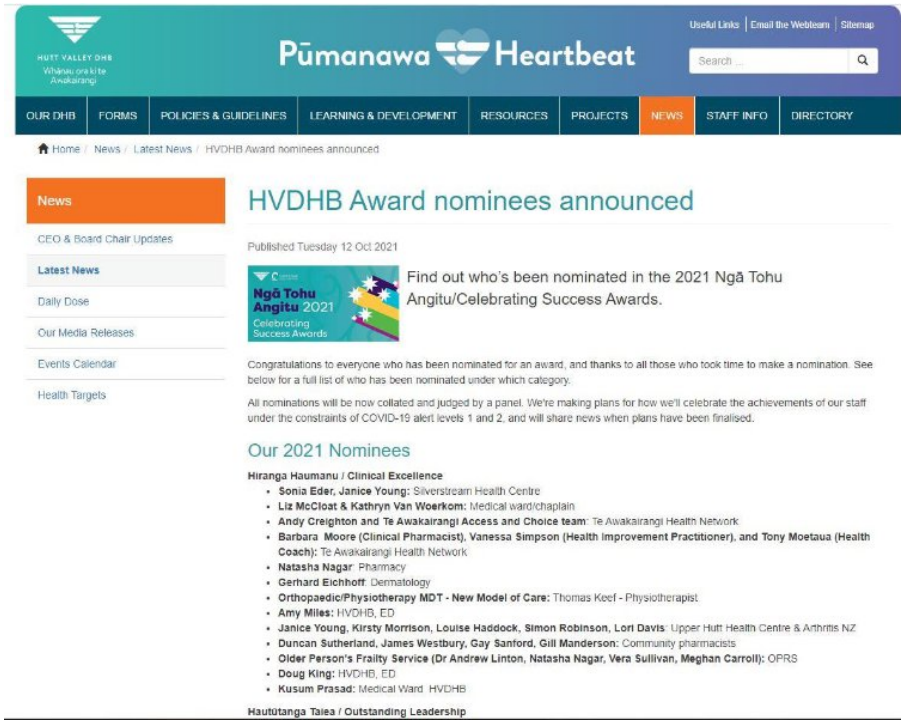
The award categories vary between each DHB, but both aim to celebrate the mahi of those working at all levels for the health of our community. A full list of the awards across the 2DHBs is below:

- Living Our Values
- Outstanding Leadership
- Excellence in Innovation, Improvement and Future Thinking
- Clinical Excellence
- Excellence in Community Health and Wellbeing
- Excellence in the Workplace
- Outstanding Contribution by Non-Clinical Staff
- 2DHB Champion of Collaboration and Integration
- Volunteer of the Year
- Outstanding contribution to nursing
- Outstanding contribution to Allied Health, Scientific & Technical
- Outstanding contribution to the medical profession
- Outstanding contribution to midwifery

As it is unlikely to be possible to hold a large physical awards ceremony this year due to COVID-19 restrictions, we are considering alternative ways to celebrate the achievements of our people using a mix of team celebrations and digital tools.

The awards sit within Celebrating Success Week, a broader celebration of organisational success. Activities planned include ELT walk-arounds, a photo action, a ‘wall of fame’ listing all nominees

placed in high-traffic areas, and resources supporting people leaders to hold smaller celebrations with their teams.



Pūmanawa Heartbeat

Useful Links | Email the Webteam | Sitemap

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OUR DHB | FORMS | POLICIES & GUIDELINES | LEARNING & DEVELOPMENT | RESOURCES | PROJECTS | NEWS | STAFF INFO | DIRECTORY

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News

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- Latest News
- Daily Dose
- Our Media Releases
- Events Calendar
- Health Targets

HVDHB Award nominees announced

Published Tuesday 12 Oct 2021

Ngā Tohu Angitu 2021 Celebrating Success Awards

Find out who's been nominated in the 2021 Ngā Tohu Angitu/Celebrating Success Awards.

Congratulations to everyone who has been nominated for an award, and thanks to all those who took time to make a nomination. See below for a full list of who has been nominated under which category.

All nominations will be now collated and judged by a panel. We're making plans for how we'll celebrate the achievements of our staff under the constraints of COVID-19 alert levels 1 and 2, and will share news when plans have been finalised.

Our 2021 Nominees

Hiranga Haumanu / Clinical Excellence

- **Sonia Eder, Janice Young:** Silverstream Health Centre
- **Liz McCloat & Kathryn Van Woerkom:** Medical ward/chaplain
- **Andy Creighton and Te Awakairangi Access and Choice team**: Te Awakairangi Health Network
- **Barbara Moore (Clinical Pharmacist), Vanessa Simpson (Health Improvement Practitioner), and Tony Moetaua (Health Coach):** Te Awakairangi Health Network
- **Natasha Nagar**: Pharmacy
- **Gerhard Eichhoff**: Dermatology
- **Orthopaedic/Physiotherapy MDT - New Model of Care:** Thomas Keef - Physiotherapist
- **Amy Miles:** HVDHB, ED
- **Janice Young, Kirsty Morrison, Louise Haddock, Simon Robinson, Lori Davis**: Upper Hutt Health Centre & Arthritis NZ
- **Duncan Sutherland, James Westbury, Gay Sanford, Gill Manderson:** Community pharmacists
- **Older Person's Frailty Service (Dr Andrew Linton, Natasha Nagar, Vera Sullivan, Meghan Carroll):** OPRS
- **Doug King:** HVDHB, ED
- **Kusum Prasad:** Medical Ward HVDHB

Hautūtanga Taiea / Outstanding Leadership

2DHB BOARD WORK PLAN 2021/2022 – 3 November 2021

	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
	WLG Hospital	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight	**Cardiology**	**TBC**	**TBC**	**TBC**	**TBC**
Quality and Safety/Health and Safety					
2DHB Quality and Safety	2DHB Quality and Safety Report	2DHB Quality and Safety (and selected focus area)	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report (and selected focus area)
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting					
Financial and Operational Performance HVDHB	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022
Financial and Operational Performance CCDHB	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022

	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Scheduled reporting					
People and Culture Report	People and Culture Report		People and Culture Report		People and Culture Report
3DHB Digital Report		Q2 Report		Q3 Report	
Māori Strategy (Te Pae Amorangi and Taurite Ora)		Q2 Report		Q3 Report	
Pacific Health and Wellbeing Strategic Plan		Q2 Report and selected focus area (To be advised)		Q3 Report and selected focus area (To be advised)	
Strategic Priorities					
Pro-Equity					
Strategic Priorities Overview	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC work plan for 24 November 2021 – and will be reported to the Boards via HSC or DSAC.*				
Our Hospitals	2DHB Hospital Network				Master Site Plan
	*2DHB Maternal and Neonatal Health System Strategy				
Commissioning and Community	*Complex Care and Long-term Conditions				
	*Inter-sectoral Priorities				
Mental Health and Addiction Services			*Kaupapa Māori and MHA development		

	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Enablers					
Committees					
FRAC items for Board Approval	FRAC items for Board Approval from meeting dated 26/11/21		FRAC items for Board Approval from meeting dated 03/03/22	FRAC items for Board Approval from meeting dated 27/04/22	FRAC items for Board Approval from meeting dated 01/06/22
MCPAC update	MCPAC update from meeting dated 26/11/21		MCPAC update and items for approval from meeting dated 3/03/2022	MCPAC update and items for approval from meeting dated 27/04/2022	MCPAC items for Board Approval from meeting dated 01/06/22
HSC update and items for Board Approval	HSC update and items for approval from meeting dated 24/11/21		HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval	DSAC update and items for approval from meeting dated 24/11/21		DSAC items for Board Approval from meeting dated 16/03/22		
Engagement					
Te Upoko o te Ika Māori Council (TUI MC)	Boards meet with TUI MC		Boards meet with TUI MC		Boards meet with TUI MC
Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group
Annual Planning and Reporting					
Budgets/Annual Plan	Planning process for 2022/2023 – subject to confirmation of process required for HNZ				
Annual Report	N/A				
Other items					
Environmental Sustainability Strategy			Sustainability Strategy update		
Procedural and Board process issues	Delegations for Summer Break				
Action log items					
Other					
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)					
Site Visit	Te Wao Nui/Children's Hospital – **TBC**				

Board information – Public

3 November 2021

HVDHB Financial and Operational Performance Report – August 2021

Action Required

The HVDHB Board notes:

(a) the DHB had a ($0.4m) deficit for the month of August 2021, being $2.5m favourable to budget;

(b) the DHB year to date deficit excluding $0.1m net COVID-19 costs was ($3.7m);

(c) the Funder result for August was $2.6m favourable, Governance $0.1m favourable and Provider ($0.2m) unfavourable to budget;

(d) total Case Weighted Discharge (CWD) Activity was 1% ahead of plan.

Strategic Alignment	Financial Sustainability
Authors	2DHB Chief Financial Officer, Rosalie Percival 2DHB General Manager Operational Finance & Planning, Judith Parkinson 2DHB Director of Provider Service, Joy Farley 2DHB Director Strategy Planning and Performance, Rachel Haggerty
Endorsed by	2DHB Chief Executive - Fionnagh Dougan
Purpose	To update the Board on the financial performance and delivering against target performance for the DHBs
Contributors	Finance Team, Health Intelligence and Decision Support, 2DHB Hospital Services.

Executive Summary

1. The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, revenue has been accrued to cover the costs reported to the Ministry. The net impact to August is additional revenue of $0.1m in relation to Regional Public health.
2. The Ministry have confirmed that holidays Act remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income. The remediation costs have been included in the 2021/22 expenditure budget but no revenue has been budgeted.
3. Excluding the net COVID-19 costs the DHB's result for the two month to 31 August 2021 is a ($3.5m) deficit, versus a budget deficit of ($5.6m).
    (a) For the two month to 31 August 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($3.6m) deficit compared to a budget deficit of ($5.6m). This includes a reduction in IDF outflow of $1.1m in August due to the COVID-19 lockdown.

4. Key underspends in the provider includes: Allied Health personnel, outsourced services and depreciation. In the funder underspends in demand driven costs includes: Community Pharmaceuticals, Other Health of Older People (Other HoP) and other external provider payments.
5. Capital Expenditure to 31 August 2021 was $1.5m with $36.1m remaining including projects that were delayed and funding which has been transferred into this financial year.
6. The DHB has a positive cash balance at month-end of $20.5 million which is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (Maternity upgrade projects and the procedure suit). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

Hospital:

7. The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that, in the constrained environment the DHBs, will not be able to deliver the full planned care funding schedule, nor reduce waiting list size so that people are treated within 120 days.
8. Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment; these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
9. Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
10. With the closure of Te Awakairangi Birthing Centre plans are in development with the staff of Te Awakairangi to support the transition of care. All LMC midwives will be given a letter to give to their women who booked at Te Awakairangi, reassuring them of their transition to Hutt Maternity, should they choose to birth at Hutt hospital. A frequently asked questions and answers letter is also being developed and will be provided to all childbirth educators, this is to reassure women at this challenging and unsettling time. Monthly meetings have been set with the Hutt Maternity Action Trust, as we work in partnership with our community, through regular engagement.
11. Continued workforce shortages across midwifery, nursing, and allied health (in particular, sonographers, social workers and radiographers) remains 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 2D Nursing and Midwifery Recruitment and Retention Strategy was developed to assist with the drive to fill vacancies in workforces at both DHBs, and seek to retain our existing staff.

Funder:

12. Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
13. Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin.
14. A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 75 below plan.
Financial	Planned deficit for HVDHB is $30.8 million with no COVID-19 impacts included.

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
N/A					

Attachments

2.2.1 Hutt Valley DHB Financial and Operational Performance Report – August 2021

Monthly Financial and Operational Performance Report

For period ending
31 August 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, revenue has been accrued to cover the costs reported to the Ministry. The net impact to August is additional revenue of $0.1m in relation to Regional Public health.
- The Ministry have confirmed that holidays Act remediation costs and costs to calculate the remediation and rectify the systems will be funded via additional deficit support not operating income. The remediation costs have been included in the 2021/22 expenditure budget but no revenue has been budgeted.
- Excluding the net COVID-19 costs the DHB's result for the two month to 31 August 2021 is a ($3.5m) deficit, versus a budget deficit of ($5.6m).
  - For the two month to 31 August 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($3.6m) deficit compared to a budget deficit of ($5.6m). This includes a reduction in IDF outflow of $1.1m in August due to the COVID-19 lockdown.
- Key underspends in the provider include; Allied Health personnel, outsourced services and depreciation. In the funder underspends in demand driven costs including; Community Pharmaceuticals, Other Health of Older People (Other HoP) and other external provider payments.
- Capital Expenditure to 31 August was $1.5m with $36.1m remaining including projects that were delayed and funding which has been transferred into this financial year.
- The DHB has a positive cash balance at month-end of $20.5 million which is better than budget due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (Maternity upgrade projects and the procedure suit). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

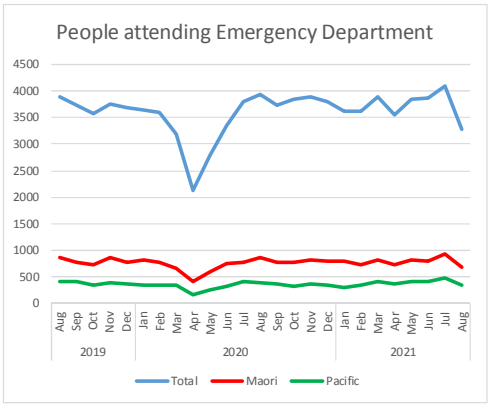
Executive Summary (continued)

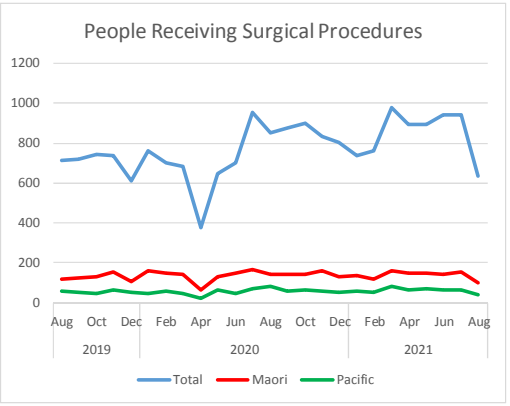
- **Hospital:** The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days.
- Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
- Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- With the closure of Te Awakairangi Birthing Centre plans are in development with the staff of Te Awakairangi to support the transition of care. All LMC midwives will be given a letter to give to their women who booked at Te Awakairangi reassuring them of their transition to Hutt Maternity, should they choose to birth at Hutt hospital. A frequently asked questions and answers letter is also being developed and will be provided to all childbirth educators, this is to reassure women at this challenging and unsettling time. Monthly meetings have been set with the Hutt Maternity Action Trust, as we work in partnership with our community, through regular engagement.
- Continued workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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 2D 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.
- **Funder:** Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin.
- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

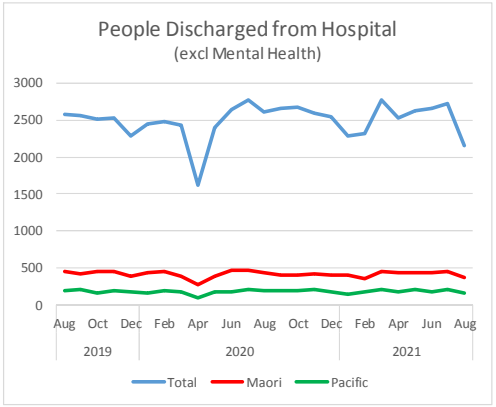
Performance Overview: Activity Context (People Served)

The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. The start of the month was busy but was impacted by the Covid-19 Level 4 lockdown from 16th August. Note Mental Health now reported by CCDHB as they are the DHB of service for MHAIDS

People attending ED	**3,280**	693 Maori, 343 Pacific
People receiving Surgical Procedures	**637**	100 Maori, 38 Pacific
People discharged from Hospital (excl Mental Health)	**2,151**	366 Maori, 157 Pacific







Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

7,719

1,175 Maori, 529 Pacific

Primary Care Contacts

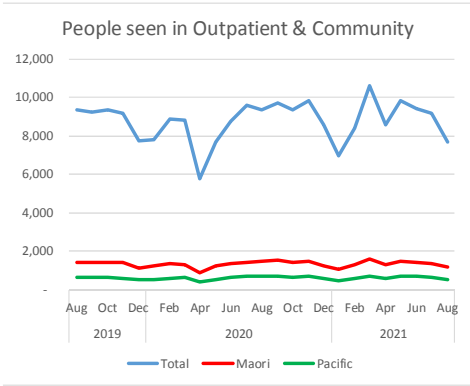
37,011

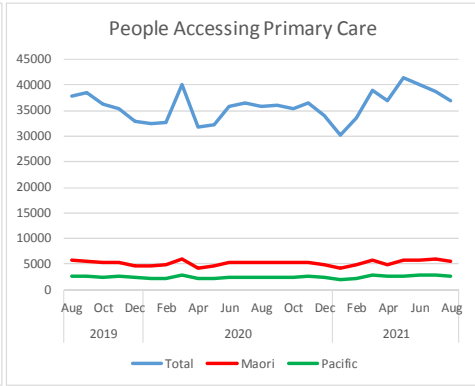
5,452 Maori, 2,721 Pacific

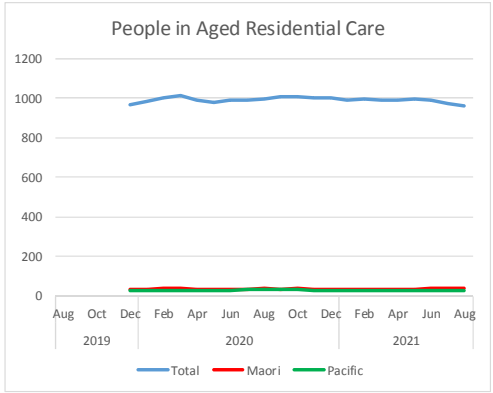
People in Aged Residential Care

960

39 Maori, 27 Pacific







Financial Overview – August 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$3.6.m deficit	$0.1m surplus	$3.9m deficit	$1.5m
Against the budgeted deficit of $5.6m.	Against the budget deficit of $0.8m.	Against the budget deficit of $4.8m.	Compared to a maximum budgeted spend of $36.1m

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
1% ahead	1,848	$22.3m
257 CWDs behind PVS plan for August. IDFs were 119 CWD below budget for the month	YTD 76 FTE below annual budget of 1,924 FTE.	This is an increase of $0.5m on prior period.

Hospital Performance Overview – August 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
81%	1,021	717	67%
14% below the ED target of 95%, and below August 20 87%.	Against a target of zero long waits a monthly increase of 91.	Against a target of zero long waits a monthly increase of 75	We were below the 62 day target this month. The 31 day target was achieved at 97%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
1% ahead	1,840	3
257 CWDs behind PVS plan for August. IDFs were 119 CWD below budget for the month	75 below YTD budget of 1,915 FTE. Month FTE was 74 under budget an upwards movement from July of 23 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a favourable variance of $2.6m for the month, which includes reduced IDF outflow costs of $1.1m due to the COVID-19 lockdown.
- Aged residential care costs are ($215k) unfavourable for the month, Other Health of Older People costs are favourable $183k for the month and Pharmaceutical costs are under $611k for the month.
- Mental Health costs are favourable $47k for the month reflecting timing of contracts which will be rectified with the acute care continuum.
- Engagement with the full set of WCTO visits in the first year of life is challenging. The factors influencing performance are complex and varied, particularly for Māori and Pacific women. A lack of continuity in support throughout the first 1,000 days, exacerbated by ongoing midwifery shortages. Our commissioning team is looking at our learnings from COVID Vaccine Commissioning to see how we can achieve equity using a different commissioning and provider model.
- Poor control of long term conditions are a driver of ASH rates, in particular cardiovascular and respiratory conditions are the top presenting conditions, particularly for Māori and Pacific peoples. To address these areas we are focusing on access to acute care in primary care practices including the focus for diabetes is on upskilling nurses and GPs with regard to the new funded specialist authority medication Empagliflozin. A hui was held to discuss complex patient management with GPs, nurses and MDTs and CVRA screening in Māori and Pacific (particularly males) continues in PHOs through flexible appointment arrangements and Saturday clinics to support prevention and early intervention. We continue to work with our PHOs on new ways to engage and recall Māori and Pacific.
- The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21. We have analysed data across our 2DHB Hospital Network and identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system (see June update). We are responding through a series of targeted performance based projects including ‘front of whare’ and ‘planned care’.
- A Mental Health and Addiction Commissioning Forum has been established to steer the redesign and implementation of a whole of population, equitable, MHA system of care to support the wellbeing of the people in the region. The Commissioning Forum will focus on upholding our Te Tiriti o Waitangi obligations developing a kaupapa Māori approach across the continuum of services and designing services that improve wellbeing and achieve equity for our priority populations: Māori, Pacific people and Disabled people.

Funder Financial Statement – August 2021

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of August 2021

Month					$000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
39,832	39,837	(5)	37,970	1,862	Base Funding	79,664	79,673	(9)	75,939	3,724	478,038	455,083
3,517	2,411	1,106	2,913	604	Other MOH Revenue	5,951	4,822	1,129	5,348	603	28,932	34,030
25	26	(0)	317	(291)	Other Revenue	51	51	0	280	(229)	307	733
9,041	9,557	(515)	9,293	(252)	IDF Inflows	18,598	19,113	(515)	18,464	134	114,678	111,945
52,416	**51,830**	**586**	**50,493**	**1,923**	**Total Revenue**	**104,265**	**103,659**	**606**	**100,032**	**4,233**	**621,955**	**601,791**
					Expenditure							
349	349	0	416	67	DHB Governance & Administration	697	697	0	831	134	4,183	4,652
20,958	21,391	433	21,033	75	DHB Provider Arm	42,449	42,781	333	41,893	(555)	256,689	252,732
					External Provider Payments							
3,727	4,338	611	3,482	(244)	Pharmaceuticals	7,919	8,577	658	6,346	(1,573)	50,057	37,162
4,374	4,448	74	4,216	(159)	Laboratory	8,762	8,897	135	8,853	91	53,169	52,577
2,689	2,684	(5)	2,535	(155)	Capitation	5,400	5,369	(31)	5,239	(160)	32,214	31,021
1,380	1,264	(115)	1,231	(149)	ARC-Rest Home Level	2,535	2,529	(6)	2,487	(48)	14,858	13,871
2,109	2,009	(100)	1,946	(163)	ARC-Hospital Level	3,944	4,017	74	3,811	(133)	23,599	21,724
2,620	2,803	183	2,315	(305)	Other HoP & Pay Equity	5,397	5,606	208	5,027	(371)	33,635	30,335
975	1,022	47	968	(7)	Mental Health	2,034	2,044	10	1,883	(151)	12,265	11,898
2,248	1,982	(266)	2,864	616	Other External Provider Payments	4,507	3,988	(519)	4,650	143	24,403	25,067
10,847	11,991	1,144	8,637	(2,210)	IDF Outflows	24,538	23,982	(556)	17,743	(6,795)	143,894	108,813
52,277	**54,281**	**2,004**	**49,643**	**(2,634)**	**Total Expenditure**	**108,182**	**108,488**	**306**	**98,764**	**(9,418)**	**648,967**	**589,851**
139	**(2,452)**	**2,591**	**850**	**(711)**	**Net Result**	**(3,917)**	**(4,829)**	**912**	**1,268**	**(5,185)**	**(27,012)**	**11,939**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($5k) to budget for the month.
- Other MoH revenue is favourable $1,106k for August.
- IDF inflows ($515k) unfavourable based on information available.

Other MOH Revenue Variance	MTH $000's	YTD $000's
Capitation Funding	113	135
2021/22 Planned Care	-	-
COVID-19 Funding	1,057	1,057
2020/21 Planned Care	55	55
Crown funding agreements		
B4 School Check Funding	(10)	(73)
Additional Immunisation funding	-	-
More Heart and diabetes checks	(5)	(11)
Additional School Based MH Services	0	(19)
Maternity Quality and Safety Programme	(0)	100
Rheumatic Fever Prevention Services	(91)	(100)
Other CFA contracts	13	15
Year to date Variance $000's	**1,106**	**1,129**

Expenditure:

Governance and Administration is on target for August. Provider Arm payments variance includes IDF Inflows passed through to the Provider.

External Provider Payments:

Pharmaceutical costs are favourable $611k for August.

Capitation expenses are ($5k) unfavourable for the month, partially offset by changes to revenue.

Aged residential care costs are ($215k) unfavourable for the month.

Other Health of Older People costs are favourable by $183k for the month and $68k YTD.

Mental Health costs are favourable $47k for the month, partly reversing the trend over the last two months.

Other External Provider Payments are ($266k) unfavourable for the month, driven by COVID-19 related payments of $855k offset by revenue.

IDF Outflows are favourable $1,144k for the month based on available information and impacted by COVID-19 lockdown.

Inter District Flows (IDF)

IDF Wash-ups and Service Changes August 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	0	0
	-	-
	-	-
Wash-ups		
2021/22 Outflows - inpatient	1,039	(661)
	-	-
2020/21 Outflows - inpatient	-	-
2020/21 Outflows - outpatient	-	-
2020/21 Outflows - PCT	(10)	(10)
2020/21 Outflows ATR	-	-
2020/21 PHO	-	-
2020/21 FFS	21	21
2020/21 Community Pharmacy	93	93
Rounding (timing) differences	-	-
IDF Outflow variance	**1,144**	**(556)**

The movement of patients between hospitals generates inter district flows where one DHB funds another for the care provided that cannot be safely provided locally.

IDF inflow (revenue):

- Based on the data available, overall IDF inflows are ($515k) unfavourable for the month.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are favourable for the month $1,144k due to COVID-19 lockdown, unfavourable YTD ($566k) which includes a high cost patient.

Commissioning: Families & Wellbeing

What is this measure?

- Decrease in the ambulatory sensitive hospitalisation rate (0-4 years)
- 95% of children fully immunised at 5 years
- 90% of children have their B4SC completed

Why is this important?

- Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through preventative care and coordinated care in the community and primary care setting.
- Children who receive the complete set of age-appropriate vaccinations are less likely to become ill from certain diseases.
- The B4 School Check aims 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.

How are we performing?

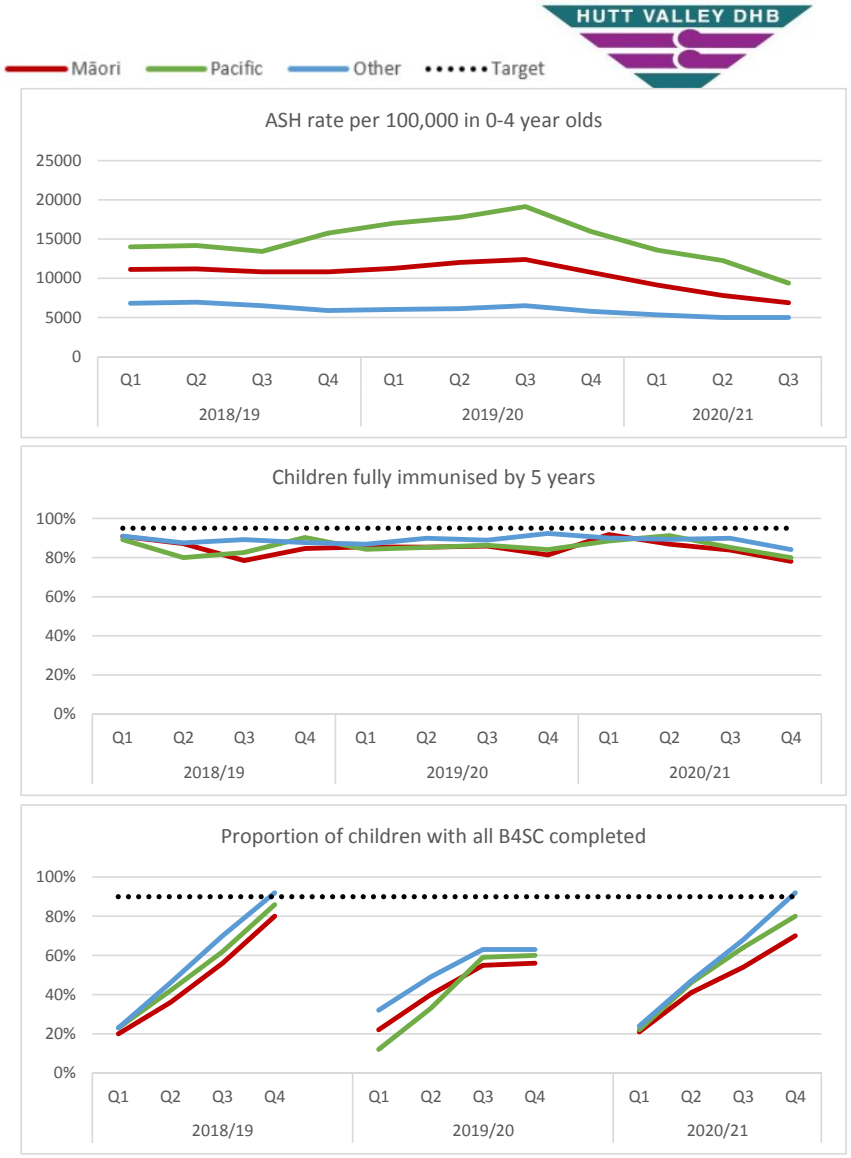
- Performance is 6,862 for Māori, 9,381 for Pacific and 5,008 for non-Māori, non-Pacific.
- Performance is below the 95% target for 5 year old immunisation coverage for Māori (78%), Pacific (80%), and non-Māori, non-Pacific (84%).
- Performance is below the 90% target for children receiving all B4SC checks for Māori (70%) and Pacific (80%), and non-Māori, non-Pacific (92%).

What is driving performance?

- Increases in hand hygiene and border closures have had the most significant impact on reducing ASH rates.
- The 1 October change to the schedule (which changed the two MMR doses from 12 months and 4 years to 12 months and 15 months) may be impacting immunisation coverage. A 2DHB Immunisation Improvement Plan has been developed to drive performance improvement
- Plunket subcontracts part of its service to Ora Toa PHO to meet part of the needs for Tamariki Māori.
- The new regional B4SC coordinator is working to establish relationships with local Māori health and social service providers to improve B4SC performance for tamariki Māori in the Hutt Valley.

Management comment

- Future work in this area includes examining opportunities to raise the profile of, and linkages to, respiratory support services (such as those provided by the Tū Kotahi Asthma Trust) across primary and secondary care.
- Work is underway to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register. HVDHB aims to improve the immunisation rates for this age group by identifying how both providers can be supported to reach families with children still needing vaccinations.
- We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for tamariki Māori.



Commissioning: Primary & Complex Care

What is this measure?

End of life

- % of clients assessed by InterRAI with an Enduring Power of Attorney (EPOA) in place
- % of clients assessed by InterRAI having funded Advanced Care Plan (ACP) consultation

Why is this important?

- An EPOA appoints someone to make decisions about an individual's personal care and welfare on their behalf.
- Advance Care Planning is a voluntary process of discussion and shared planning for future health care. The process assists the individual to identify their personal beliefs and values, and incorporates them into plans for future health care. This may indicate who the EPOA is. The 2DHB ACP aligns with the HQSC's national ACP overarching vision to "Empower New Zealanders to participate in planning their future care." This has a particular focus on removing inequities in healthcare and outcomes for Māori.

How are we performing?

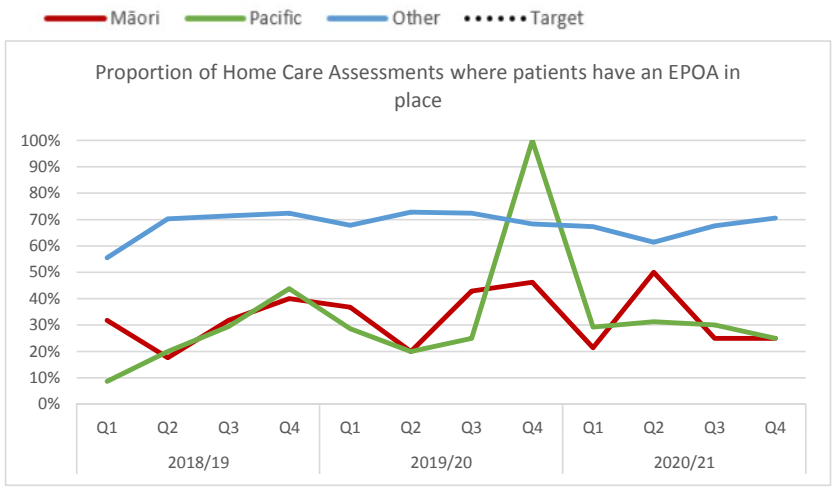
- There are no national or local targets for these performance measures.
- Performance for Home Care Assessments where an EPOA was in place is 25% for Māori, 25% for Pacific, and 71% for non-Māori, non-Pacific.
- Performance for Home Care Assessments with a completed ACP is 0% for Māori, 3.0% for Pacific, and 4.5% for non-Māori, non-Pacific.

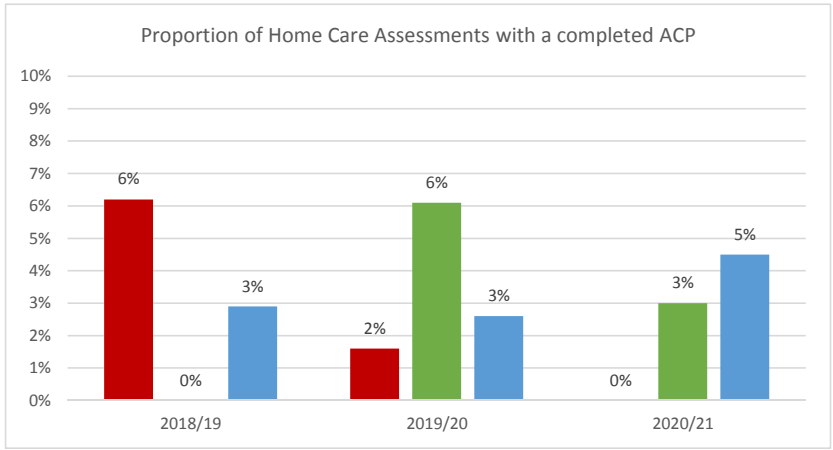
What is driving performance?

- HVDHB is not funded for ACP referrals in the community. We know that investment in our NGOs to support the implementation of ACPs works. NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities.

Management Comment

- The 3DHB ACP coordinator continues engage with key providers of care and community forums across HVDHB to support patients and whanau to complete their ACPS.





Commissioning: Hospital & Speciality Services

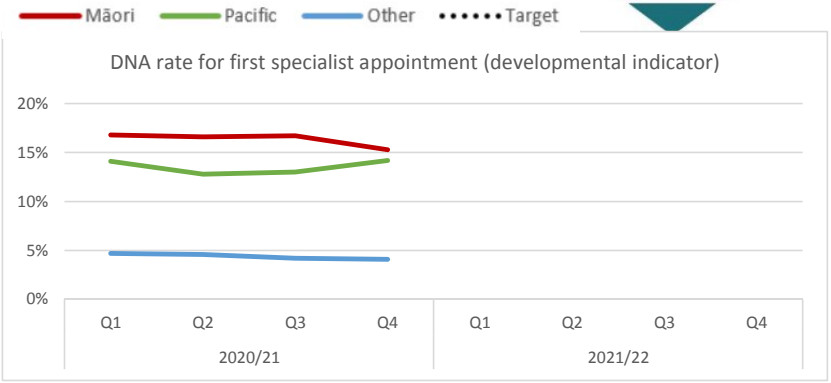
What is this measure?
Planned Care
- Did not attend (DNA) rate for first specialist appointment (FSA)
- 95% of patients with accepted referrals for CT scans will receive their scan and results within 6 weeks
- 0% of patients given a commitment to treatment, but not yet treated within the required timeframe (ESPI 5)

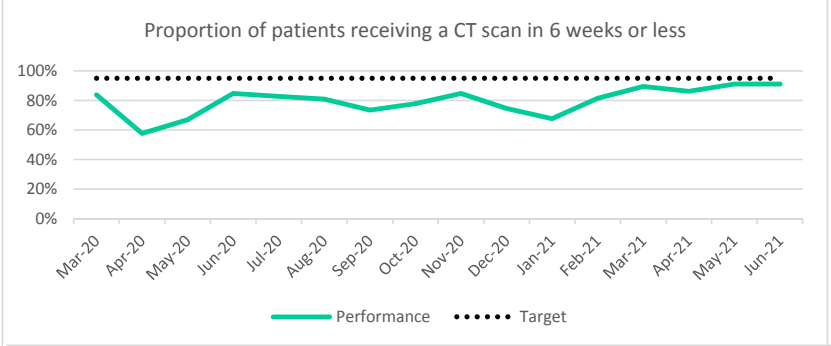
Why is this important?
Equity: patients receive care that safely meets their needs, regardless of where they live and who they are.
Access: patients can access the care they need in the right place, with the right health provider.
Quality: Services are appropriate, safe, effective, efficient, respectful and support improved health.
Timeliness: patients receive care at the most appropriate time to support improved health.
Experience: You and your whānau work in partnership with healthcare providers to make informed choices and get care that responds to your needs, rights and preferences.

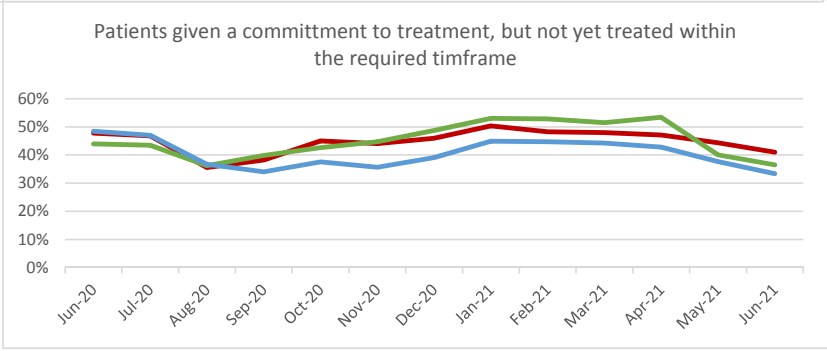
How are we performing?
- The DNA rate for First Specialist Appointments is 15% for Māori, 14% for Pacific and 4% for non-Māori, non-Pacific.
- Performance is below the 95% target for patients receiving a CT scan in 6 weeks or less (91%).
- Performance is above the 0% target for ESPI 5 for Māori (41%), Pacific (37%), and non-Māori, non-Pacific (33%).

What is driving performance?
- There is significantly more activity than planned for this financial year and most of it is acute. The majority of the acute activity is surgical and this is impacting planned care provision.

Management comment:
- We continue to implemented our waitlist recovery plan in July with a MoH set expectation of zero patients waiting longer than 4 months for and FSA or an elective surgical intervention.
- Subsequently the health system has seen significant disruption to service delivery and therefore variation to plan such as
    - Industrial Acton
    - RSV
    - COVID 19 National Alert level 4 and 3







Commissioning: Mental Health & Addictions

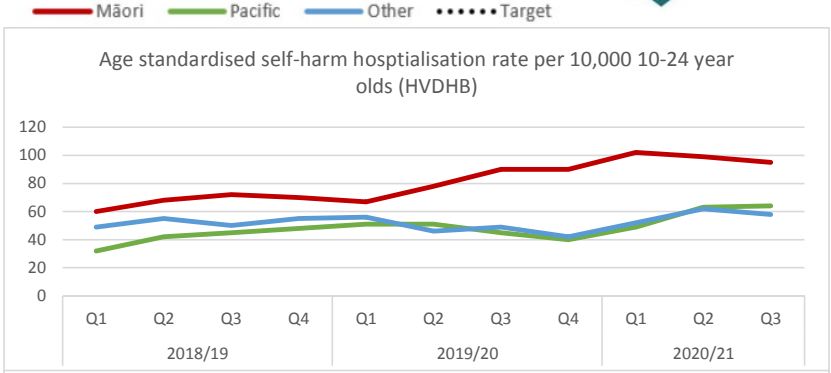
What is this measure?
- Number of self-harm hospitalisations (0-24 years)
- Number of activities delivered via technology-enabled services
- Number of referrals from Access and Choice general practices to specialist mental health services

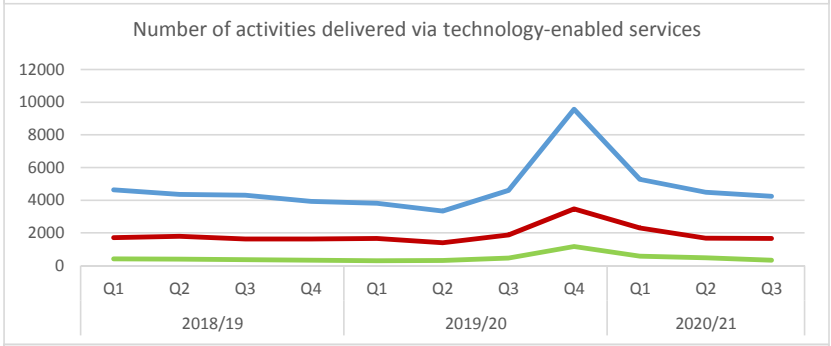
Why is this important?
- Intentional self-harm in young people is indicative of distress. Proactive support for young people includes through primary mental health responsiveness and referral pathways, appropriate secondary care, and cross-sector/community support.
- Technology-enabled services, such as telehealth and video counselling, made it possible for services to be delivered remotely during COVID-19 lockdowns, and are being evaluated as viable long-term options to improve accessibility.
- The Access and Choice service aims to educate people on the specialist mental health services available to them, and how to access them. This enables people to engage and make choices that are right for them.

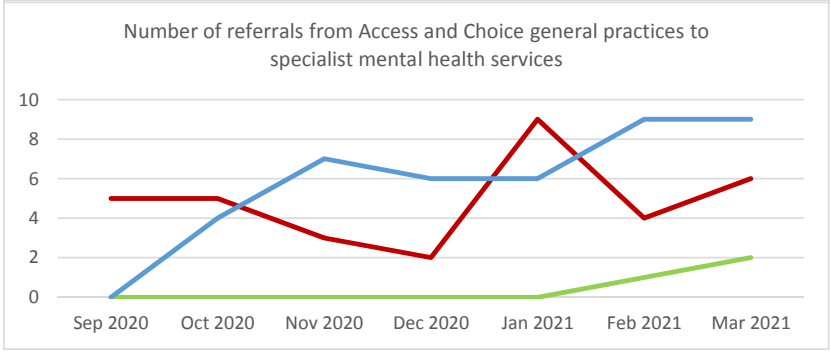
What is driving performance?
- The rate of self-harm hospitalisations per 10,000 10-24 year olds is 95 for Māori, 64 for Pacific and 58 for non-Māori, non-Pacific.
- The number of activities delivered by technology-enabled services was 1,659 for Māori, 323 for Pacific, and 4,244 for non-Māori, non-Pacific.
- The number of referrals Access and Choice was 6 for Māori, 2 for Pacific and 9 for non-Māori, non-Pacific.

What is driving performance?
- Partnerships between PHOs and NGO provider services such as Piki Services contributed to activities that lead to improved performance for 2020/21.

Management comment
- Further improvements are planned following the investment in primary mental health and primary liaison services. We are embedding some of the learnings from our COVID-19 experience.
- We are expanding primary mental health and addiction support across the 3DHBs through the Access and Choice initiative. We are working with Tū Ora Compass Health and our specialist community providers to develop a monitoring framework to evaluate outcomes and ensure equitable access.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination roll-out

Why is this important?

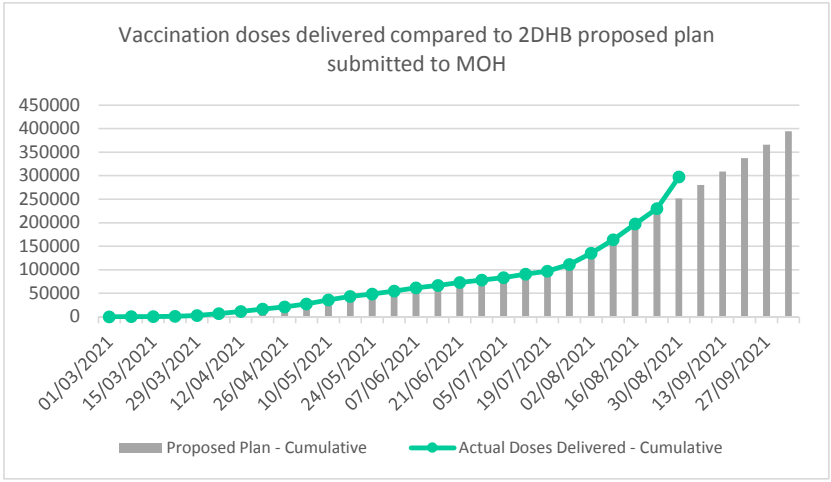
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

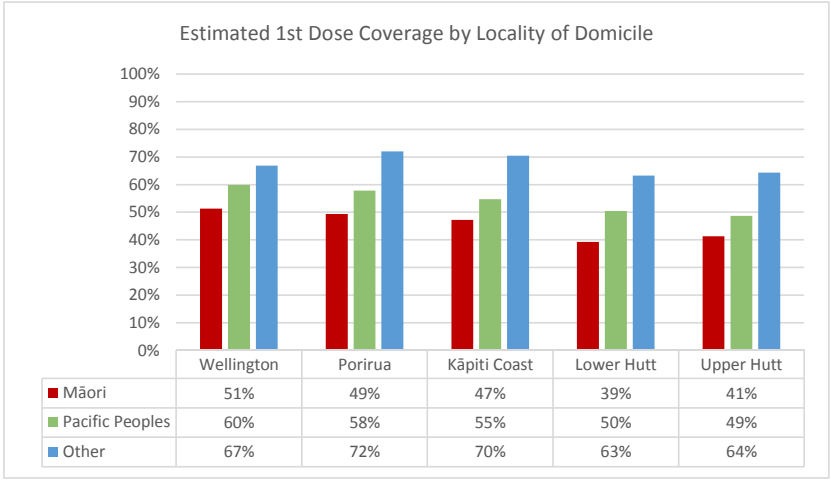
How are we performing?

- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area
- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings
- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

Data and statistics about the rollout of COVID-19 vaccines in CCDHB can be found here.

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 04/08/2021
Data current at: 06/08/2021 @11:00am





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	51%	49%	47%	39%	41%
Pacific Peoples	60%	58%	55%	50%	49%
Other	67%	72%	70%	63%	64%

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days.
- Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
- Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- With the closure of Te Awakairangi Birthing Centre plans are in development with the staff of Te Awakairangi to support the transition of care. All LMC midwives will be given a letter to give to their women who booked at Te Awakairangi reassuring them of their transition to Hutt Maternity, should they choose to birth at Hutt hospital. A frequently asked questions and answers letter is also being developed and will be provided to all childbirth educators, this is to reassure women at this challenging and unsettling time. Monthly meetings have been set with the Hutt Maternity Action Trust, as we work in partnership with our community, through regular engagement.
- Continued workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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 2D 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.
- A cautious start to the new financial year – meeting budget.

Hospital Throughput

Completed for period					Hutt Valley DHB Hospital Throughput YTD Aug-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
843	1,243	400	1,161	318	Surgical	2,105	2,429	324	2,445	340	14,143	13,880
1,779	1,819	40	1,948	169	Medical	3,864	3,577	(287)	3,829	(35)	20,853	22,570
360	361	1	412	52	Other	742	741	(1)	878	136	4,464	5,221
2,982	**3,423**	**441**	**3,521**	**539**	**Total**	**6,711**	**6,747**	**36**	**7,152**	**441**	**39,461**	**41,671**
					CWD							
935	1,270	335	1,251	317	Surgical	2,310	2,507	197	2,548	239	14,879	13,880
946	974	28	990	44	Medical	2,130	1,953	(177)	1,955	(175)	11,317	22,570
395	441	46	433	37	Other	798	903	105	839	41	5,146	5,087
2,276	**2,685**	**409**	**2,674**	**398**	**Total**	**5,238**	**5,363**	**125**	**5,342**	**104**	**31,342**	**41,537**
					Other							
3,711	4,211	500	4,281	570	Total ED Attendances	8,303	8,325	22	8,320	17	49,261	50,206
907	1,010	103	1,017	110	ED Admissions	1,921	2,026	105	2,086	165	11,294	12,086
594	886	292	792	198	Theatre Visits	1,461	1,741	280	1,660	199	10,232	9,587
102	130	28	142	40	Non- theatre Proc	237	282	45	302	65	1,638	1,631
7,477	7,494	17	7,874	396	Bed Days	15,540	14,893	(647)	15,464	(76)	84,357	89,609
4.48	4.55	0.06	4.73	0.24	ALOS Inpatient	4.34	4.55	0.21	4.53	0.19	4.55	4.55
2.17	2.08	(0.10)	2.14	(0.04)	ALOS Total	2.02	2.08	0.05	2.06	0.03	2.08	2.08
7.72%	8.02%	0.30%	7.05%	-0.66%	Acute Readmission	7.72%	8.02%	0.30%	7.14%	-0.58%	7.31%	7.80%

Reduced services under the national COVID-19 lockdown beginning August 18 has affected volumes for the month. For August, Medical and Surgical discharges are lower than budget and the same time last year. Other services are close to budget for discharges but caseweights are below budget. Year to date, Medical caseweights are higher than budget and the same time last year mainly due to high discharges in July for Emergency (treated over 3 hours and discharged) during the RSV outbreak.

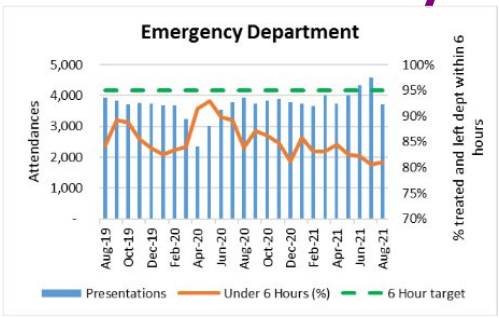
Total ED visits were 13% lower than last year. Patients admitted to inpatient wards from ED was 11% lower than last year. Theatre visits were 33% lower than budget for the month. Bed days were close to budget for the month but 5% lower than last year. Inpatient ALOS in August was shorter than budget and the same time last year. The acute readmission rate was lower than budget but higher than the same time last year.

Operational Performance Scorecard – 13 mths

Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Safe	Serious Safety Events[1] confirmed	Zero	3	1	2	3	0	1	3	3	3	0	2	0	3
	SABSI Cases [2]	Zero	0	1	2	1	1	1	0	1	0	0	1	3	2
	C. difficile infected diarrhoea cases	Zero	4	1	1	4	0	1	0	1	2	1	1	2	5
	Hand Hygiene compliance (quarterly)	≥ 80%	82%		79%			79%			80%				
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		36.7	11.4	13.3	1.4	43.6	7.6	22.4	39.8	13.6	21.0	21.4	16.9	22.4
Timely	Emergency Presentations	49,056	4,281	3,997	4,273	4,328	4,259	4,059	4,026	4,315	3,982	4,315	4,331	4,593	3,711
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.5%	79.0%	80.0%
	SSiED % within 6hrs - non admitted	≥95%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	89.2%	86.5%	87.0%
	SSiED % within 6hrs - admitted	≥95%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	56.8%	55.5%	60.2%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	913	915	992	1,002	1,115	1,251	1,328	1,238	1,177	1,020	904	930	1,021
	No. Theater surgeries cancelled (OP 1-8)		148	154	142	128	138	87	139	198	124	127	186	153	206
	Total Elective & Acute Operations in MainTheatres 1-8[6]		792	805	824	775	744	664	712	898	816	843	856	867	594
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	798	674	723	704	758	1,016	1,124	1,093	1,015	808	625	624	717
	Outpatient Failure to Attend %	≤6.3%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.6%	6.5%	6.4%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	($19.72)	($20.40)	($25.09)	($25.43)	($3.94)	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	($14.25)	($14.01)	($16.93)	($12.23)	($30.84)	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.9%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.8%	88.4%	87.8%	87.3%	87.1%	86.0%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.76	4.52	4.26	4.72	4.79	4.50	4.37	4.89	4.35	4.69	4.80	4.64	4.92
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	21	17	15	21	24	21	34	20	23	29	22	20	24
	Overnight Beds (General Occupancy) - Average Occupied	≤130	151	144	130	138	144	130	149	146	143	148	152	153	144
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	98.5%	94.3%	89.1%
	All Beds - ave. beds occupied[8]	≤250	254	249	231	240	240	229	253	253	243	255	256	260	241
	% sick Leave v standard	≤3.5%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%	3.8%	4.1%	4.4%
	% Nursing agency v employee (10)	≤1.49%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	13.0%	11.8%	0.4%	14.5%	0.0%	TBC
	% overtime v standard (medical) (10)	≤9.22%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	7.9%	8.3%	10.1%	8.7%	11.2%	TBC
	% overtime v standard (nursing)	≤5.47%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	11.2%	15.7%	13.2%	15.9%	12.5%	TBC

Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 20/21.

Shorter Stays in Emergency Department (ED)



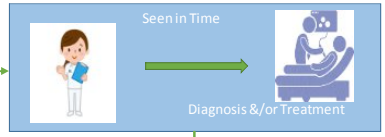
Arrivals -
Month - 3,711 (4,281)
YTD - 8,303 (8,320)

Self Referred
Month - 2,362 (2,808)
YTD - 5,484 (5,449)

GP Referred
Month - 336 (433)
YTD - 716 (884)

Other
Month - 1,013 (1,040)
YTD - 2,103 (1,987)
Current (Last Year)

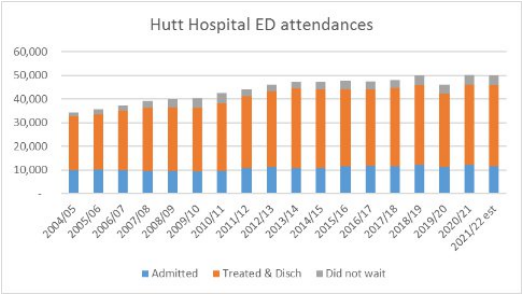
Category	Volume	% Seen in time
1	32 (69)	100% (100%)
2	660 (1,559)	33% (34%)
3	1,530 (3,374)	27% (23%)
4	1,182 (2,635)	41% (39%)
5	307 (667)	72% (69%)
	Mth (YTD)	Mth (YTD)



Did Not Wait
Month - 262 (337) 7%
YTD - 677 (584) 8%

Treated & Disch
Month - 2,542 (2,927) 87% <6hr
YTD - 5,705 (5,650) 87%

Admitted
Month - 907 (1017) 60% <6hr
YTD - 1,921 (2,086) 57%



- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Due to the Covid-19 lock down part way through August volumes were lower than August 2020. This led to a small improvement in the shorter stays target 81%
- **What is driving Performance**
  - Target improvements were impacted by red and green zones within ED as well as some inpatient wards. Ensuring correct IPC principles and placement of patients to reduce the risk of transmission for our community was our priority.
  - The fall in ED attendances was not as marked as it was last year
- **Management Comment**
  - ED presentations were high during the first part of the month but fell following level 4 lockdown although the reduction in attendances was not as marked as in April 2020. There has been some improvement in the shorter stays performance during this period however high acuity and high occupancy in the hospital has continued to put pressure on this target.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

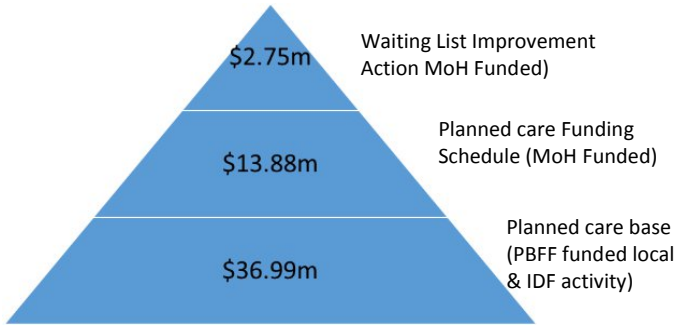
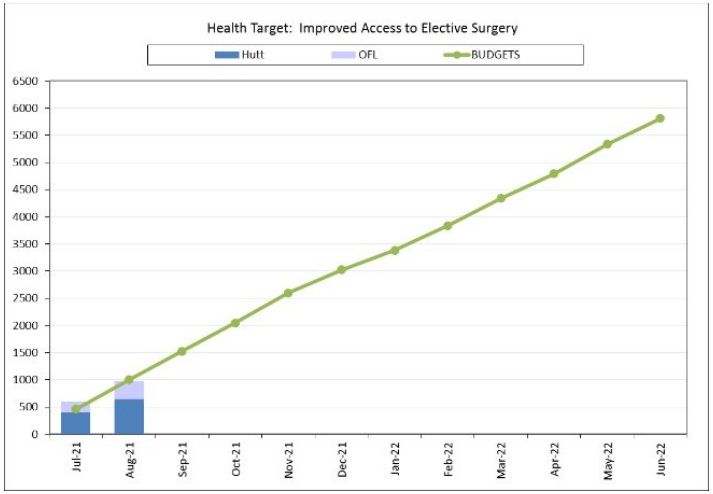
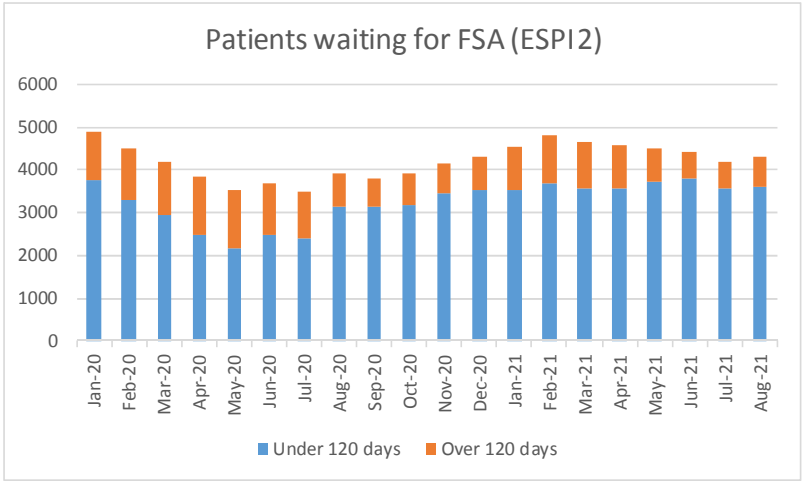


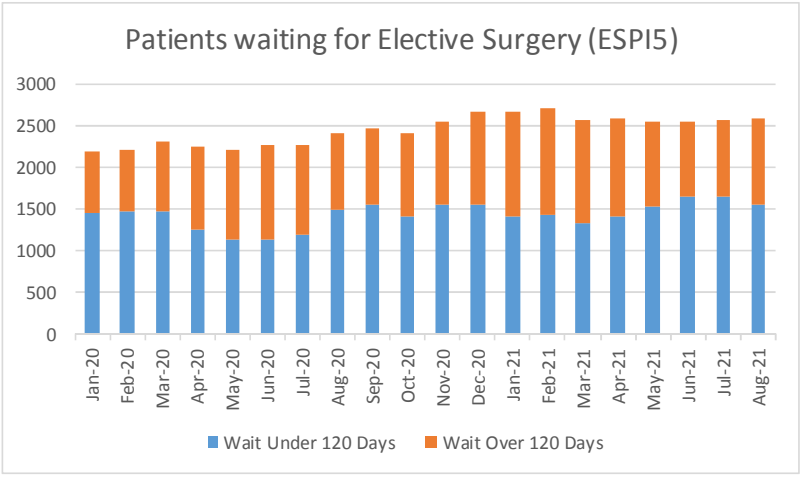
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 97%



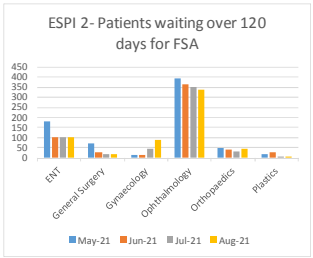
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 29 behind plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 97% as per figure 2.
  - August result was impacted by the Covid-19 lock down and preparations for the NZNO and MERAS strikes (which were cancelled).
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases.
  - At the beginning of the month there continued to be bed blockage due to the RSV outbreak
- **What is driving performance?**
  - Discussion will take place with the Ministry of Health at a national level on how best post Covid-19 to manage Planned Care delivery for 2021-2022 and the trajectory approach.
  - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is continuing in the new financial year with funding carried over. This model is significantly assisting in reduction of the orthopaedic ESPI 2 waitlist.
  - Work on the 2 DHB closed RFP for outsourcing progressed and is due back from providers in September. It is anticipated that this will commence in Quarter 2 at the latest. In the interim an outsourcing schedule for HVDHB is being delivered utilising PCI recovery funding for 2021-2022.
  - Commenced on project design of the Optometrists in cataract First Specialist Assessment and surgical follow which will reduce the ESPI 2 waitlist by 200 patients in 2021-2022
  - Capital investment of $3,647k to establish a 5 room procedure suite. The Minister of Health approved funding for the build and concept plans have been finalised. The GETS tender process completed and the DHB are currently in the process of appointing a builder.

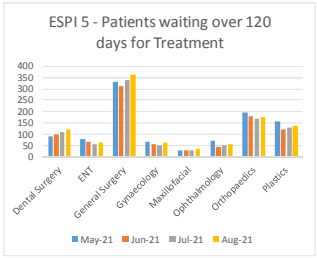
Planned Care – waiting times-

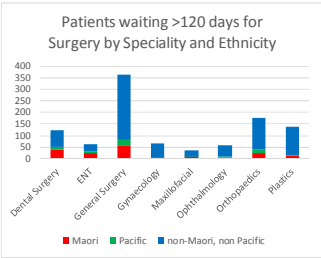




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 2.7% (115) this month. The number waiting over 120 days rose by 12% (75)
  - The number waiting for elective surgery rose by 4 to 2,583 and the number waiting over 120 days by 91 to 1,021
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

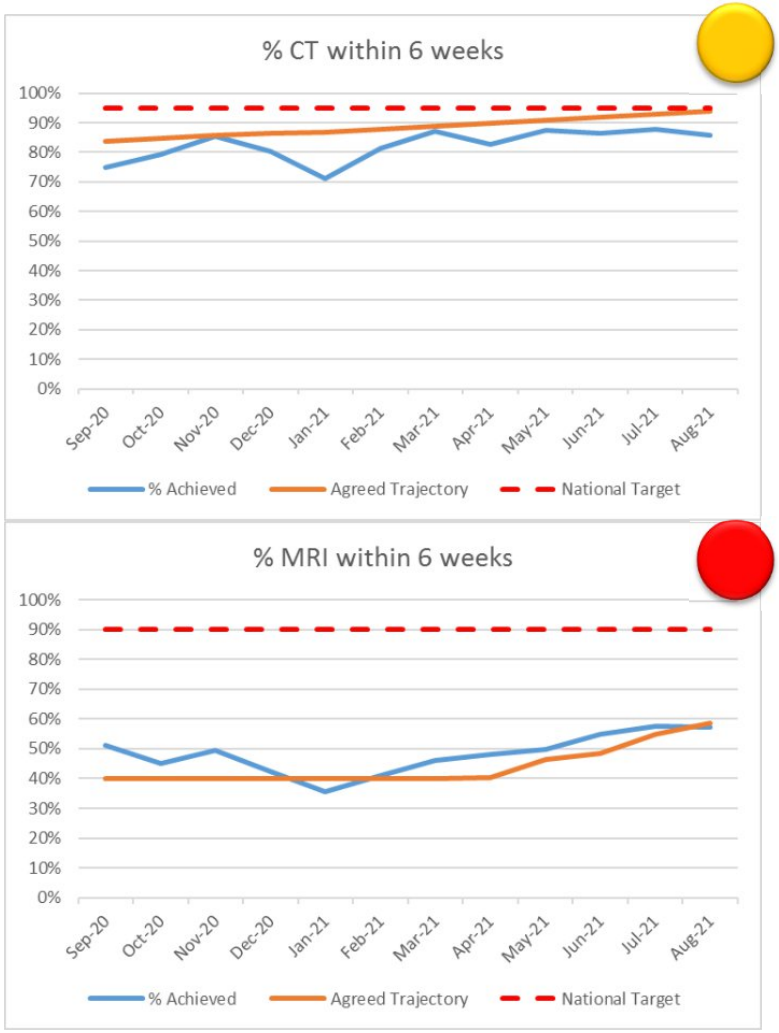






- **What is driving performance?**
  - Impact of COVID lockdown and preparations for the NZNO and MERAS strikes
  - Work continues on system improvements to address our waiting list management along with a strong focus to maximise clinic capacity and improve scheduling processes.
  - A 2DHB project relating to ophthalmology model of care continues exploring scope of practice of professionals involved in FSA, Treatment and Follow-ups. The initial work stream focus is based on glaucoma.
  - SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

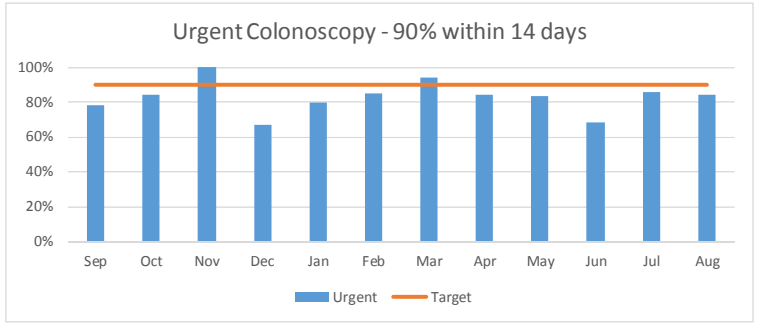
CT & MRI wait times



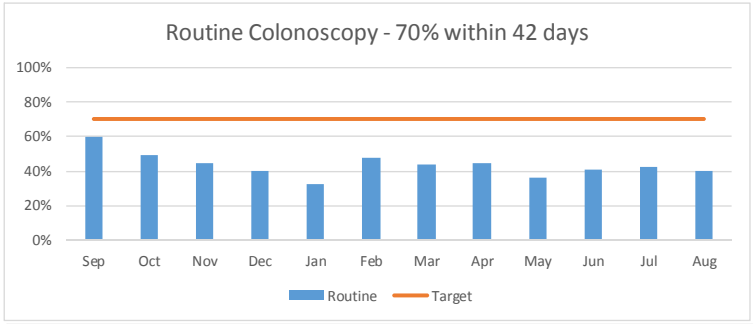
- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is improving.
  - CT wait times remain close to target.
- **What is driving performance?**
  - CT performance continues to improve with 91.4% scanned and reported within 6 weeks.
  - MRI performance is just below the newly agreed (with MOH) trajectory with 54% scanned and reported within 6 weeks. Outsourced scans/reports have been delayed due to capacity issues with the external provider.
  - Covid-19 Response meant only Urgent patients were scanned from 18 August 2021 (P1 and P2 priority), with most outpatient work deferred.

- **Management comment**
  - Actions currently underway:
    - CT weekends have recommenced with Outpatient lists for Saturdays and Sundays
    - Voluntary overtime weekend MRI day lists – approximately 4 days per month have recommenced
    - MOH additional Planned Care trajectory funding assumption of additional revenue is being used to outsource 30 MRIs per month & the reading of 100 CT scans per month

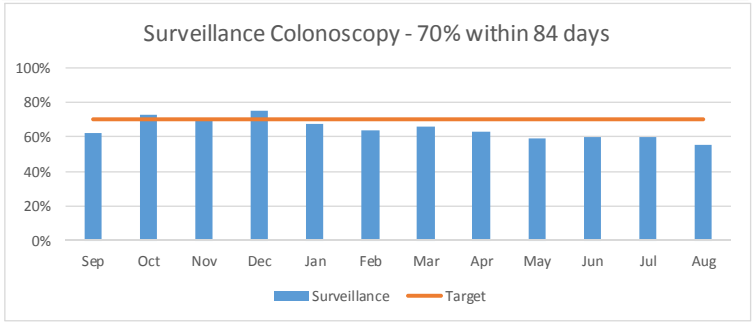
Colonoscopy Wait Times



Urgent
85% YTD



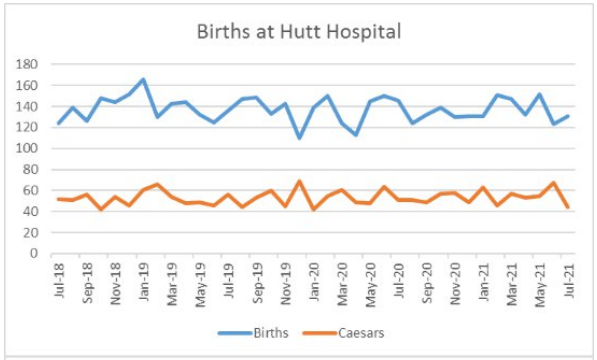
Routine
46% YTD

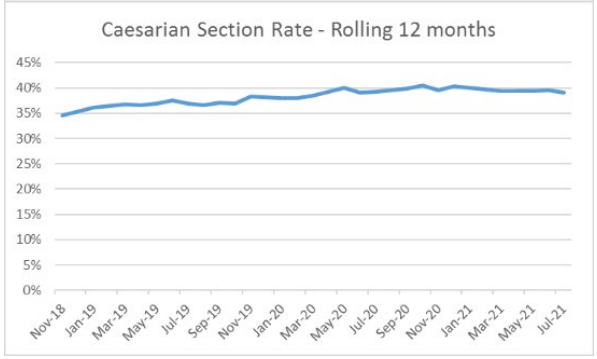


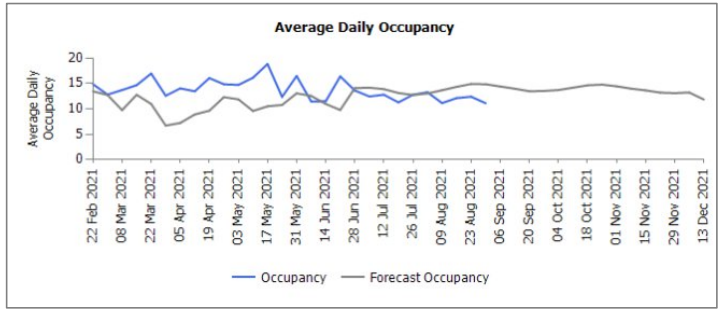
Surveil
61% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The service is balancing the overall improvement in performance with a trajectory to full compliance within the coming months.
  - August sees an improved performance across the urgent wait times and a similar outcome to June for routine and surveillance
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - There is concerted effort occurring to ensure that there are no Maori or Pacific patients overdue for any category however this has been a challenge in August with a total of 20 Maori or Pacific patients who are overdue across all categories (and 6 deferred).
  - The recent level 4 and 3 lockdown has meant some of the patients booked were required to be re-scheduled for September dates.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - The service is now projecting full recovery by December 2021 with it being in a stable position from then.

Maternity

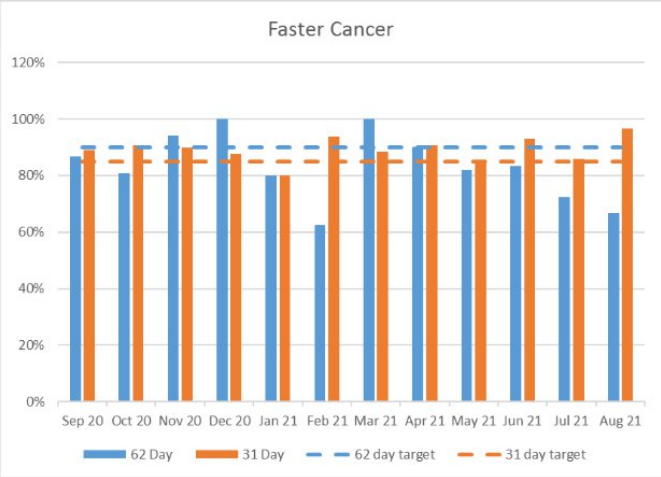


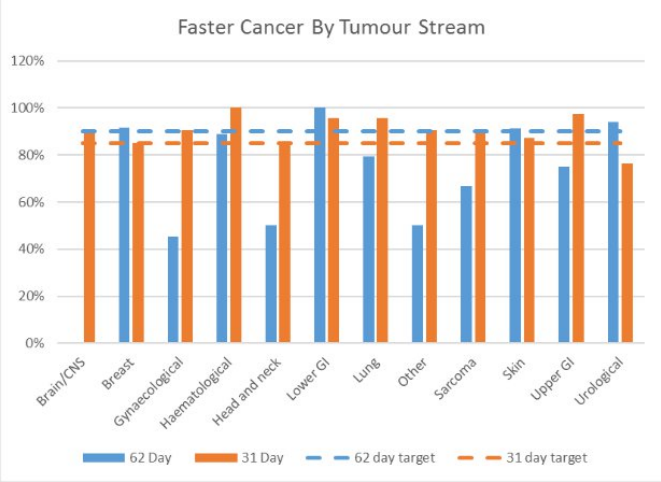




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - Hutt Valley DHB continues to progress the birthing optimisation project and audit of caesarean cases. This audit covers the period from April-June 2021 and focuses on the criteria for caesarean sections and pathways for optimal birth.
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU). Phase One of building work (CMT space) is complete. Phase Two (MAU) is in final design - concept and building consent stage. An upgrade of rooms 1-6 in the post-natal ward will be undertaken in Q2. The Senior Midwives, Service Group Manager and Director of Midwifery have worked in partnership with MERAS to design a work programme aimed at improving the retention and recruitment of our Midwives.
  - With the closure of Te Awakairangi Birthing Centre plans are in development with the staff of Te Awakairangi to support the transition of care. All LMC midwives will be given a letter to give to their women who booked at Te Awakairangi reassuring them of their transition to Hutt Maternity, should they choose to birth at Hutt hospital. A frequently asked questions and answers letter is also being developed and will be provided to all childbirth educators, this is to reassure women at this challenging and unsettling time.
  - Monthly meetings have been set with the Hutt Maternity Action Trust, as we work in partnership with our community, through regular engagement.

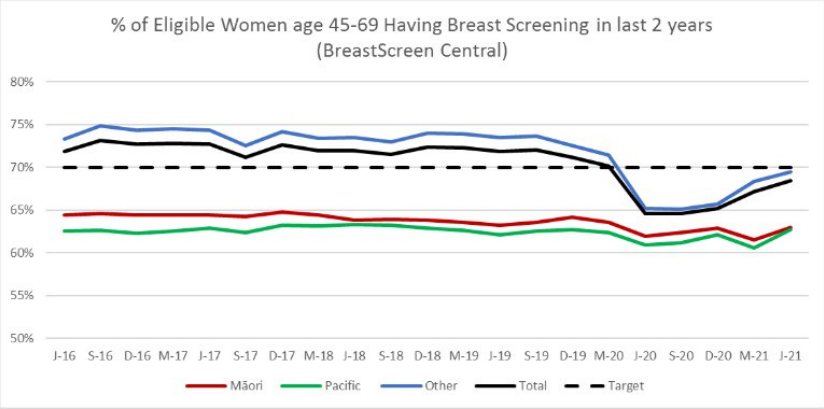
Faster Cancer Treatment

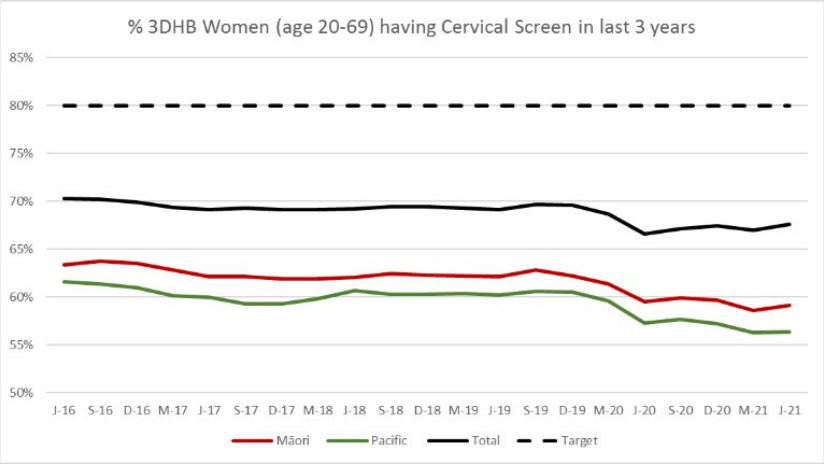




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have 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 it important?**
  - 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?**
  - 66.7% of patients met the HVDHB 62 day pathway for August - (2 out of 6 patients breached due to capacity related issues). 97.1% for the 31 day target pathway was achieved.
- **What is driving performance?**
  - The first component of assessment from referral is well achieved and the latter part of treatment is the area needing focus.
- **Management Comment**
  - Individual breaches are viewed through MDT across both DHBs.

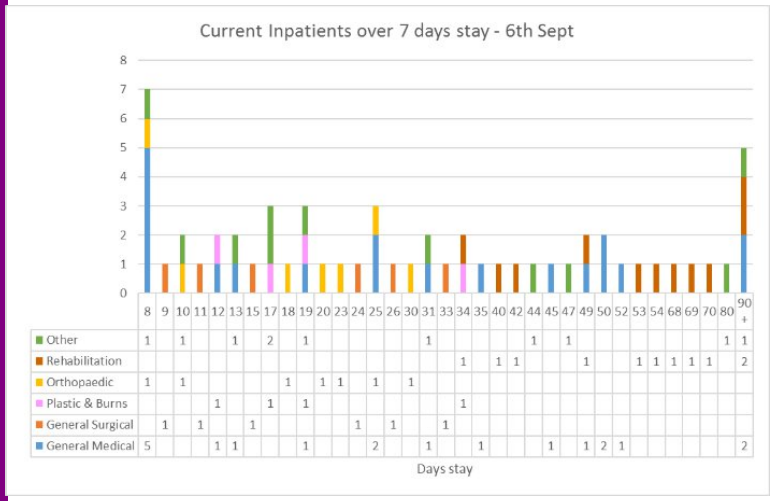
Screening

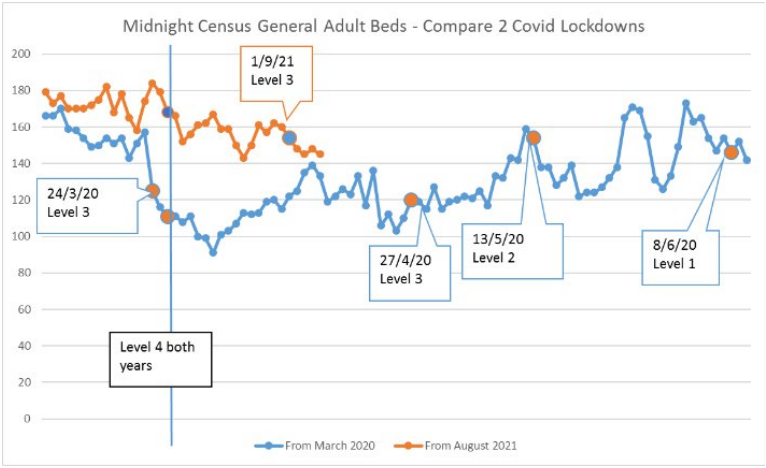




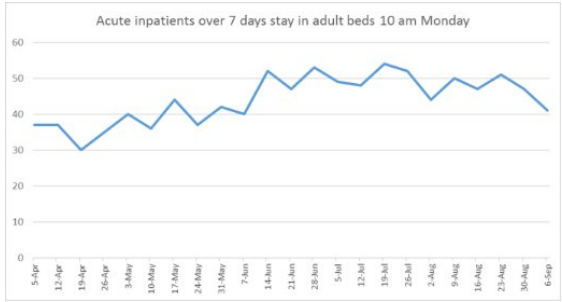
- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 45-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist 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
- **How are we performing?**
  - Our Breast screening was impacted by COVID-19 lockdown resulting in 1,187 less women screened.
  - Cervical Screening coverage in August was also impacted by COVID-19, priority population clinics had to be deferred resulting in the loss of 130 screens in August.
- **What is driving performance?**
  - In August, we have started to use new PHO data report (unenrolled women) to enrol Maori and Pacific women, this will improve the Maori and Pacific Coverage stats in coming months. We are continuing to do this for each practice at a Regional level.
  - The service continues to provide Saturday and evening sessions on a (staff) volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued.
  - Recruitment for replacement Breast Radiologist has resulted in two offers being made to two international candidates it is expected they will start in December.
- **Management Comment**
  - The decrease in screening numbers for both Breast and Cervical screening due to Covid-19 has resulted in a decrease of screened women this month. The service is on track to make up this with extended clinics on weekends and evening.
  - 'Free Cervical Screening' after hour evening clinics and Saturday clinics targeted at wāhine Māori, Pacific and Asian women continues to be a focus

Long Stay inpatients





- **What is this measure?**
  - For medical and surgical these are patients who have stayed more than 7 days. For rehabilitation and neonates where stays are longer these are cases staying over last year's average.
- **Why is it important?**
  - These patients are reducing the ability of the hospital to cope with acute demand. Longer stays are often associated with deconditioning and adverse outcomes for the patient.
- **How are we performing?**
  - On 6th Sept there were 41 current long staying patients; most were acute adults. There has been a reduction in occupancy with Covid-19 but not as marked as last year.
- **What is driving performance?**
  - A group of extremely complex patients remain unable to be discharged because community services and supports are reluctant to support these patients on discharge either due to extremely high needs, complex behaviour, housing issues, or health and safety concerns for service staff.
- **Management comment**
  - A dedicated role to work with these and similar patients is planned to work with clinical, NASC, and commissioning staff to put sustainable different discharge arrangements in place for these folk. Enhanced Early Supported Discharge for mild-moderate stroke patients and some medical patients will go live in August. This will support earlier discharge for this group of patients and better hospital flow over all.



Section 4

Financial Performance & Sustainability

Summary of Financial Performance for August 2021

Month					$000s	Year to Date						
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					Revenue							
43,349	42,249	1,100	40,883	2,466	Devolved MoH Revenue	85,615	84,499	1,116	81,287	4,328	506,994	489,113
1,858	1,621	237	1,789	69	Non Devolved MoH Revenue	3,936	3,242	694	3,787	149	20,179	21,680
553	622	(69)	645	(92)	ACC Revenue	907	1,177	(270)	1,240	(333)	6,976	7,129
461	502	(41)	503	(42)	Other Revenue	1,028	1,013	15	1,107	(80)	6,054	7,483
9,041	9,557	(515)	9,293	(252)	IDF Inflow	18,598	19,113	(515)	18,464	134	114,678	111,945
1,070	1,025	45	778	292	Inter DHB Provider Revenue	2,375	2,050	325	1,250	1,125	12,302	13,197
56,332	**55,577**	**756**	**53,891**	**2,442**	**Total Revenue**	**112,459**	**111,094**	**1,365**	**107,137**	**5,322**	**667,183**	**650,547**
					Expenditure							
					Employee Expenses							
5,865	5,485	(380)	5,475	(390)	Medical Employees	11,096	10,968	(128)	10,841	(255)	65,246	62,678
6,100	6,155	55	6,089	(11)	Nursing Employees	12,300	12,302	2	13,057	757	73,986	72,415
2,570	2,560	(10)	2,594	23	Allied Health Employees	4,985	5,118	133	5,523	538	30,467	28,663
854	806	(48)	696	(158)	Support Employees	1,718	1,612	(106)	1,528	(189)	9,619	9,579
2,251	2,306	56	2,259	8	Management and Admin Employees	4,558	4,613	54	4,994	435	27,053	26,733
17,639	**17,312**	**(327)**	**17,112**	**(527)**	**Total Employee Expenses**	**34,658**	**34,613**	**(45)**	**35,943**	**1,285**	**206,370**	**200,068**
					Outsourced Personnel Expenses							
208	205	(3)	405	197	Medical Personnel	384	410	26	630	246	2,458	5,973
28	15	(13)	66	38	Nursing Personnel	27	30	3	179	151	181	6,407
(12)	60	72	45	58	Allied Health Personnel	6	119	114	78	72	715	4,561
62	42	(20)	35	(27)	Support Personnel	142	85	(57)	109	(33)	507	491
636	621	(15)	381	(255)	Management and Admin Personnel	1,186	1,243	57	497	(689)	7,457	7,031
922	**943**	**21**	**933**	**11**	**Total Outsourced Personnel Expenses**	**1,745**	**1,887**	**142**	**1,493**	**(252)**	**11,318**	**24,463**
599	953	354	632	33	Outsourced Other Expenses	1,482	1,906	424	1,472	(10)	11,454	13,157
2,701	2,466	(235)	2,544	(157)	Treatment Related Costs	5,414	4,945	(469)	5,333	(81)	30,698	33,080
1,971	2,054	82	1,999	28	Non Treatment Related Costs	4,015	4,132	118	3,838	(177)	24,765	36,000
10,847	11,991	1,144	8,637	(2,210)	IDF Outflow	24,538	23,982	(556)	17,743	(6,795)	143,894	108,813
20,124	20,551	426	19,557	(567)	Other External Provider Costs	40,498	41,027	529	38,296	(2,202)	244,201	223,654
1,883	2,110	227	2,318	435	Interest, Depreciation & Capital Charge	3,755	4,220	465	4,530	774	25,321	23,537
56,687	**58,381**	**1,694**	**53,733**	**(2,954)**	**Total Expenditure**	**116,105**	**116,712**	**607**	**108,647**	**(7,458)**	**698,022**	**662,772**
(355)	**(2,805)**	**2,450**	**158**	**(512)**	**Net Result**	**(3,646)**	**(5,618)**	**1,972**	**(1,511)**	**(2,136)**	**(30,839)**	**(12,226)**
					Result by Output Class							
139	(2,452)	2,591	850	(711)	Funder	(3,917)	(4,829)	912	1,267	(5,185)	(27,012)	11,939
66	6	60	(81)	147	Governance	145	18	128	29	116	112	1,261
(559)	(359)	(201)	(611)	52	Provider	126	(807)	933	(2,807)	2,933	(3,939)	(25,425)
(355)	**(2,805)**	**2,450**	**157**	**(512)**	**Net Result**	**(3,646)**	**(5,618)**	**1,972**	**(1,511)**	**(2,136)**	**(30,839)**	**(12,226)**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $1,365k
- Personnel and outsourced Personnel favourable $96k
  - Medical unfavourable ($102k); Nursing favourable $4k; Allied Health favourable $246k, Support Staff unfavourable ($163k); Management and Admin favourable $111k; Annual leave Liability cost has increased by $46k since August 2020
- Outsourced other expenses favourable $424k
- Treatment related Costs unfavourable ($469k)
- Non Treatment Related Costs favourable $118k
- IDF Outflow unfavourable ($556k)
- Other External Provider Costs favourable $529k
- Interest depreciation and capital charge favourable $465k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $756k for the month
  - Devolved MOH revenue $1,100k favourable, reflecting unbudgeted COVID-19 expenditure, which includes a corresponding increase in expenditure.
  - Non Devolved revenue $237k favourable driven largely by Public Health COVID-19 funding $280k.
  - ACC Revenue ($69k) unfavourable.
  - Other revenue ($41k) unfavourable for the month driven by Patient Revenue.
  - IDF inflows unfavourable ($515k) for the month reflecting lower than expected volumes.
  - Inter DHB Revenue favourable $45k.

COVID–19 Revenue and Costs

YTD Result - August 2021	Funder	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) (1)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19	681	29	840	1,549
Expenditure				
Employee Expenses				
Medical Employees		6	53	59
Nursing Employees		17	121	138
Allied Health Employees		16	141	157
Support Employees		1	0	1
Management and Admin Employees		22	34	57
Total Employee Expenses	**0**	**63**	**349**	**411**
Expenses				
Outsourced - Provider	0	0		0.0
External Providers - Funder	1,019			1,019.3
Clinical Expenses - Provider	0	0	3	3.1
Non-clinical Expenses- Provider	0	3	47	50.2
Total Non Employee Expenses	**1,019**	**3**	**50**	**1,072.5**
Total Expenditure	**1,019**	**66**	**399**	**1,484**
Net Impact	**(339)**	**(37)**	**441**	**66**

(1) Excludes overhead charges

- The August year to date financial position includes $1.4m additional costs in relation to COVID-19.
- Revenue of $1.5m has been recognised to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.1m surplus.

Analysis of Operating Position – Personnel

- **Total Personnel** including outsourced unfavourable ($306k) for the month
  - Medical personnel incl. outsourced favourable ($383k). Outsourced costs are ($3k) unfavourable. Medical Staff Internal are ($380k) unfavourable, driven by the impact of RMO transfers and leave.
  - Nursing incl. outsourced $41k favourable. Employee costs are $55k favourable, driven by largely by vacancies.
  - Allied Health incl. outsourced $62k favourable, with outsourced favourable $72k and internal employees unfavourable ($10k).
  - Support incl. outsourced unfavourable ($67k), with Outsourced ($20k) unfavourable, and employee costs ($48k) unfavourable, driven by Orderlies ($18k), Sterile Assistants ($13k) and Tradesmen ($17k).
  - Management & Admin incl. outsourced favourable $41k, internal staff favourable $56k, outsourced unfavourable ($15k).
  - Sick leave for August was 4.4%, which is higher than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Aug-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
280	290	10	287	7	Medical	282	290	7	285	3	289	279
755	781	27	822	67	Nursing	758	781	24	823	65	790	763
349	365	16	395	46	Allied Health	348	365	17	397	48	365	352
151	147	(5)	143	(8)	Support	151	147	(5)	143	(8)	147	147
314	341	27	346	32	Management & Administration	320	341	21	347	27	338	321
1,848	**1,924**	**75**	**1,993**	**145**	**Total FTE**	**1,860**	**1,924**	**64**	**1,995**	**135**	**1,930**	**1,862**
					$ per FTE							
20,964	18,942	(2,022)	19,075	(1,889)	Medical	39,298	37,878	(1,420)	37,999	(1,299)	224,867	233,613
8,081	7,876	(205)	7,406	(675)	Nursing	16,232	15,743	(490)	15,864	(369)	93,662	97,019
7,368	7,008	(361)	6,568	(800)	Allied Health	14,316	14,010	(306)	13,929	(387)	83,014	86,588
5,646	5,497	(149)	4,861	(785)	Support	11,349	10,994	(355)	10,681	(668)	65,680	65,337
7,171	6,765	(406)	6,528	(643)	Management & Administration	14,240	13,529	(711)	14,383	143	79,996	84,263
9,543	**8,999**	**(544)**	**8,585**	**(958)**	**Average Cost per FTE all Staff**	**18,635**	**17,991**	**(644)**	**18,015**	**(620)**	**106,762**	**110,832**

Medical under budget for the month by 10 FTE, driven by SMOs under budget by 11 FTE, partly offset by RMO's & House Officers.

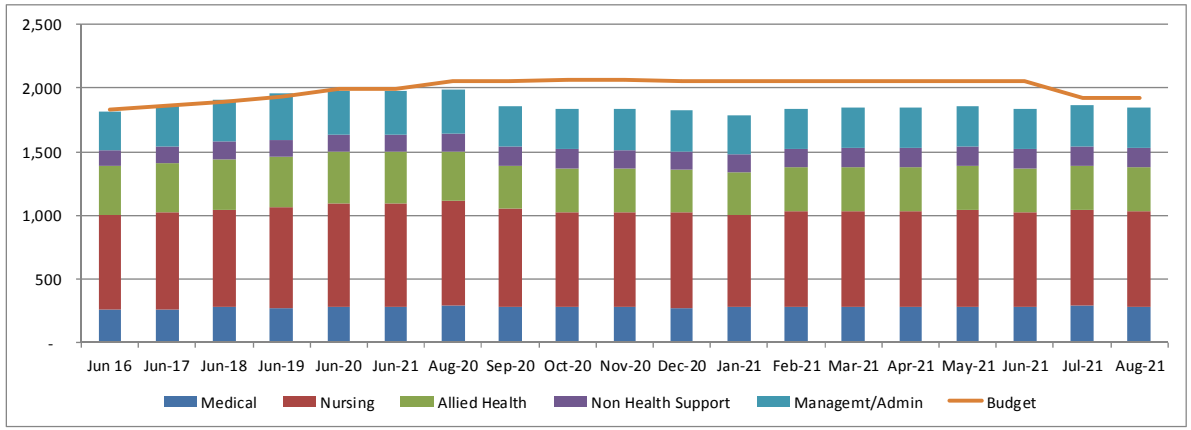
Nursing under by 27 FTE for the month the contribution to movements were; Internal Bureau Nurses, Midwives and HCA's are over budget (18) FTE mostly driven by General Surgery (4) FTE, General Medical (6) FTE, ED (4FTE) and other variances. This is offset by Midwives 15 FTE and Registered Nurses 10 FTE and HCA's. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

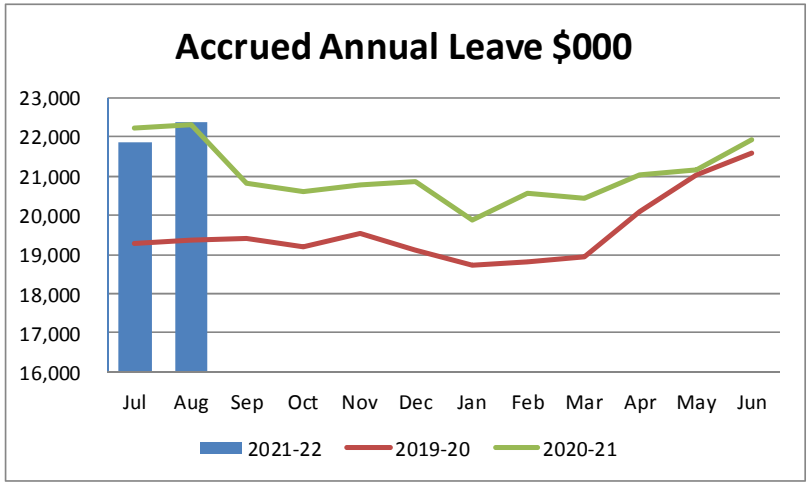
Allied FTEs are under by 16 FTEs for the month, driven by Regional Public Health 8 FTE, Community Health 8FTE.

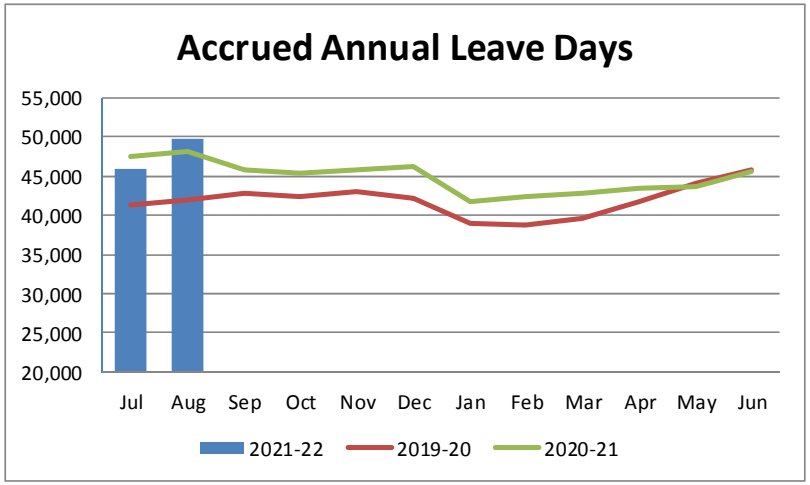
Support FTEs are (5) FTEs over budget driven by Food Services (3) FTE, Property services (1) FTE and Orderlies (2) FTE and other variances.

Management & Admin are under budget by 27 FTEs driven by SPO 1 FTE, Quality 3 FTE, Communications 1FTE, Director of Provider Services 2 FTE, Quality 5FTE, Surgical Women's & Children's 6 FTE, Medical and Acute 5 FTE and Regional Screening 2 FTE and other variances.

FTE Analysis







The combined impact of the MHAIDS & ITS restructures on Accrued Annual leave during the 2020-21 financial year was estimated to be a reduction of 3,175 days and $1,561k in respect of Leave Liability.

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other favourable $354k for the month, due to favourable variance for Clinical Services $252k, outsourced Finance functions $37k, Governance $70k , IT and Procurement services $74k.
  - Treatment related costs ($235k) unfavourable for the month, Pharmaceuticals ($142k), Treatment Disposables ($278k), offset by Implants and Prostheses $39k and Instruments and equipment $96k.
  - Non Treatment Related costs favourable $82k.
  - IDF Outflows $1,144k favourable for the month, driven by the August COVID-19 lockdown.
  - Other External Provider costs favourable $426k, mostly driven by Community Pharmaceuticals.
  - Interest, Depreciation & Capital Charge favourable $227k, driven by Depreciation $234k, which is expected to reverse over the year.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 August 2021

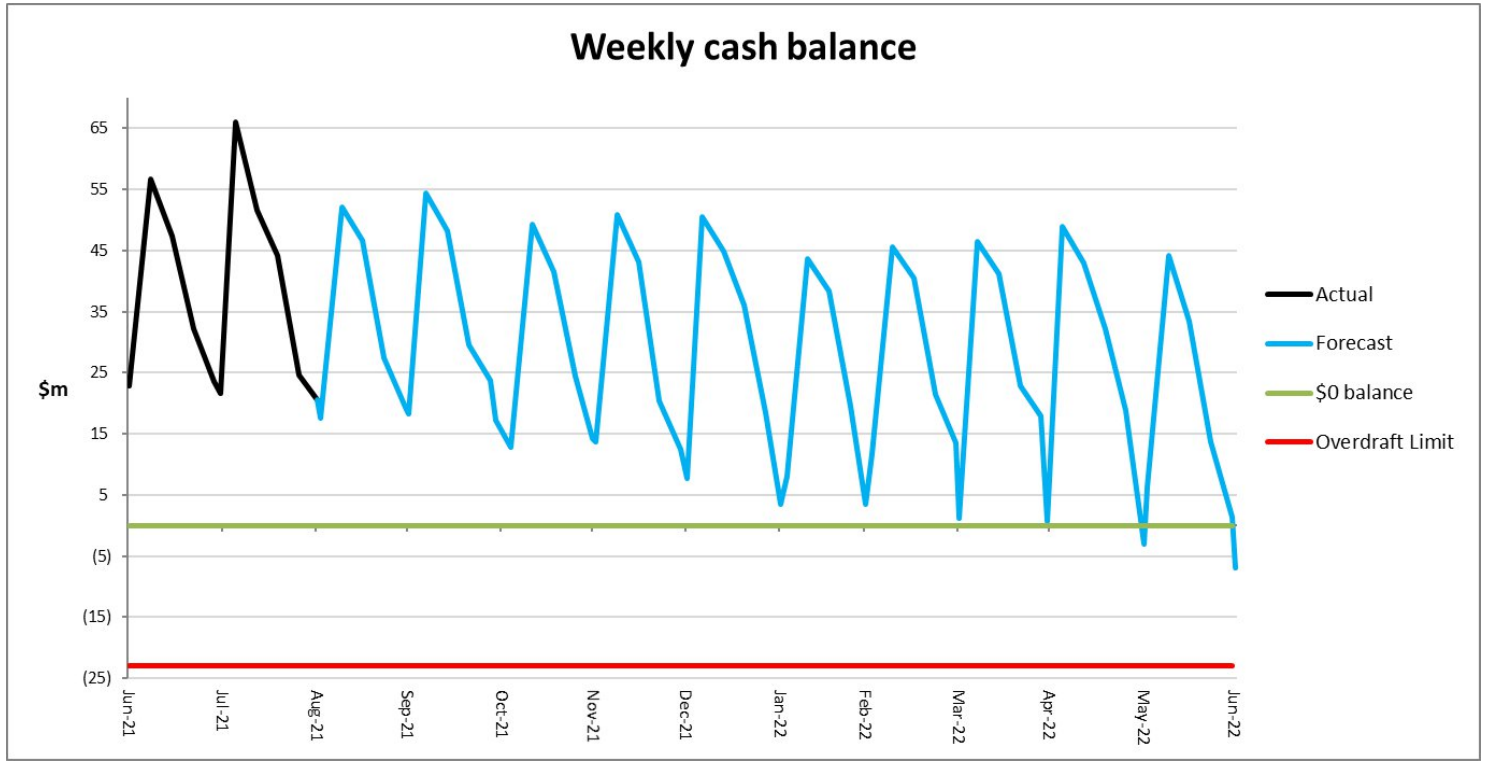
$000s	Actual	Budget	Variance	Jun 21	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	20,489	4,275	16,214	22,890	(2,401)	Average bank balance in Aug-21 was $38.5m
Bank - Non DHB Funds *	3,317	5,831	(2,514)	5,236	(1,919)	
Accounts Receivable & Accrued Revenue	35,847	23,831	12,016	33,457	2,390	
Stock	2,172	2,614	(442)	2,322	(150)	
Prepayments	2,103	1,161	942	1,241	862	
Total Current Assets	**63,928**	**37,712**	**26,216**	**65,146**	**(1,219)**	
Fixed Assets						
Fixed Assets	222,980	228,272	(5,292)	223,741	(761)	
Work in Progress	9,809	7,905	1,905	9,218	591	
Total Fixed Assets	**232,789**	**236,176**	**(3,387)**	**232,958**	**(170)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,237	1,266	(29)	1,221	16	
Total Investments	**2,387**	**2,416**	**(29)**	**2,371**	**16**	
Total Assets	**299,103**	**276,305**	**22,799**	**300,476**	**(1,372)**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	82,222	77,223	(5,000)	79,873	(2,349)	Includes Holidays Act Provision of $30.7m
Crown Loans and Other Loans	35	3	(31)	42	7	
Capital Charge Payable	1,383	4,001	2,618	0	(1,383)	
Current Employee Provisions	27,509	28,199	690	27,029	(480)	
Total Current Liabilities	**111,150**	**109,426**	**(1,724)**	**106,944**	**(4,206)**	
Non Current Liabilities						
Other Loans	136	178	42	136	0	
Long Term Employee Provisions	9,150	8,972	(178)	9,150	0	
Non DHB Liabilities	3,317	5,831	2,514	5,236	1,919	
Trust Funds	1,207	1,226	18	1,221	13	
Total Non Current Liabilities	**13,811**	**16,207**	**2,396**	**15,743**	**1,932**	
Total Liabilities	**124,961**	**125,633**	**672**	**122,686**	**(2,274)**	
Net Assets	**174,143**	**150,672**	**23,471**	**177,789**	**(3,646)**	
Equity						
Crown Equity	158,709	141,918	16,790	158,709	0	
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(127,208)	(131,916)	4,708	(114,982)	(12,226)	
Net Surplus / (Deficit)	(3,646)	(5,618)	1,972	(12,226)	8,579	
Total Equity	**174,143**	**150,672**	**23,471**	**177,789**	**(3,646)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 August 2021

$000s	Jul Actual	Aug Actual	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	43,259	43,479	44,025	43,871	43,882	44,025	43,871	43,871	44,025	43,944	43,895	44,025
Receipts from Other DHBs (Including IDF)	10,208	7,504	10,582	10,582	10,582	10,582	10,582	10,582	10,582	10,582	10,582	10,582
Receipts from Other Government Sources	492	664	720	730	812	687	660	727	615	655	615	727
Other Revenue	4,907	(460)	112	116	113	263	271	113	113	116	113	113
Total Receipts	**58,866**	**51,187**	**55,439**	**55,298**	**55,388**	**55,556**	**55,384**	**55,292**	**55,335**	**55,296**	**55,205**	**55,446**
Payments for Personnel	(17,569)	(16,888)	(18,248)	(17,468)	(18,262)	(19,137)	(17,534)	(16,859)	(19,223)	(17,631)	(18,411)	(18,415)
Payments for Supplies (Excluding Capital Expenditure)	(9,630)	(5,793)	(5,473)	(5,486)	(5,473)	(5,494)	(5,488)	(5,510)	(5,510)	(5,515)	(5,537)	(6,449)
Capital Charge Paid	0	0	0	0	0	(4,150)	0	0	0	0	0	(4,150)
GST Movement	(848)	8	0	0	0	0	0	0	0	0	0	0
Payments to Other DHBs (Including IDF)	(11,963)	(11,858)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)	(11,991)
Payments to Providers	(18,979)	(16,766)	(20,230)	(20,482)	(20,411)	(20,631)	(20,254)	(19,217)	(20,125)	(20,516)	(20,786)	(20,523)
Total Payments	**(58,989)**	**(51,297)**	**(55,942)**	**(55,427)**	**(56,137)**	**(61,404)**	**(55,268)**	**(53,576)**	**(56,849)**	**(55,653)**	**(56,725)**	**(61,528)**
Net Cashflow from Operating Activities	**(123)**	**(110)**	**(503)**	**(129)**	**(749)**	**(5,848)**	**115**	**1,716**	**(1,514)**	**(357)**	**(1,520)**	**(6,082)**
Investing Activities												
Interest Receipts	23	23	21	21	21	21	21	21	21	21	21	21
Dividends	0	0	4	4	4	4	4	4	4	4	4	4
Total Receipts	**23**	**23**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(1,192)	(1,007)	(2,926)	(2,926)	(2,256)	(2,926)	(2,926)	(2,256)	(2,256)	(2,905)	(2,256)	(2,914)
Increase in Investments and Restricted & Trust Funds Assets	(24)	7	0	0	0	0	0	0	0	0	0	0
Total Payments	**(1,216)**	**(999)**	**(2,926)**	**(2,926)**	**(2,256)**	**(2,926)**	**(2,926)**	**(2,256)**	**(2,256)**	**(2,905)**	**(2,256)**	**(2,914)**
Net Cashflow from Investing Activities	**(1,193)**	**(976)**	**(2,901)**	**(2,901)**	**(2,231)**	**(2,901)**	**(2,901)**	**(2,231)**	**(2,231)**	**(2,880)**	**(2,231)**	**(2,889)**
Financing Activities												
Equity Injections - Capital	0	0	0	2,000	0	0	2,000	0	0	4,000	0	5,000
Total Receipts	**0**	**0**	**0**	**2,000**	**0**	**0**	**2,000**	**0**	**0**	**4,000**	**0**	**5,000**
Interest Paid on Finance Leases	(0)	(0)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Total Payments	**(0)**	**(0)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**
Net Cashflow from Financing Activities	**(0)**	**(0)**	**(2)**	**1,998**	**(2)**	**(2)**	**1,998**	**(2)**	**(2)**	**3,998**	**(2)**	**4,998**
Total Cash In	58,889	51,211	55,464	57,323	55,413	55,581	57,409	55,317	55,360	59,321	55,230	60,471
Total Cash Out	(60,204)	(52,296)	(58,870)	(58,355)	(58,395)	(64,332)	(58,196)	(55,834)	(59,107)	(58,560)	(58,983)	(64,444)
Net Cashflow												
Opening Cash	22,890	21,575	20,489	17,083	16,051	13,069	4,319	3,531	3,013	(734)	27	(3,726)
Net Cash Movements	(1,316)	(1,086)	(3,406)	(1,032)	(2,982)	(8,751)	(788)	(517)	(3,747)	761	(3,753)	(3,973)
Closing Cash	**21,575**	**20,489**	**17,083**	**16,051**	**13,069**	**4,319**	**3,531**	**3,013**	**(734)**	**27**	**(3,726)**	**(7,698)**

Weekly Cash Flow – Actual to 31 August 2021



Note

- the overdraft facility shown in red is set at $24.2 million as at August 2021
- the lowest bank balance for the month of August was $20.5m

Capital expenditure – Actual to 31 August 2021

Project description	Budget rolled over from 2020/21	New budget for 2021/22	Prior year approved projects budget	Prior year approved projects spend	Committed costs from prior year approved projects budget	Total maximum spend in 2021/22	Actual 2021/22 spend till date	Remaining funds available in 2021/22
	$000	$000	$000	$000	$000	$000	$000	$000
Baseline								
Buildings and Plant	4,385	7,700	3,651	2,740	910	12,996	631	12,366
Clinical Equipment	629	6,043	3,824	974	2,850	9,522	687	8,835
Information Technology (Hardware)	1,211	1,828	862	408	454	3,493	37	3,456
Intangible Assets (Software)	26	1,045	356	185	170	1,241	5	1,236
Baseline Total	**6,252**	**16,617**	**8,691**	**4,308**	**4,384**	**27,253**	**1,360**	**25,892**
Strategic								
Buildings and Plant	1,065	-	-	-	-	1,065	-	1,065
Clinical Equipment	2,275	1,460	2,301	451	1,850	5,586	97	5,488
IT	722	2,154	1,066	359	707	3,584	82	3,502
Strategic Total	**4,063**	**3,614**	**3,367**	**809**	**2,558**	**10,235**	**179**	**10,056**
Pandemic								
Buildings and Plant	-	-	-	-	-	-	-	-
Clinical Equipment	-	-	-	-	-	-	-	-
IT	-	-	-	-	-	196	6	190
Pandemic Total	**-**	**-**	**-**	**-**	**-**	**196**	**6**	**190**
Total Capital (excluding MOH, Trust, Gym)	**10,315**	**20,231**	**12,058**	**5,117**	**6,941**	**37,685**	**1,545**	**36,138**

Summary of Leases – as at 31 August 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,199	14,386		1/11/2020	31/10/2023	Operating
Public Trust House Lower Hutt	Community Mental Health		27,717	332,601		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		10,241	122,887		15/03/2015	14/03/2025	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,626	31,510		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		500	5,998		16/06/2020	16/05/2023	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
Pretoria St, Lower Hutt	RPH & Covid Team		8,360	100,320		1/08/2021	31/01/2023	Operating
			56,987	**683,825**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (121 Vehicles, including 2 Nissan Leaf EV's)			41,275	495,301		Ongoing	Ongoing	Operating
			41,275	**495,301**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost R90	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90 (Room 2)	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90 (Room 1)	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Mobile Diagnost R2 (Resus)	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	28/01/2026	Operating
3 x Carestream Mobile X-ray Units	De Lage Landen (paid monthly in arrears)		9,960	119,517	597,586	27/04/2021	27/04/2026	Operating
2x Digital Diagnost C90 (Room 3 & Room 4)	De Lage Landen (paid monthly in arrears)		11,552	138,623	693,114	13/05/2021	13/05/2026	Operating
		293,188	**131,412**	**1,576,974**	**6,668,212**			
Total Leases			**229,674**	**2,756,100**				

Treasury as at 31 August 2021

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$38,522	$42,449
Lowest balance for the month	$20,499	$21,564
Average interest rate	0.71%	0.64%
Net interest earned/(charged) for the month	$23	$23

2) Hedges

No hedging contracts have been entered into for the year to date.

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	4
Total value of transactions	$19,330 NZD
Largest transaction	$8,677 NZD

	No. of transactions	Equivalent NZD
AUD	3	$10,653
GBP		
SGD		
USD	1	$8,677
Total	**4**	$19,330

4) Debtors ($000)

Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Capital & Coast District Health Board	$5,791	$396	$366	$1,666	$85	$115	$203	$2,961
Ministry of Health	$834	$590	$73	$112	$35	$8	$16	$0
Accident Compensation Corporation	$640	$329	$24	$11	$30	$46	($21)	$222
Wairarapa District Health Board	$608	$60	$120	$62	$0	$54	$115	$196
Wellington Southern Community Laboratories	$98	$0	$0	$98	$0	$0	$0	($0)
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
WellNZ Limited	$54	$3	$24	$1	$2	$19	($0)	$6
Non Resident	$53	$0	$0	$0	$0	$0	$0	$53
Ministry of Social Development	$48	$0	$0	$48	$0	$0	$0	$0
Non Resident	$26	$0	$0	$0	$0	$0	$0	$26
Total Top 10 Debtors	**$8,215**	**$1,439**	**$608**	**$1,999**	**$152**	**$241**	**$312**	**$3,464**

Board Information – Public

3 November 2021

CCDHB Financial and Operational Performance Report – August 2021	
Action Required **The CCDHB Board notes:** (a) The DHB had a ($5.7m) deficit for the month of August 2021, being ($1.2m) unfavourable to budget before excluding COVID-19; (b) The DHB year to date had a deficit of ($8.3m), being ($1.2m) unfavourable to budget before excluding COVID-19; (c) In the two month we have incurred $3.0m additional net expenditure for COVID-19; (d) The DHB has an overall YTD deficit of ($5.3m) from normal operations (excluding COVID-19) being $1.2m favourable to the underlying budget.	
Strategic Alignment	Financial Sustainability
Authors	Rosalie Percival, Chief Financial Officer Joy Farley, Director of Provider Services Rachel Haggerty, Director Strategy Planning & Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board and FRAC in relation to the financial performance and delivery against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS, Director Strategy Planning & Performance

Executive Summary

1. There is ongoing significant cost due to the COVID-19 response into the 21/22 fiscal year, which has been largely funded by the Ministry. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 20/21, these are being considered outside our responsible deficit and budgets.

2. Excluding the COVID-19 net expenses the DHB's result for the one month to 31 August 2021 is ($5.3m) deficit, versus a budget deficit of ($7.2m).

3. Additional net COVID-19 related expenditure above funding, year to date is $3.0m.

4. For the two months to 31 August 2021 the overall DHB year to date result, including COVID-19 costs is ($8.3m) deficit.

5. The DHB has submitted an annual baseline budgeted surplus of $1m, resulting from the recognition of a $60m donation for the new Children's Hospital in March 2022. The underlying deficit is ($59m) including Holidays Provision. The DHB is working with the Ministry to have the budget and Annual Plan signed off.

6. Capital Expenditure including equity funded capital projects was $15.0m year to date.

7. The DHB had a negative cash Balance at month-end of $35.7million offset by positive "Special Funds" of $13.2 million, net negative cash balance of $19.5 million. It should be noted that there is a significant amount of the COVID-19 response that has not been funded by the Crown and this has a negative cash impact on the DHB.
8. The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that, in the constrained environment the DHBs, will not be able to deliver the full planned care funding schedule, nor reduce waiting list size so that people are treated within 120 days.
9. Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment; these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
10. Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
11. Continued workforce shortages across midwifery, nursing, and allied health (in particular, sonographers, social workers and radiographers) remains 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 2D Nursing and Midwifery Recruitment and Retention Strategy was developed to assist with the drive to fill vacancies in workforces at both DHBs, and seek to retain our existing staff.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 244 FTE below annual budget.
Financial	The YTD result for the DHB was ($5.3m) deficit from normal operations, against the DHB budget of ($7.1m). An additional ($3.0m) net was spend on COVID-19 costs in the provider arm.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

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
N/A	Financial outturn	Rosalie Percival, Chief Financial Officer	Currently on track but will be impacted by current events	Major (but no payment impacts)	Major (no operational impacts)

Attachment/s

3.1.1 CCDHB Financial and Operational Performance Report – August 2021

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 August 2021

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 response into the 21/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID response costs in 21/22. The Ministry have asked DHBs to separately report unfunded net COVID impacts for 21/22, these being considered outside our responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the two month's to 31 August 2021 is $4.2m deficit, versus a budget deficit of $4.5m.
- Additional net COVID-19 related expenditure above funding, year to date is $3.0m.
- For the two month's to 31 August 2021 the overall DHB year to date result, including COVID-19 costs is $7.1m deficit.
- The DHB has submitted an Annual baseline budget of $1m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($59m)
- Capital Expenditure including equity funded capital projects was $15.0m year to date.
- The DHB has a negative cash Balance at month-end of $35.7 million offset by positive "Special Funds" of $13.2 million (net $19.5m). It should be noted that there is a certain amount 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.

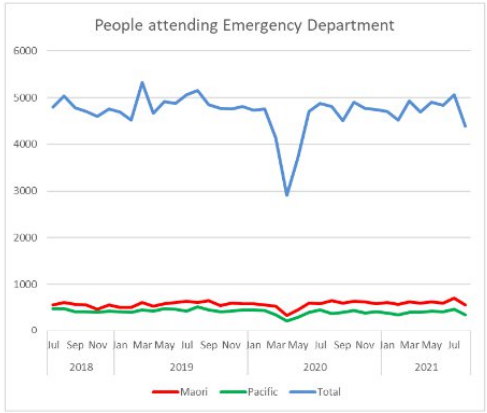
Executive Summary continued

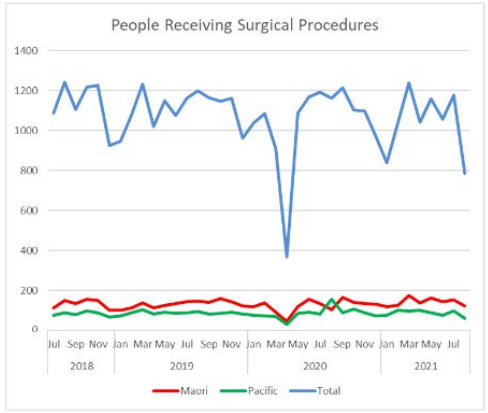
- **Hospital**: The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days.
- Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
- Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- Continued workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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 2D 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.
- **Funder:** To reduce ASH rates we have trialed after-hour GP video consults, expanding school-based health services in pre-schools and reviewing relevant respiratory health pathways. Our immunisation decline insights work has commenced. We're also strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children who are yet to receive vaccinations are followed-up with by their GP. We are also looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Tamariki Māori. Plunket has also developed an Action Plan to drive its performance for Māori.
- At the end of 2020, Tū Ora Compass was funded to reimburse NGOs for completion of ACPs with clients. This investment took place because NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities. The NGO-incentivised scheme for Advanced Care Plan completion recognises the valuable work of NGOs and provides financial support to undertake what can be challenging, lengthy and rich ACP conversations. The key benefits include: more ACPs completed and uploaded; client wishes are more accessible and can be followed by clinicians; further ACP promotion, support and socialisation to clients, whānau and staff.
- Partnerships between PHOs and NGO provider services such as Piki Services contributed to activities that lead to improved performance for 2020/21. Further improvements are planned following the investment in primary mental health and primary liaison services. We are embedding some of the learnings from our COVID-19 experience. We are expanding primary mental health and addiction support across the 3DHBs through the Access and Choice initiative. We are working with Tū Ora Compass Health and our specialist community providers to develop a monitoring framework to evaluate outcomes and ensure equitable access.

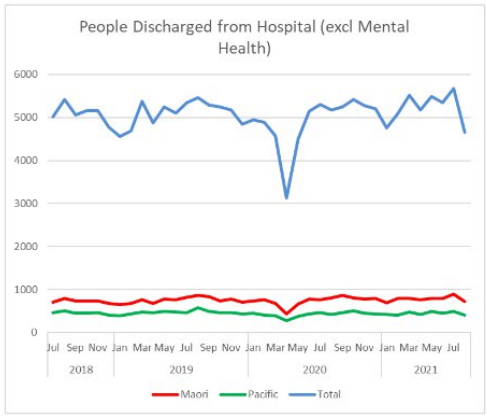
Performance Overview: Activity Context (People Served)

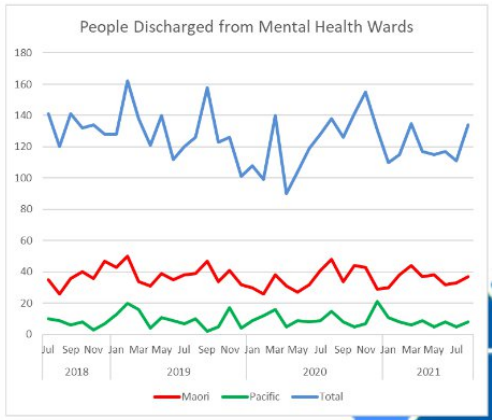
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,388**	555 Maori, 349 Pacific
People receiving Surgical Procedures (in main theatres)	**786**	121 Maori, 61 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**4,662**	723 Maori, 402 Pacific
People discharged from Mental Health Wards	**134**	37 Maori, 8 Pacific



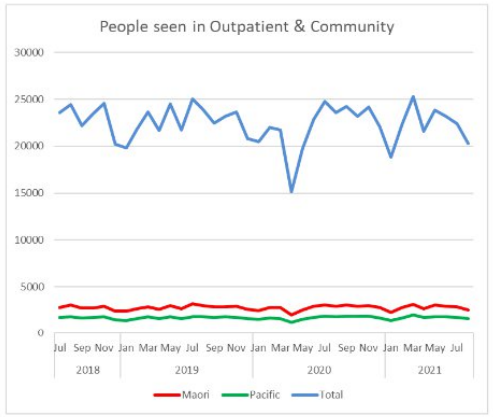


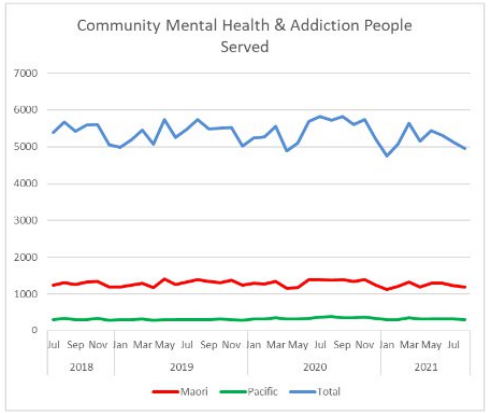


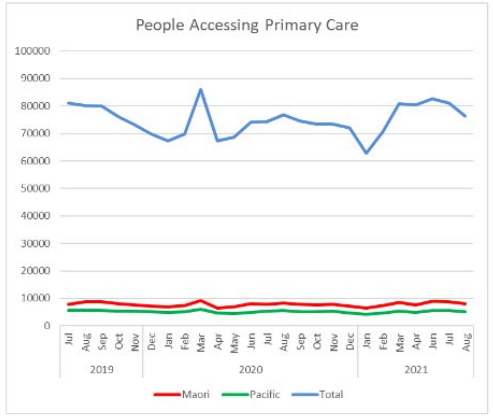


Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**20,294**	2,520 Maori, 1,601 Pacific
Community Mental Health & Addiction People Served	**4,957**	1,193 Maori, 316 Pacific
People accessing primary care	**76,256**	8,137 Maori, 5,128 Pacific
People in Aged Residential Care	**1,901**	82 Maori, 70 Pacific







Financial Overview – August 2021

YTD Operating Position

$8.3m deficit

Incl. $3.0m net COVID-19 costs

Against a budgeted YTD deficit of $7.1m. BAU Month result was $300k favourable. YTD $1.8m favourable BAU variance.

YTD Provider Position

$392k deficit

Incl. $3.0m net COVID-19 costs

Against a budgeted YTD surplus of $1.6m. BAU Month result was $300k unfavourable. BAU YTD $1m favourable variance.

YTD Funder Position

$7.9m deficit

Against a budgeted YTD Deficit of $8.7m. BAU Month result was $573k favourable result. YTD $768k favourable BAU variance.

YTD Capital Exp

$15.0m spend

Incl. $9.0m strategic capex

Against a KPI of a budgeted baseline (non-strategic) spend of $7.0m.
Strategic incorporates funded project such as Children's Hospital & ISU

YTD Activity vs Plan (CWDs)

0.5% behind[1]

-677 CWDs behind PVS plan (-286 IDF CWDs , but -131 Hutt behind). Month result -1,034 CWDs excluding work in progress.

YTD Paid FTE

5,823.77[3]

YTD 244 below annual budget of 6,068 FTE. There is 591 FTE vacancies at end of July

Annual Leave Taken

($16.0m) annualised[4]

Underlying YTD annual leave taken is under by 6.2 days per FTE and Lieu leave taken for public holidays is short by 3.3 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 423 cwd outsourced (223 events) ~$2.6m 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 – August 2021

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
66.6%	567	412**	2
29.4% below the ED target of 95% Monthly +19%	Against a target of zero long waits a monthly movement of +126	Against a target of zero long waits, a monthly movement of +117 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.5% behind[1]	3,800.26[3]	$6,154*
-677 CWDs behind PVS plan (-286 IDF CWDs , but -131 Hutt behind). Month result -1,034 CWDs excluding work in progress.	YTD 39 below annual budget of 3,839 FTE. 267.75FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Jul 2021

[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 423 cwd outsourced (423 events) ~$2.6m 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 Funder has an August YTD favourable variance of $0.8m made up of a favourable revenue variance of $8.4m offset by an unfavourable cost variance of ($7.6m).
- CCDHB has additional COVID-19 accrued and paid revenue of $9.6m. The offsetting COVID-19 costs are ($9.6m). MoH has agreed to a full cost recovery for the COVID-19 response. The ongoing demand for managed isolation facilities, and community surveillance continues. The COVID-19 vaccination rollout is progressing and will ramp up over the next 4 to 6 months. Due to the Delta outbreak and the level 4 lockdown, the vaccination programme was accelerated with a number of pop-up and drive-through vaccination sites activated at very short notice. There is a strong focus on equity for Māori, Pacific and vulnerable communities as part of the rollout to make sure vaccination coverage of these populations is prioritised.
- The cost of funding non COVID community services is $0.07m favourable to budget. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also below budget.
- The volume throughput in HHS reduced in August due to the level 4 lockdown and the funder paid $2m less for the Provider Arm services and received ($2.2m) less IDF revenue from other DHBs.
- 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:
    - To reduce ASH rates we have trialed after-hour GP video consults, expanding school-based health services in pre-schools and reviewing relevant respiratory health pathways. Our immunisation decline insights work has commenced. We're also strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children who are yet to receive vaccinations are followed-up with by their GP. We are also looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Tamariki Māori. Plunket has also developed an Action Plan to drive its performance for Māori.
    - At the end of 2020, Tū Ora Compass was funded to reimburse NGOs for completion of ACPs with clients. This investment took place because NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities. The NGO-incentivised scheme for Advanced Care Plan completion recognises the valuable work of NGOs and provides financial support to undertake what can be challenging, lengthy and rich ACP conversations. The key benefits include: more ACPs completed and uploaded; client wishes are more accessible and can be followed by clinicians; further ACP promotion, support and socialisation to clients, whānau and staff.
    - Partnerships between PHOs and NGO provider services such as Piki Services contributed to activities that lead to improved performance for 2020/21. Further improvements are planned following the investment in primary mental health and primary liaison services. We are embedding some of the learnings from our COVID-19 experience. We are expanding primary mental health and addiction support across the 3DHBs through the Access and Choice initiative. We are working with Tū Ora Compass Health and our specialist community providers to develop a monitoring framework to evaluate outcomes and ensure equitable access.

Funder Financial Statement of Performance

Month					Capital & Coast DHB	Year to Date				
			Variance		Funder Result - $000				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Aug 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
76,176	76,176	72,885	(0)	3,291	Base Funding	152,352	152,352	145,770	(0)	6,582
5,652	5,292	6,503	360	(851)	Other MOH Revenue - Funder	11,277	10,584	11,214	693	63
5,367	0	0	5,367	5,367	COVID Revenue from MOH	9,637	0	124	9,637	9,513
84	46	329	38	(244)	Other Revenue	133	92	428	41	(295)
2,850	2,892	2,974	(42)	(125)	IDF Inflows PHOs	5,964	5,784	6,227	181	(263)
21,172	23,133	16,952	(1,961)	4,220	IDF Inflows 20/21 Wash-up Prov	44,038	46,265	35,468	(2,227)	8,570
111,301	**107,539**	**99,643**	**3,762**	**11,658**	**Total Revenue**	**223,402**	**215,077**	**199,232**	**8,325**	**24,170**
					Internal Provider Payments					
839	839	824	0	(15)	DHB Governance & Administration	1,678	1,678	1,647	0	(30)
57,777	60,939	52,433	3,162	(5,344)	DHB Provider Arm Internal Costs - HHS	119,983	123,570	108,712	3,587	(11,271)
11,558	11,558	7,752	0	(3,806)	DHB Provider Arm Internal Costs - MH	23,116	23,116	15,503	0	(7,613)
1,548	201	1,940	(1,347)	392	DHB Provider Arm Internal costs - Corp	1,984	402	3,880	(1,582)	1,896
1,623	0	0	(1,623)	(1,623)	DHB Provider Arm Internal costs - COVID	2,260	0	0	(2,260)	(2,260)
73,344	**73,537**	**62,948**	**193**	**(10,396)**	**Total Internal Provider**	**149,021**	**148,766**	**129,743**	**(255)**	**(19,278)**
					External Provider Payments:					
6,389	6,571	5,862	182	(526)	- Pharmaceuticals	13,139	13,141	11,565	2	(1,574)
7,147	6,932	6,733	(215)	(414)	- Capitation	14,154	13,864	13,460	(289)	(694)
7,327	7,454	7,027	126	(300)	- Aged Care and Health of Older Persons	14,732	14,908	14,067	176	(665)
3,359	3,184	2,769	(175)	(590)	- Mental Health	6,697	6,368	5,765	(329)	(932)
551	879	793	328	242	- Child, Youth, Families	1,404	1,759	1,575	354	171
759	845	644	86	(115)	- Demand driven Primary Services	1,593	1,689	1,279	96	(314)
2,424	2,440	2,326	17	(98)	- Other services	4,795	4,880	4,580	86	(214)
4,002	4,002	3,814	0	(188)	- IDF Outflows Patients to other DHBs	8,004	8,004	7,642	0	(362)
5,176	5,190	5,467	13	290	- IDF Outflows Other	10,401	10,380	10,801	(22)	400
37,134	**37,496**	**35,436**	**362**	**(1,698)**	**Total External Providers**	**74,919**	**74,993**	**70,734**	**74**	**(4,184)**
3,044	0	2,567	(3,044)	(477)	- Community COVID PHO	5,217	0	2,908	(5,217)	(2,310)
700	0	397	(700)	(303)	- Community COVID Other	2,160	0	573	(2,160)	(1,587)
114,223	**111,033**	**101,348**	**(3,190)**	**(12,094)**	**Total Expenditure**	**231,317**	**223,758**	**203,957**	**(7,559)**	**(27,359)**
(2,922)	**(3,495)**	**(1,705)**	**573**	**(1,217)**	**Net Result**	**(7,915)**	**(8,681)**	**(4,725)**	**766**	**(3,190)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	1,623	2,260
COVID-19 Community funding	3,744	7,377
PHOs volume variances offset	162	584
Mental Health, Aged Care, Family CFAs	160	262
CWD IDF 2020/21 below target	(1,927)	(2,159)
Year to Date Revenue Variances	**3,762**	**8,325**

External Revenue Variances

- COVID-19 actual funding and accrued provision of $9.64m in support of GP assessment testing, pharmaceutical costs, vaccine rollout, quarantine hotel staffing & response funding for Maori and Pacific groups. The DHB will be fully funded for all COVID community, MIQ and Vaccine rollout costs.
- PHO additional wash-ups and volume funding of $0.6m. There are increased costs of ($0.35m) offsetting this revenue. New funding for Mental Health and Child & Youth services of $0.3m has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by ($2.2m) mainly due to COVID lockdown period in August.

CCDHB Funder Arm total net variance to budget for the month of Aug 2021 is $0.8m

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(1,623)	(2,260)
COVID-19 Community funding	(3,744)	(7,377)
HHS PVS services reduced due to COVID	1,815	2,005
PHOs volume variances offset revenue	(180)	(349)
Volume driven costs impacted by COVID	541	423
Year to Date Payment Variances	**(3,190)**	**(7,559)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs ($9.64m) mainly due to ongoing GP test assessment claims and vaccine rollout in support of the COVID-19 response as directed by the Ministry.
- PHO Capitation expenses are ($0.35m) unfavourable. Additional costs due to volume changes are offset by additional revenue.
- Other Community NGO contracts have a net YTD variance of $0.4m. New funded NGO contracts offset lower volume trends in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- Provider Arm paid $2m less due to lower volumes achieved related to COVID lockdown period.

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Aug 2021 $000's
Inpatient CWD	(1,747)
Outpatient Non DRG	(304)
Uncoded & PCT	(108)
PHO Volume changes	184
Other IDF Inflows	(72)
Total per Financials	**(2,046)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($1.7m) YTD. Breakdown of the variance commented below:

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($408k): Cardiology ($537k), Haematology ($323k), Neurosurgery ($307k), followed Vascular Surgery ($215k), General Surgery ($156k), Renal Medicine ($154k), Spec Paediatric Surgery ($115k), and Offset by Cardiothoracic Surgery $399k, Orthopaedic Surgery $354k, Otorhinolaryngology $214k Gen Med $158k, Maternity Service $137k Oncology $101k
  - Planned Care: ($1,339m); Cardiothoracic ($769), Neurosurgery ($312k), Vascular Surgery ($169k), Cardiology ($151k), General Surgery ($135k) and offset by Ophthalmology $204k, Orthopaedic $98k
  - 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

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

Commissioning: Families & Wellbeing

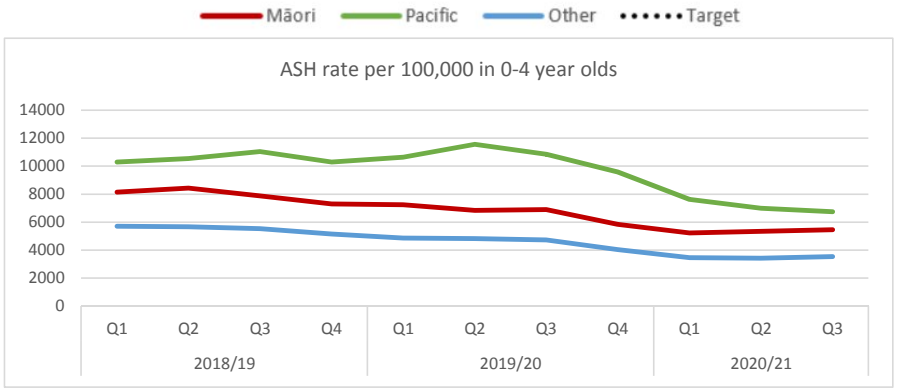
What is this measure?
- Decrease in the ambulatory sensitive hospitalisation rate (0-4 years)
- 95% of children fully immunised at 5 years
- 90% of children have their B4SC completed

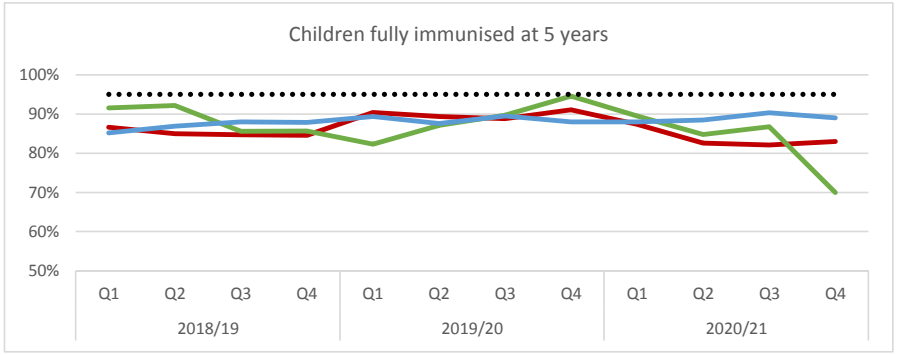
Why is this important?
- Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through preventative care and coordinated care in the community and primary care setting.
- Children who receive the complete set of age-appropriate vaccinations are less likely to become ill from certain diseases.
- The Before School Check (B4SC) aims 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.

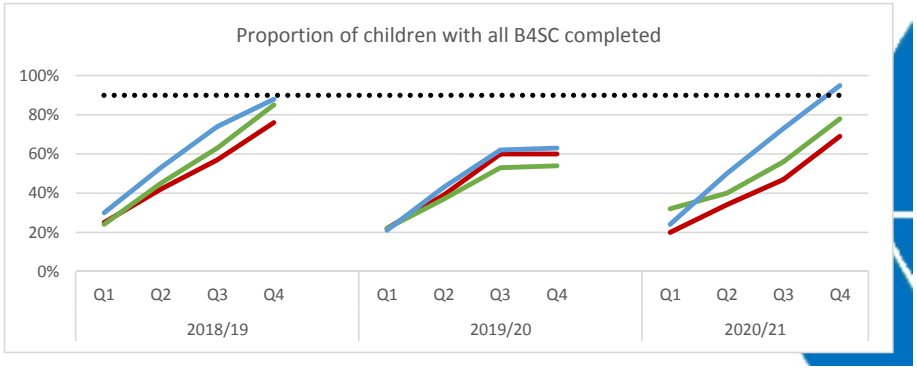
How are we performing?
- Performance for CCDHB ASH rates is 5,455 for Māori, 6,736 for Pacific and 3,532 for non-Māori, non-Pacific.
- Performance is below the 95% target for 5 year old immunisation coverage for Māori (83%), Pacific (70%), and non-Māori, non-Pacific (89%).
- Performance is below the 90% target for children receiving all B4SC checks for Māori (69%) and Pacific (78%). Performance is above target for non-Māori, non-Pacific (95%).

What is driving performance?
- Increases in hand hygiene and border closures have had the most significant impact on reducing ASH rates.
- The 1 October change to the schedule (which changed the two MMR doses from 12 months and 4 years to 12 months and 15 months) may be impacting immunisation coverage. A 2DHB Immunisation Improvement Plan has been developed to drive performance improvement.
- Plunket subcontracts part of its B4SC service to Ora Toa PHO to meet part of the needs for Tamariki Māori.

Management Comment
- To reduce ASH rates we have trialed after-hour GP video consults, expanding school-based health services in pre-schools and reviewing relevant respiratory health pathways.
- Our immunisation decline insights work has commenced. We're also strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children who are yet to receive vaccinations are followed-up with by their GP.
- We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Tamariki Māori. Plunket has also developed an Action Plan to drive its performance for Māori.







Commissioning: Primary & Complex Care

What is this measure?

End of life

- % of clients assessed by InterRAI with an Enduring Power of Attorney (EPOA) in place
- % of clients assessed by InterRAI having funded Advanced Care Plan (ACP) consultation

Why is this important?

- An EPOA appoints someone to make decisions about an individual's personal care and welfare on their behalf.
- Advance Care Planning is a voluntary process of discussion and shared planning for future health care. The process assists the individual to identify their personal beliefs and values, and incorporates them into plans for future health care. This may indicate who the EPOA is. The 2DHB ACP aligns with the HQSC's national ACP overarching vision to "Empower New Zealanders to participate in planning their future care." This has a particular focus on removing inequities in healthcare and outcomes for Māori.

How are we performing?

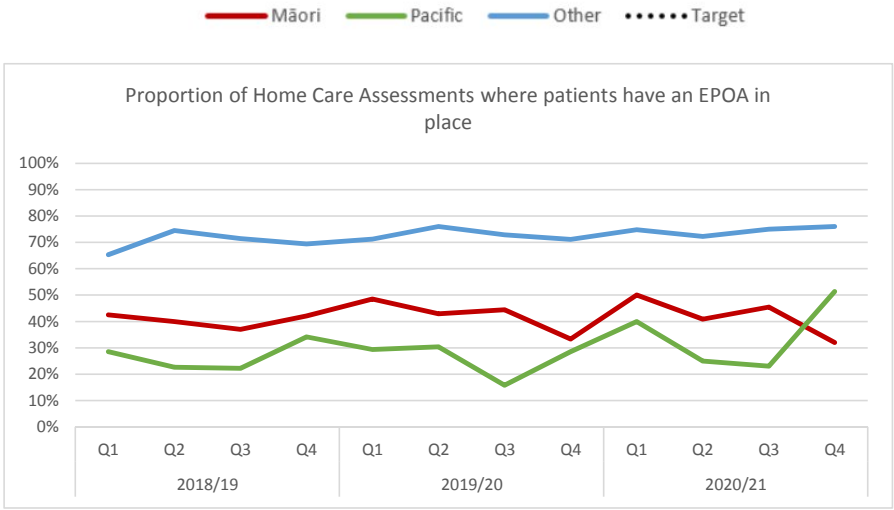
- There are no national or local targets for these performance measures.
- Performance for Home Care Assessments where an EPOA was in place is 32% for Māori, 51% for Pacific, and 76% for non-Māori, non-Pacific.
- Performance for Home Care Assessments with a completed ACP is 6% for Māori, 3% for Pacific, and 6% for non-Māori, non-Pacific.

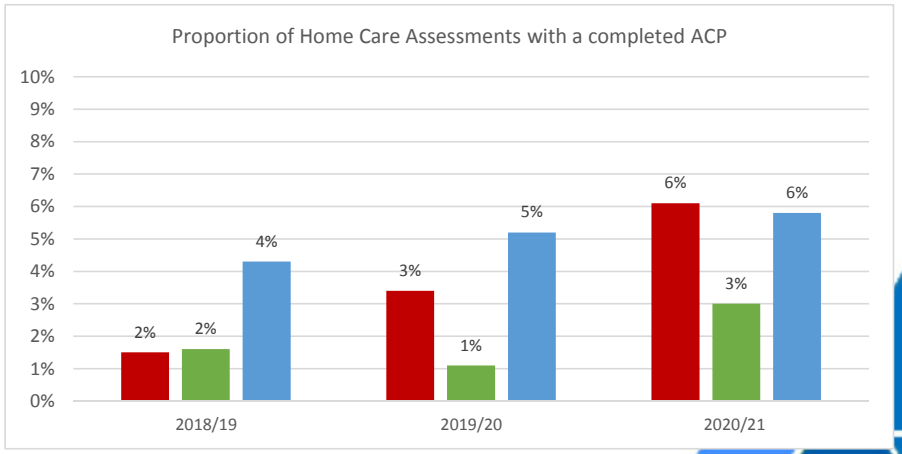
What is driving performance?

- At the end of 2020, Tū Ora Compass was funded to reimburse NGOs for completion of ACPs with clients.
- This investment took place because NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities.

Management comment:

- The NGO-incentivised scheme for Advanced Care Plan completion recognises the valuable work of NGOs and provides financial support to undertake what can be challenging, lengthy and rich ACP conversations.
- The key benefits include: more ACPs completed and uploaded; client wishes are more accessible and can be followed by clinicians; further ACP promotion, support and socialisation to clients, whānau and staff.





Commissioning: Hospital & Speciality Services

What is this measure?

Planned Care

- Did not attend (DNA) rate for first specialist appointment (FSA)
- 95% of patients with accepted referrals for CT scans will receive their scan and results within 6 weeks
- 0% of patients given a commitment to treatment, but not yet treated within the required timeframe (ESPI 5)

Why is this important?

Equity: patients receive care that safely meets their needs, regardless of where they live and who they are.
Access: patients can access the care they need in the right place, with the right health provider.
Quality: Services are appropriate, safe, effective, efficient, respectful and support improved health.
Timeliness: patients receive care at the most appropriate time to support improved health.
Experience: You and your whānau work in partnership with healthcare providers to make informed choices and get care that responds to your needs, rights and preferences.

How are we performing?

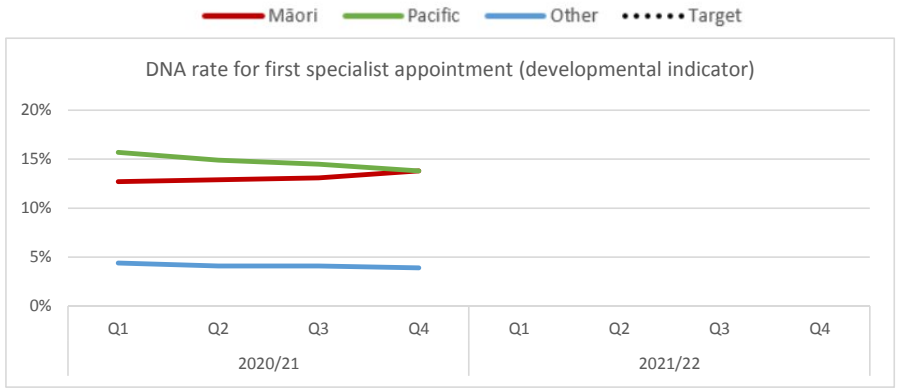
- The DNA rate for First Specialist Appointments is 14% for Māori, 14% for Pacific and 4% for non-Māori, non-Pacific.
- Performance is below the 95% target for patients receiving a CT scan in 6 weeks or less (60%).
- Performance is above the 0% target for ESPI 5 for Māori (11%), Pacific (11%), and non-Māori, non-Pacific (10%).

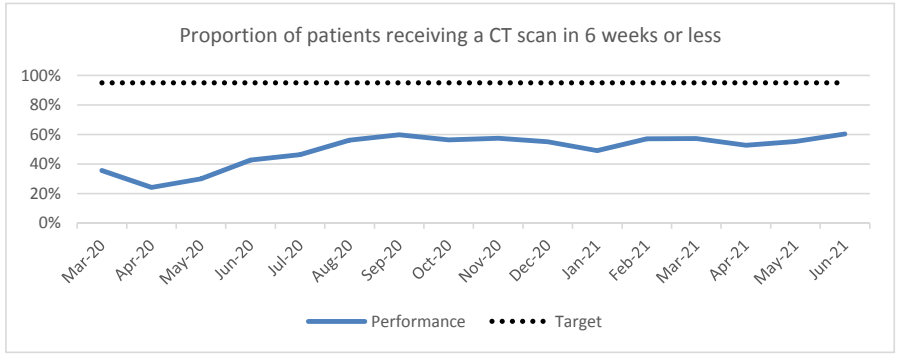
What is driving performance?

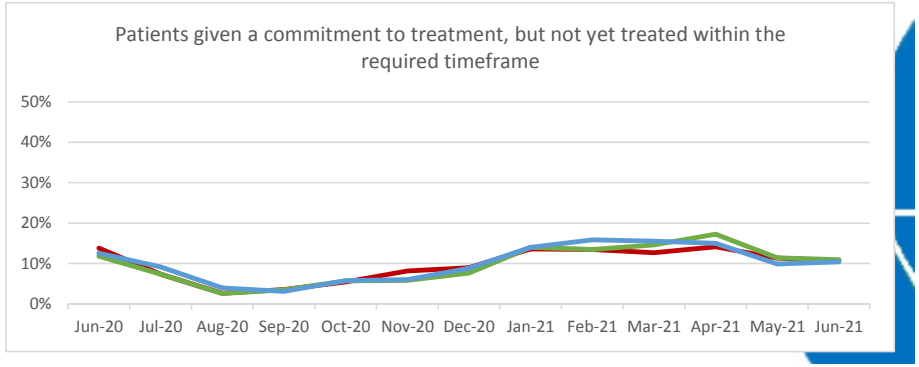
- There is significantly more activity than planned for this financial year and most of it is acute. The majority of the acute activity is surgical and this is impacting planned care provision.

Management comment:

- We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to first specialist appointments (dermatology & respiratory), access to diagnostics (CT & MRI) and access to elective general surgery. CCDHB has chosen to focus our $4.2 million service delivery funding in areas of greatest need, and are focused on areas of increasing demand, inequities and historical performance.
- Investment in CT has been prioritised to address the growing unmet demand and reduce diagnostic inequities by improving access. A mobile CT is expected to provide ~5,000 additional appointments per year and make it easier for patients to access diagnostics in the community.







Commissioning: Mental Health & Addictions

What is this measure?
- Number of self-harm hospitalisations (0-24 years)
- Number of activities delivered via technology-enabled services
- Number of referrals from Access and Choice general practices to specialist mental health services

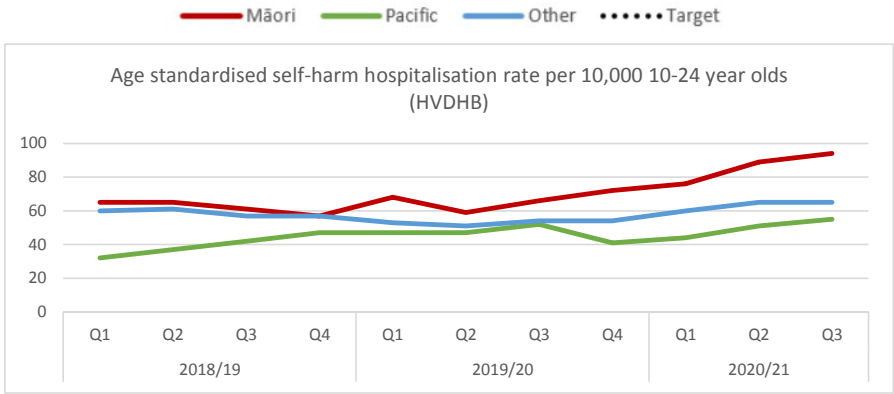
Why is this important?
- Intentional self-harm in young people is indicative of distress. Proactive support for young people includes through primary mental health responsiveness and referral pathways, appropriate secondary care, and cross-sector/community support.
- Technology-enabled services, such as telehealth and video counselling, made it possible for services to be delivered remotely during COVID-19 lockdowns, and are being evaluated as viable long-term options to improve accessibility.
- The Access and Choice service aims to educate people on the specialist mental health services available to them, and how to access them. This enables people to engage and make choices that are right for them.

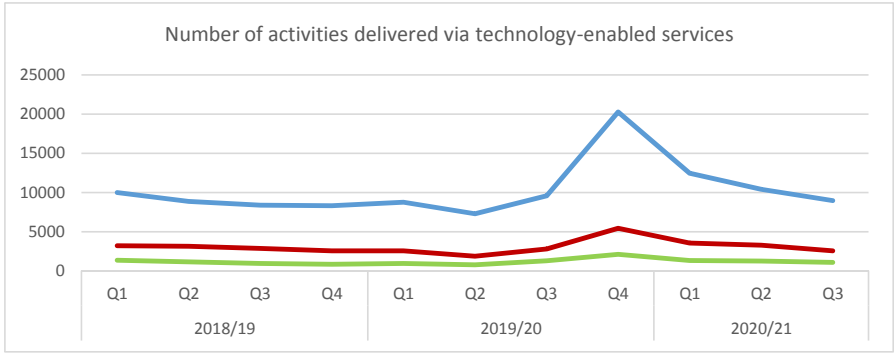
How are we performing?

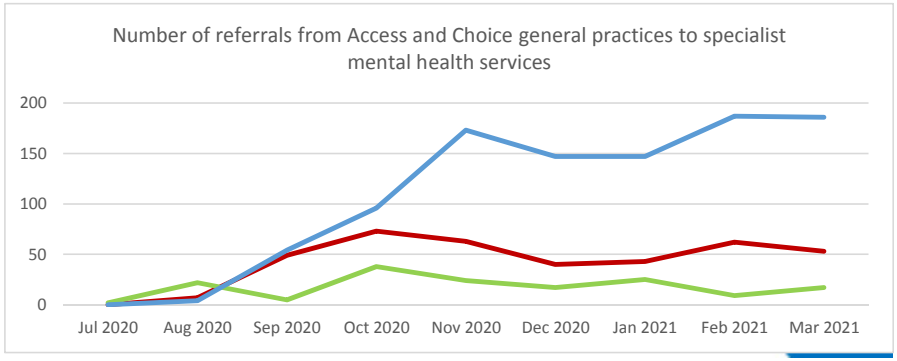
There are no national or local targets for these performance measures.
- The rate of self-harm hospitalisations per 10,000 10-24 year olds is 94 in Māori, 55 in Pacific and 65 in non-Māori, non-Pacific.
- The number of activities delivered by technology-enabled services was 2,566 for Māori, 1,071 for Pacific, and 8,946 for non-Māori, non-Pacific.
- The number of referrals to Access and Choice was 53 for Māori, 17 for Pacific, and 196 for non-Māori, non-Pacific.

What is driving performance?
- Partnerships between PHOs and NGO provider services such as Piki Services contributed to activities that lead to improved performance for 2020/21.

Management comment
- Further improvements are planned following the investment in primary mental health and primary liaison services. We are embedding some of the learnings from our COVID-19 experience.
- We are expanding primary mental health and addiction support across the 3DHBs through the **Access and Choice** initiative. We are working with Tū Ora Compass Health and our specialist community providers to develop a monitoring framework to evaluate outcomes and ensure equitable access.







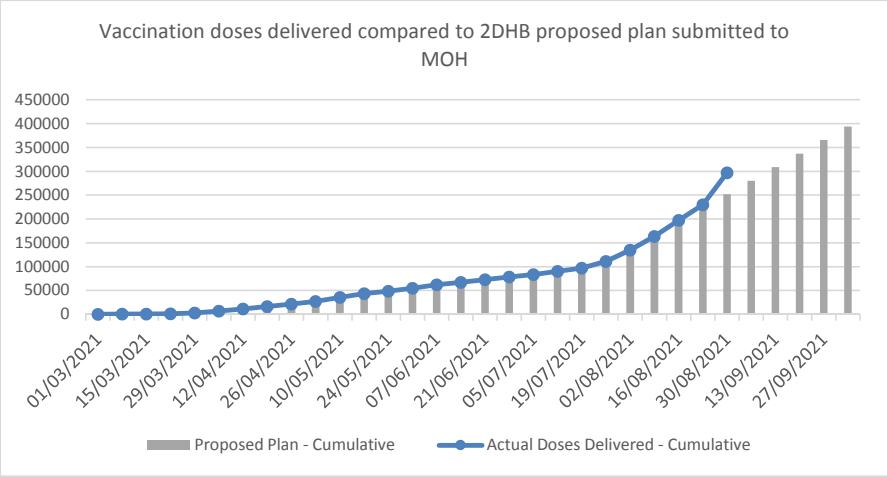
2DHB COVID-19 Response

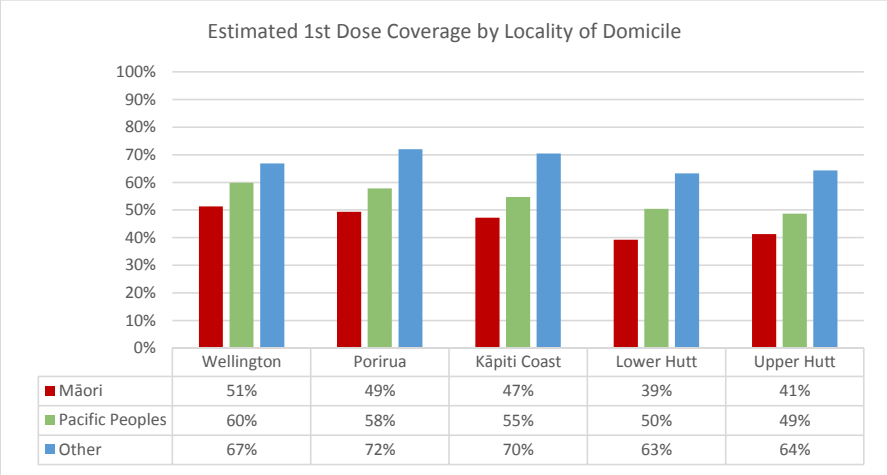
What is this measure?
- COVID-19 vaccination roll-out

Why is this important?
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

How are we performing?
- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area
- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings
- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

Data and statistics about the rollout of COVID-19 vaccines in CCDHB can be found here.





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	51%	49%	47%	39%	41%
Pacific Peoples	60%	58%	55%	50%	49%
Other	67%	72%	70%	63%	64%

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 29/08/2021
Data current at: 30/08/2021 @10.15am

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 lockdown was felt across all specialities and services. In particular capacity to provide Planned Care surgery already disrupted by acute demand, RSV outbreaks, industrial action, was exacerbated by the further COVID-19 lockdowns. Access to Planned Care services is prioritised based on clinical acuity, however there remains a service delivery and financial risk that in the constrained environment the DHBs will not be able to deliver the full planned care funding schedule nor reduce waiting list size so that people are treated within 120 days.
- Both DHBs are maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity. Investment in innovation will help to provide alternative solutions for people to access and reduce the number of people requiring treatment, these will take time to implement. The DHBs remain committed to providing Planned Care to the populations that we serve.
- Work continues with the Front of Whare, 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt) – in respect of the former, this work is supported by expertise from the MOH and is inextricably linked to other ongoing work to assess and address overall hospital capacity.
- Continued workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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 2D 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.
- A cautious start to the new financial year – meeting budget.

CCDHB Contract Activity Performance

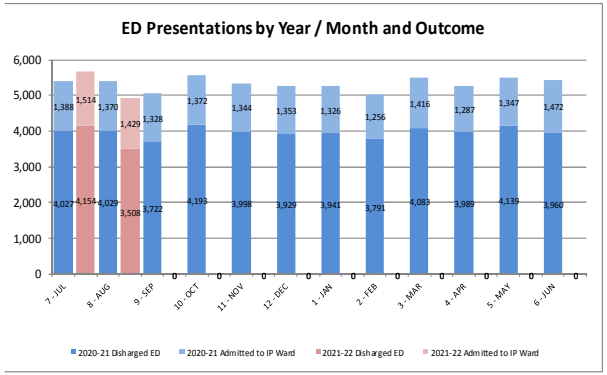
Capital and Coast DHB: August 2021

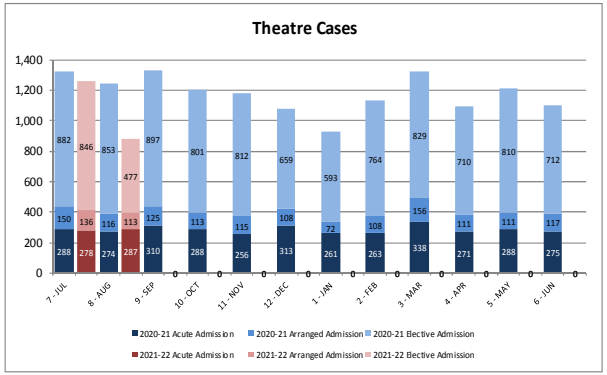
ED Presentations

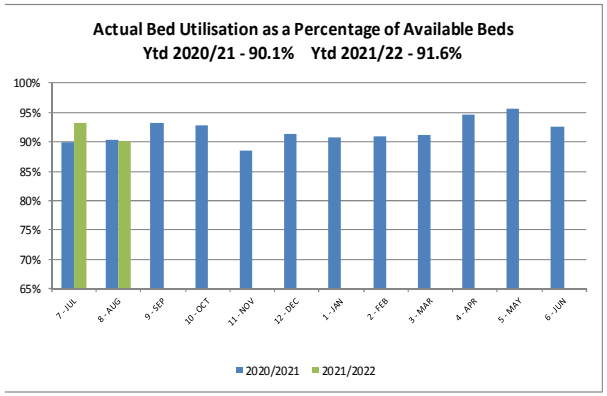
	2020/21	2021/22
YTD Totals	10,814	10,605
Change		-209
% Change		-2%

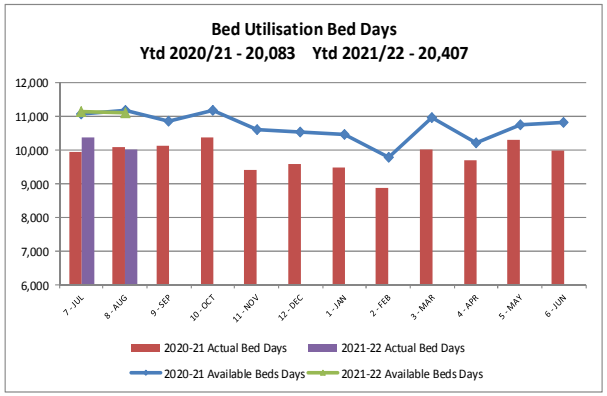
Theatre Cases

	2020/21	2021/22
YTD Totals	2,563	2,137
Change		-426
% Change		-17%









ED

- The total number of presentations to ED in August 2019 was 5,756 (this includes 464 DNWs)
- The total number of presentations to ED in August 2020 was 5,369 (this includes 401 DNWs)
- The total number of presentations to ED in August 2021 was 5,292 (this includes 297 DNWs)
- The average number of daily presentations in August 2021 was 160.1, this is lower than last month July 2021 183.6 which can be largely attributed to lockdown protocols.
- The average number of presentations prior to lockdown (1st August to 17th August) was 165 which in itself is low but during the lockdown period (18th August to 31st August) the number fell further to an average of 133 presentations per day.
- The number of Patients with a triage level of 1-3 combined in August 2021 is 3,311 this represents 66.7% of the total presentations, this is the same as August 2020 which had a rate of 66.4% but a significant increase on the 62.3% rate recorded in August 2019.

Bed Utilisation

- The utilisation of available of adult beds in core wards in August was 90.1% which is similar to the 90.3% rate recorded in August 2020. The number of available beds in August 2021 (358) is lower than in August 2020 (361) with more beds temporarily opened at Kenepuru in August 2021 but countered by with more beds available in Wellington August 2020.
- The number of Elective theatre cases has decreased for the month of August 2021 by 44.1%
- (376 cases) when compared to August 2020. This can solely be attributed to lockdown protocols with decreases most evident in General Surgery (74) Gynaecology (65), Ophthalmology (57), Orthopaedics (43) and ENT (33).

CCDHB Activity Performance

Capital and Coast DHB: August 2021

HSS Inpatient Caseweight Activity

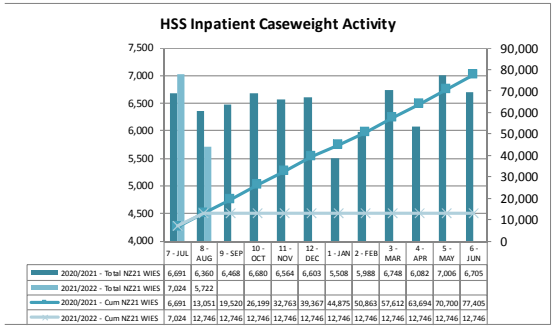
	2020/21	2021/22
YTD Totals	13,051	12,746
Change		-305
% Change		-2.3%

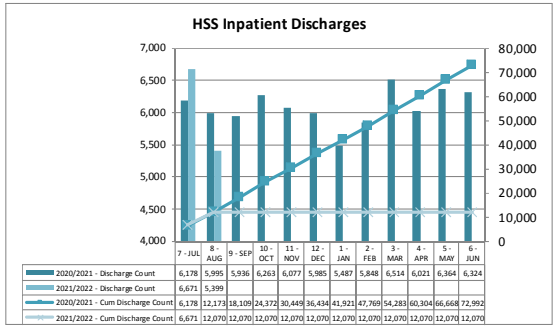
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2020/21	2021/22
YTD Totals	12,173	12,070
Change		-103
% Change		-0.8%

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



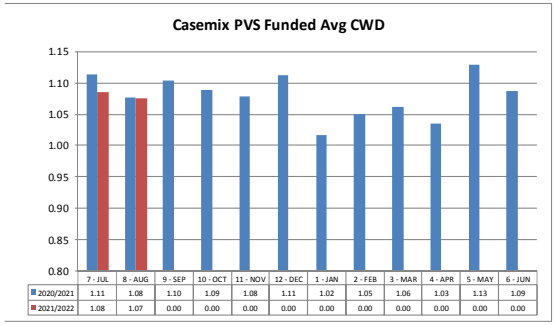


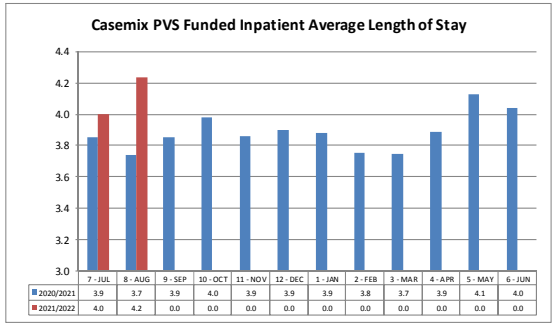
Casemix PVS Funded Avg CWD

	2020/21	2021/22
YTD Totals	1.08	1.08
Change		0.00
% Change		0%

Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	4.11
Change		0.22
% Change		5.7%





Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (334 CWDs) with an increase in discharges; a higher ALOS and a similar average CWD. The discharge increase is driven primarily by Paediatric Medicine and Emergency Medicine. The CWD increase is driven primarily by Paediatric Medicine, General Medicine and Emergency Medicine.
- Local Elective CWDs are lower than the previous financial year (-298 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by General Surgery, ENT and Cardiology. The CWD decrease is driven primarily by General Surgery and Orthopaedic Surgery.
- IDF acute CWDs are higher (341 CWDs) than the previous financial year also with an increase in discharges; a higher ALOS and similar average CWD. The discharge increase is driven primarily by Gynaecology and Cardiology. The CWD increase is driven primarily by Neonatal and Orthopaedic Surgery.
- IDF Elective CWDs are higher than the previous financial year (-408 CWDs) with less discharges; a higher ALOS and a higher average CWD. The discharge decrease is driven primarily by Cardiothoracic Surgery and Vascular Surgery. The CWD decrease is driven by Cardiothoracic Surgery, Neurosurgery and Vascular Surgery.
- In combination these four admission groups equate to a decrease of 129 CWDs compared to the previous year. The services that most significantly impact this shift are Cardiothoracic Surgery (-395), Neurosurgery (-172) countered by increases in Neonatal (195), Paediatric Medicine (171) and Emergency Medicine (150).

Discharges:

- The number of publicly funded casemix discharges for the month of August 2021 has decreased by 486 (8.2%) in comparison to the number of discharges recorded in August 2020. This decrease can be largely attributed to the impact of lockdown which impacted primarily both the number of Elective Discharges (420) and presentations to ED (Emergency Medicine (130)).
- The number of outsourced discharges recorded in August 2021 was 70 which is 30 higher than August 2020. CCDHB in August 2021 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.
- However the impact on volumes overall was smaller than the last level 4 lockdown – we will look at the entire lockdown period for the next report. At the time of writing this report the number of cancelled planned care surgeries at Capital coast during lockdown, is circa 702.

HHS Operational Performance Scorecard – period Aug 20 to Aug 21

Domain	Indicator	2021/22 Target	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug
Care	Serious Safety Events	TBD	9	11	5	19	6	12	13	3	9	7	4	9	2
	Total Reportable Events	TBD	1,270	1,370	1,359	1,418	1,512	1,424	1,483	1,451	1,423	1,540	1,364	1,479	1,242
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	94.3%	93.9%	94.9%	90.9%	83.0%	93.1%	95.5%	92.3%	93.7%	93.4%	87.4%	78.9%	98.2%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,399	5,050	5,565	5,342	5,282	5,267	5,047	5,499	5,276	5,486	5,432	5,668	4,937
	Emergency Presentations Per Day		174	168	180	178	170	170	180	177	176	177	181	183	159
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%	64.0%	56.2%	66.6%
	ELOS % within 6hrs - non admitted	TBD	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%	75.6%	71.7%	76.1%	73.2%	64.5%	77.4%
	ELOS % within 6hrs - admitted	TBD	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%	42.7%	40.6%	41.2%	42.1%	37.0%	42.4%
	Total Elective Surgery Long Waits	Zero Long Waits	107	99	184	208	306	492	541	529	527	354	376	441	567
	Additions to Elective Surgery Wait List		1,376	1,543	1,397	1,391	1,288	922	1,243	1,454	1,223	1,451	1,350	1,221	859
	% Elective Surgery treated in time	TBD	84.2%	90.3%	89.0%	86.3%	88.4%	75.5%	75.6%	72.2%	72.1%	75.0%	82.4%	83.2%	81.4%
	No. surgeries rescheduled due to specialty bed availability	TBD	9	13	14	1	6	2	6	11	7	13	21	16	6
	Total Elective and Emergency Operations in Main Theatres	TBD	1,192	1,254	1,130	1,118	1,002	878	1,076	1,270	1,063	1,190	1,085	1,209	807
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	85.0%	87.0%	82.0%	85.0%	88.0%	82.0%	90.0%	88.0%	86.0%	83.0%	96.0%	85.0%	81.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	83.0%	88.0%	88.0%	83.0%	89.0%	88.0%	83.0%	96.0%	79.0%	83.0%	91.0%	76.0%	77.0%
	Specialist Outpatient Long Waits	Zero Long Waits	571	314	245	225	314	353	355	302	244	211	265	295	412
	% Specialist Outpatients seen in time	Zero Long Waits	84.9%	90.1%	88.7%	92.1%	92.9%	89.1%	88.0%	85.5%	79.9%	90.4%	90.2%	89.0%	88.3%
	Outpatient Failure to Attend %	TBD	6.7%	7.0%	7.6%	7.7%	7.9%	7.3%	7.5%	7.2%	7.1%	7.4%	7.0%	7.3%	7.0%
	Maori Outpatient Failure to Attend %	TBD	13.7%	15.1%	15.3%	16.0%	16.6%	16.0%	16.1%	15.6%	15.7%	15.0%	15.2%	16.4%	14.5%
	Pacific Outpatient Failure to Attend %	TBD	14.4%	14.6%	16.3%	16.2%	18.7%	19.6%	17.7%	16.7%	15.5%	16.3%	15.6%	15.9%	16.5%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1m	$1m
	Contracted FTE (Internal labour)		5,035	5,237	5,267	5,264	5,257	5,256	5,344	5,346	5,366	5,364	5,340	5,335	5,363
	Paid FTE (Internal labour)		5,369	5,607	5,608	5,651	5,694	5,695	5,813	5,727	5,791	5,783	5,745	5,758	5,814
	% Main Theatre utilisation (Elective Sessions only)	85.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%	80.0%	79.0%	79.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	22.8%	24.8%	22.2%	25.1%	22.6%	22.3%	21.9%	23.2%	25.3%	23.6%	25.3%	20.7%	21.8%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	35	51	33	34	37	37	38	41	37	35	38	44	40
	Adult Overnight Beds - Average Occupied WLG	TBD	363	382	378	363	360	355	373	381	381	386	387	383	355
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	19	18	23	18	17	16	14	19	19	22	17	32	34
	Adult Overnight Beds - Average Occupied KEN	TBD	72	74	76	67	64	67	71	69	72	73	73	79	83
	Child Overnight Beds - Average Occupied	TBD	23	22	23	24	22	17	19	22	22	22	25	30	23
	NICU Beds - ave. beds occupied	36	31	38	36	33	35	38	39	44	39	42	36	40	38
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.74	3.85	3.98	3.86	3.90	3.88	3.75	3.75	3.88	4.13	4.04	4.00	4.23
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%	4.0%	4.0%	4.3%
	Presentations to ED within 48 hours of discharge	TBD	201	215	254	171	170	218	202	194	247	253	218	224	211
Staff Experience	Staff Reportable Events	TBD	156	138	179	173	175	147	185	162	156	149	158	153	125
	% sick Leave v standard	TBD	4.0%	3.6%	3.4%	3.4%	3.2%	2.0%	2.7%	3.5%	3.0%	3.6%	3.8%	4.3%	4.1%
	Nursing vacancy	TBD	265.3	251.1	247.4	267.4	268.5	267.8	223.4	234.7	235.6	244.0	249.1	275.4	273.0
	% overtime v standard (medical)	TBD	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%	1.8%	2.0%	1.9%	2.4%	2.2%

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.
- Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services.
- Increasing performance on this measure will also result in a more unified health system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay.

How are we performing?

- CCDHB SSIED performance for August 2021 was 66.4%. This result is an increase on the 55.9% recorded last month in July 2021.
- CCDHB SSiED performance for August 2021 is 33.0% lower than the Target for SSiED. The count of breaches in ED 1,569 in August 2021 is similar to 1,576 recorded in August 2020 1,569. The performance for ED treated and discharged patients for August 2021 was 79%, which is a 1% increase on the result for August 2021. The performance for ED admitted patients for August 2021 was 43%, which is 8% lower than the result for August 2021.
- Bed occupancy continues to be one of the most significant contributing factors to SSiED compliance. The occupancy percentage utilisation for August was 90% (optimum occupancy of 95%).
- The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in August 2021 was 358.
- During the month of August 2021 there was a single presentation where the patient was suspected of having COVID-19 but whose results were later returned as negative.

Performance	JUN	JUL	AUG
2018-19	76%	78%	75%
2019-20	75%	73%	68%
2020-21	64%	56%	66%

Breaches	JUN	JUN	AUG
2018-19	1,188	1,149	1,315
2019-20	1,259	1,358	1,576
2020-21	1,782	2,223	1,569

ED Volumes	JUN	JUN	AUG
2018-19	5,031	5,285	5,284
2019-20	4,952	5,024	4,998
2020-21	4,982	5,036	4,664

What is driving performance?

- Our performance being less than target continues to be due to the increase of acute surgical work. A significant increase in the acuity of acutely admitted patients have contributed to very high hospital occupancy and subsequent access block. We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our inpatient wards to manage COVID case definition vs. non-COVID patients. The requirement to enhance these processes were a major factor in worsening access blocks during the Wellington Alert level 4 lockdown in late August. Our acute flow programme of work continues as mentioned in the previous report. Unfortunately, these processes have reached breaking point and do not result in any further improvement for patient waiting times and patient flow from ED.

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. The very small footprint of the Emergency Department cannot tolerate any delays in moving patients from ED to the wards and this, combined with the high hospital occupancy and long waiting list for rest homes placement contributes significantly to the level of overcrowding in ED.
- Other work streams continue to be progressed but are unlikely to have any noticeable effect on patient flow unless the capacity issue is addressed. Complexity of cases on the ward is contributing to high hospital occupancy.
- It is important to note that while these initiatives are all very important and will continue, they will not make any further impact on the very poor SSiED performance at CCDHB without a complete revamp of the way in which acute patients present and are processed from the front door (including transition to assessment and observation units). The Front of Whare project will identify the barriers and confirm the need for improved resources (facilities and personnel). This work is supported by expertise from the MOH and 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?

- This month we are unable to report on our year to date position as the IDF outflow data submitted by other DHB's is yet to be actualised.
- Reporting our internal planned care results for August month show us 353 adverse to the planned 860 discharges.
- Our in-house elective surgical PUC results were 248 adverse to the planned 561 and outsourcing adverse 98 to the planned 157. Elective non-surgical PUC resulted 6 behind our planned target. Arranged surgical 8 behind plan and arranged non-surgical 7 ahead.
- Minor procedures both in-house reporting 138 over the planned 214 for August.

What is driving performance?

- Reduced access to theatres because of the COVID 19 pandemic from 19 August in Wellington for all specialties other than cardiac and neurosurgery has been driver of this result.

Management Comment

- Due to the Delta variant of Covid-19 in our region we have had less access to our own operating theatres as well as private, who set a different criteria previously. Since lockdown on August 19 we have only had access to 7 theatre sessions in private for urgent cancer work.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

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 but are slowly trending up, though flattening out in late 2020/early 2021 mainly due to high demand for both services and high technical staffing vacancies.

What is driving Performance?

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

Figure Two: CT wait times

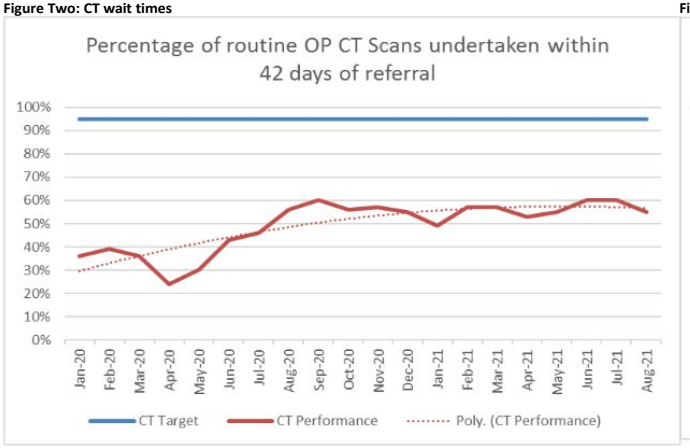
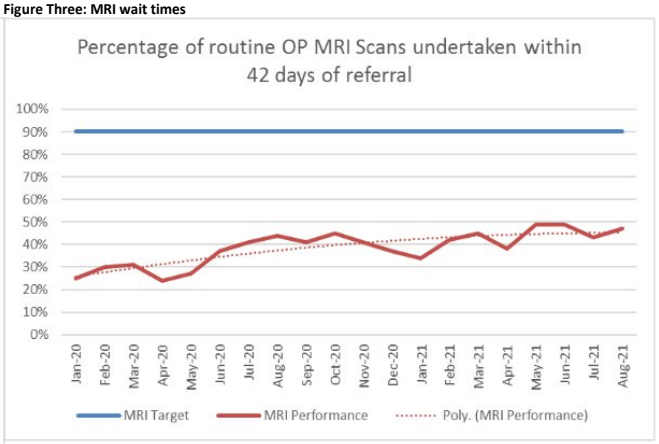


Figure Three: MRI wait times



Management Comment

- With current waiting times there is still 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.
- The Radiology service has received over 12 resignations from within the technical team (MIT – Medical Imaging Technologist) workforce since Easter 2021. This is over 20% of MIT workforce and creates a significant gap in capacity. For CT scanning this has resulted in an approximately 17% reduction in outpatient (OP) booking slots as shifts are unable to be filled.
- Recruitment for the vacant positions continues but due to the specialised nature of the MIT workforce and lack of a timely overseas recruitment process, we are unlikely to see any significant reduction in the MIT vacancy within the department. We do not anticipate a recovery of internal OP capacity until 2022 following the yearly intake of NZ-trained MITs who will graduate in December 2021.
- The latest lockdown will again further increase waiting times with significant disruption to both internal capacity and outsourced capacity. Recovery from this dip will be extremely challenging as private capacity to increase outsourced services is limited.
- Unfortunately, we expect waiting times to increase over the next 6 – 8 months. Outsourcing continues at the maximum capacity across service providers available within the region.

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 99.0% this month.

What is driving performance?

- Target has been met this month. Administration/booking have been focusing on ensuring timeframes are met, and interventional session cover has improved. COVID lockdown has affected total numbers

Management Comment

- With the partial return of two interventionists from parental leave session cover is better, and previous roster changes have increased the number of sessions and a reduced waiting list

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?**

  <u>Door to cath. <= 3 days July results (Target is ≥70%):</u>

National Performance	74.8% (576/770)
Central Region	76.6% (121/158)
CCDHB	89.7% (35/39)
Hawkes Bay	55.2% (16/29)
Hutt Valley	61.9% (13/21)
Mid Central	83.3% (25/30)

  As a region we achieved the target. Hawkes Bay and Hutt Valley DHB's are below target this month.

What is driving performance?

- Achievement of the target differs for each centre. The referral to transfer is directly influenced by CCDHB, ultimately this relates to access to beds. Other factors include regional decision making timeframes, and timing of presentation.

Management Comment

- While access to beds in Ward 6 South remains an issue, a number of initiatives have been introduced which will help to reduce the length of stay on the ward, provide alternatives to admission, and allow us to manage cardiology in-patient pressures by utilizing beds in both Hutt and WRH CCUs. The regional waiting times are also monitored on a daily basis with escalation measures taken if required.
- A proposal has been submitted which in the medium to long term would provide 6 additional beds in Ward 6 South.

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 August at 76% 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 non-compliant with the 31 day indicator for August at 80% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- Of the six patients who breached the 62 day target all experienced delays in diagnostic phase including accessing a FSA appointment. The breaches occurred in the Lower GI, sarcoma, head and neck and haematological tumour streams. One Māori and four Pacifica patients were covered by the 62 day target and none breached (100%). Note acute presentations are excluded from the 62 day target.
- Twelve of the seventeen breaches in the 31 day indicator were due to capacity reasons – access to surgery, industrial action and covid deferral for urological (5), breast (3), head and neck (1), lower GI (1), upper GI (1) and gynaecological (1).
- 31 day compliance was 100% for Māori (7/7pts), 83% Pacifica (5/6pts) and 78% for other ethnicities.
- Average delay for all 31 day capacity breach patients was 69 days (range 35-169 days) a marked increase over last month (40 days).

Management Comment

- Acute demand and staffing vacancies is having a negative effect upon access to FSA, diagnostic services (imaging & pathology) and surgical services. This was exacerbated in some services due to deferrals for strike planning and COVID -19.
- Four patients who commenced treatment in August had a delay in their pathway due to covid-19. One of these was a patient with breast cancer who was placed on hormones due to her surgery date being deferred.
- Thirty- nine patients who have been referred with a suspicion of cancer but have yet to commence treatment, have experienced a disrupted pathway due to covid-19. This includes deferred diagnostic procedures (biopsies, hysteroscopies, other scopes), FSAs, pre assessments and surgery dates. Some patients (estimate < 6) have been referred for an alternative treatment due to surgical delays.
- Work underway includes:
  - Working with gynaecology service to improve compliance -establishment of a bleeding clinic being scoped.
  - Diagnosis via ED presentation pathway improvement project.
  - SMO Forum presentation 16 August.

The largely manual process for prospectively tracking patients can make it difficult to intervene in a timely manner to enable outsourcing within FCT timeframes.

Figure Eight: FCT 62 day target

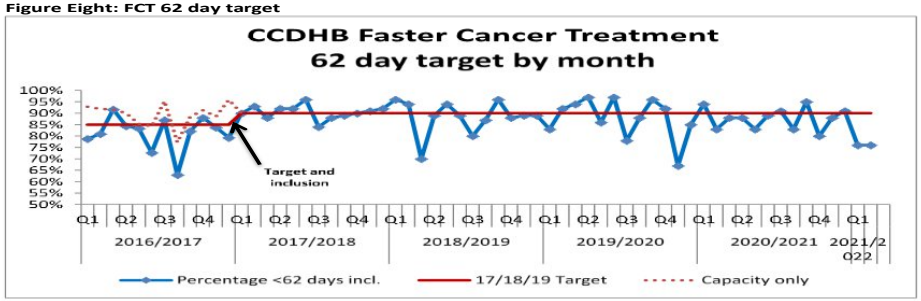
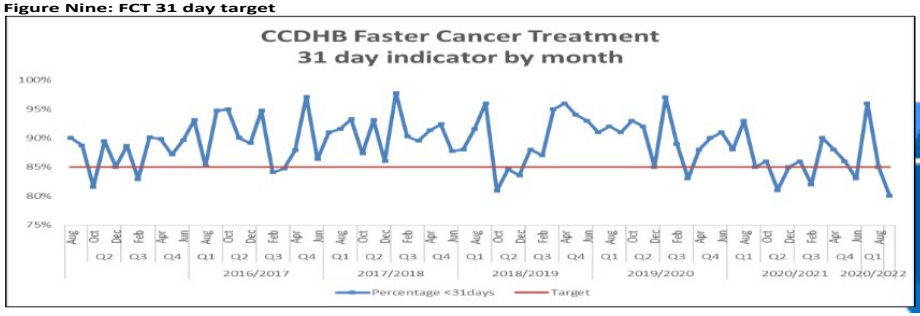


Figure Nine: FCT 31 day target



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 55.6% (target 90%). This was a significant drop in the 90.9% achieved in July. For diagnostic waits, we achieved 45.9% (target 70%) in August, which was a reduction in the July performance of 56.8%.

We exceeded the Ministry of Health target for surveillance achieving 78.7% (target 70%). This is a slight reduction from the July performance of 82.6%.

What is driving performance?

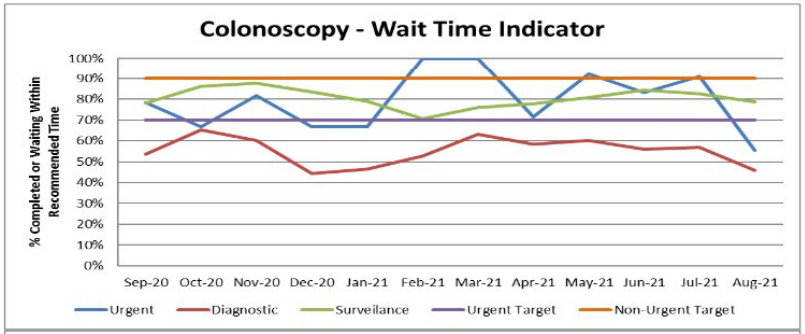
While we expected our performance to drop in August across all indicators as a result of the well documented RN vacancies and cancelled lists, the current COVID restrictions have had a significant impact on colonoscopy lists, with only the most acute cases proceeding.

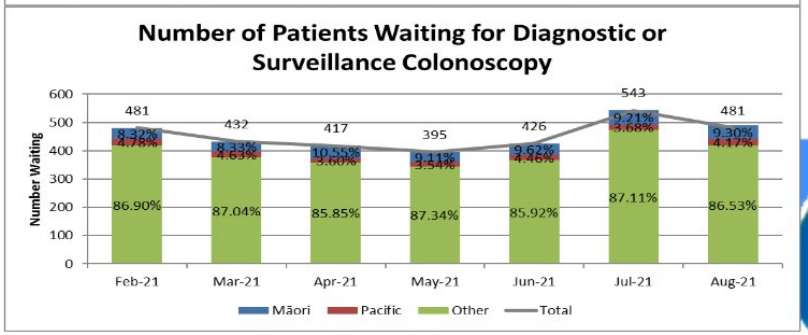
Management Comment

The current hospital COVID response level will continue to impact on the colonoscopy waiting times in September across all indicators. As restrictions ease we anticipate that will be able to resume bowel screening and urgent cases in early September.

Recruitment and training of new staff is ongoing but it will take a number of months before we are back to normal staffing levels.

An outsourcing contract has now been signed which will provide additional capacity, subject to changes to the current hospital and national COVID alert levels.





Maternity and Neonatal Intensive Care services

What is the issue?

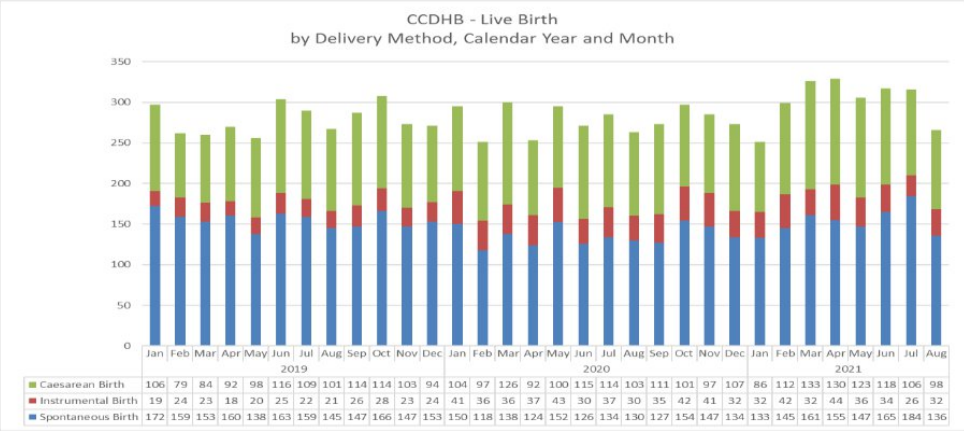
- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal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

WHS Management Comment

- Maternity services saw a reduction in births for the month of August across all birthing units. This reduced number of births corresponded to a reduction in bed utilisation for WRH birthing Suite and WRH postnatal and antenatal ward, although remains high (110%) for August.

- The MOH funded clinical coach roles (1.5 FTE) have been advertised and interviewed. The service is working with HVDHB and a recruitment agency to support the appointment of overseas and local midwives. An advertising campaign has been finalised and agreed.

Figure Eleven: Number of Births per month for CCDHB



What is the issue?

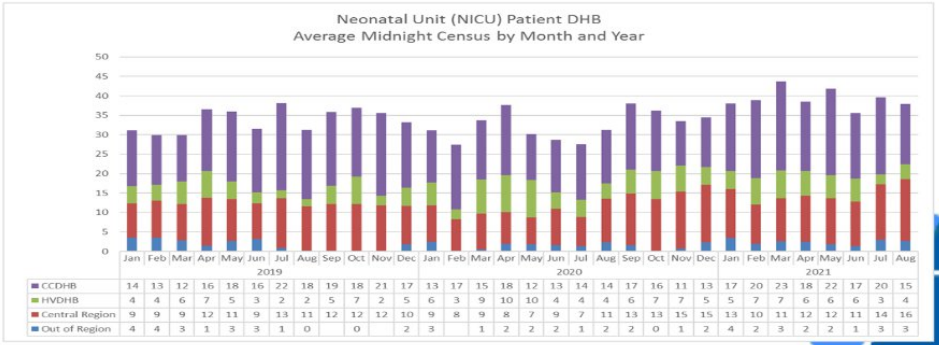
- High volumes of women birthing and on average 20% of these women transition to NICU (10% preterm, 10% other reasons).
- CCDHB's NICU has had a sustained high occupancy over the last 3 years and has consistently been above 100% occupancy for the last 12 months (graph below).
- NICU occupancy needs to be at 80-85% to safely manage the required work
- Nationally NICU's are chronically under bedded

The impact of high occupancy is:

- Increased clinical work
- Increased staffing requirements – recent increases in SMO, RMO and RN numbers.
- Care rationing where infants do not receive optimal care.
- Potential increase in infection rates (long line etc.)
- Increased sickness (average DHB 2% and NICU average 3%in last year).
- Increased intensive care operational costs (consumables and equipment).

How are we performing?

- NICU is safely managing the physical wellbeing of infants and families (with the above impacts).
- CCDM RN staffing continues to be successfully recruited too.
- The retrieval service over the last 3 years, on average, has transported 381 infants per year.
- In 2019/20 there were, on average, 26 transports undertaken per month.
- In 2020/21 there were, on average, 32 transports undertaken per month.



Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has an annual budgeted surplus of $1m, resulting from the recognition of $60m donation of the new Children's Hospital in March 22. The underlying deficit is ($59m) including Holidays Act Provision.
- The responsible deficit YTD was $400k favourable against budget.
- As an extraordinary item COVID-19 is not included within the budget, which the ministry has advised is regarded as outside the DHBs performance assessment:
  - ($3.0m); COVID-19: net additional costs during COVID-19

- The DHB's cash is under pressure for 2021/22 partly due to MOH guidance on cash funding for provider arm COVID-19 costs. This was mitigated at 20/21 year end by significant delays to capex spend (offset by non cash depreciation). The DHBs bank balance at the end of August was an overdraft of ($35.7m) with $13.2m in special fund balances.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items are shown on the next slide, this is in addition to the unfunded ($4m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs

Full Last Year		Capital & Coast DHB Operating Results - $000s	Part Year to Date		Total Provision/Expense
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	YTD August 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	COVID-19
	(31,026)	Devolved MoH Revenue		(9,764)	(40,790)
		Non-Devolved MoH Revenue			0
693		Other Revenue	0		693
		IDF Inflow			0
		Inter DHB Provider Revenue			0
693	**(31,026)**	**Total Revenue**	**0**	**(9,764)**	**(40,097)**
		Personnel			
(6,336)		Medical	(19)		(6,356)
(4,360)		Nursing	(592)		(4,952)
		Allied Health	(64)		(64)
		Support	(6)		(6)
		Management & Administration	(360)		(360)
(10,696)	**0**	**Total Employee Cost**	**(1,041)**	**0**	**(11,737)**
		Outsourced Personnel			
(88)		Medical	(54)		(142)
		Nursing	0		0
		Allied Health	0		0
		Support	0		0
		Management & Administration	(78)		(78)
(88)	**0**	**Total Outsourced Personnel Cost**	**(132)**	**0**	**(220)**
(5,088)		Treatment related costs - Clinical Supp	(172)		(5,260)
(564)		Treatment related costs - Outsourced	0		(564)
(2,028)		Non Treatment Related Costs	(1,984)		(4,012)
		IDF Outflow			0
	(15,828)	Other External Provider Costs (SIP)		(7,377)	(23,206)
		Interest Depreciation & Capital Charge			0
(7,680)	**(15,828)**	**Total Other Expenditure**	**(2,157)**	**(7,377)**	**(33,042)**
(18,464)	**(15,828)**	**Total Expenditure**	**(3,330)**	**(7,377)**	**(44,999)**
19,157	**(15,198)**	**Net result**	**3,330**	**(2,387)**	**4,903**

- The year to date financial position includes $10.7m of additional costs in relation to COVID-19.
- Revenue of $9.8m 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 – August 2021

Month - August 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
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	YTD August 2021	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
87,195	81,468	79,388	5,727	7,807	5,494		81,701	233	Devolved MoH Revenue	173,266	162,936	157,108	10,330	16,158	9,764		163,502	566
3,387	3,124	3,886	263	(499)			3,387	263	Non-Devolved MoH Revenue	8,277	7,744	7,720	533	557			8,277	533
2,631	2,969	3,028	(338)	(397)	0		2,631	(338)	Other Revenue	5,633	5,925	6,722	(292)	(1,089)	0		5,633	(292)
24,022	26,024	19,926	(2,003)	4,096			24,022	(2,003)	IDF Inflow	50,003	52,049	41,696	(2,046)	8,307			50,003	(2,046)
1,249	1,468	1,132	(219)	117		0	1,249	(219)	Inter DHB Provider Revenue	2,798	2,935	1,944	(137)	855		0	2,798	(137)
118,484	**115,053**	**107,360**	**3,431**	**11,123**	**5,494**	**0**	**112,990**	**(2,063)**	**Total Revenue**	**239,978**	**231,589**	**215,190**	**8,389**	**24,788**	**9,764**	**0**	**230,214**	**(1,375)**
									Personnel									
16,724	16,760	14,570	37	(2,153)	10	168	16,546	214	Medical	33,275	33,499	29,810	224	(3,465)	19	355	32,901	598
22,192	21,579	20,009	(613)	(2,183)	293	458	21,441	138	Nursing	44,740	43,169	39,925	(1,571)	(4,815)	592	967	43,180	(11)
6,605	6,833	5,774	228	(831)	32	147	6,427	406	Allied Health	13,398	14,019	11,524	620	(1,874)	64	310	13,024	994
1,015	994	834	(21)	(181)	3	28	984	10	Support	2,018	1,982	1,726	(36)	(292)	6	59	1,953	28
7,955	7,742	6,501	(214)	(1,455)	178	176	7,602	140	Management & Administration	15,652	15,296	12,930	(356)	(2,722)	360	372	14,921	376
54,491	**53,908**	**47,688**	**(583)**	**(6,803)**	**514**	**976**	**53,000**	**908**	**Total Employee Cost**	**109,083**	**107,964**	**95,914**	**(1,119)**	**(13,169)**	**1,041**	**2,063**	**105,979**	**1,985**
									Outsourced Personnel									
917	530	796	(387)	(122)	29	0	888	(358)	Medical	1,628	1,060	1,300	(567)	(328)	54	0	1,574	(513)
19	101	39	82	20	0		19	82	Nursing	30	202	98	172	69	0		30	172
142	143	107	1	(34)	0		142	1	Allied Health	337	285	241	(52)	(97)	0		337	(52)
20	22	49	2	29	0		20	2	Support	25	44	94	18	69	0		25	18
539	234	319	(306)	(220)	78		461	(228)	Management & Administration	779	467	705	(312)	(74)	78		701	(234)
1,637	**1,029**	**1,310**	**(608)**	**(327)**	**107**	**0**	**1,530**	**(501)**	**Total Outsourced Personnel Cost**	**2,799**	**2,058**	**2,439**	**(741)**	**(361)**	**132**	**0**	**2,668**	**(609)**
10,130	11,933	11,346	1,803	1,216	87		10,043	1,890	Treatment related costs - Clinical Supp	21,650	23,726	22,479	2,076	829	172		21,478	2,248
2,296	2,648	2,997	352	701	0		2,296	352	Treatment related costs - Outsourced	4,869	5,279	4,865	409	(4)	0		4,869	409
9,769	8,104	6,951	(1,665)	(2,818)	1,809	0	7,960	145	Non Treatment Related Costs	18,031	15,794	13,237	(2,237)	(4,794)	1,984	0	16,047	(253)
9,178	9,192	9,192	13	14			9,178	13	IDF Outflow	18,405	18,383	18,251	(22)	(154)			18,405	(22)
31,700	28,305	29,208	(3,396)	(2,492)	3,478		28,222	83	Other External Provider Costs (SIP)	63,891	56,609	55,963	(7,282)	(7,928)	7,377		56,514	96
4,935	4,405	4,859	(530)	(75)			4,935	(530)	Interest Depreciation & Capital Charge	9,520	8,828	10,020	(692)	500			9,520	(692)
68,008	**64,587**	**64,553**	**(3,421)**	**(3,455)**	**5,374**	**0**	**62,634**	**1,953**	**Total Other Expenditure**	**136,367**	**128,620**	**124,817**	**(7,747)**	**(11,550)**	**9,534**	**0**	**126,833**	**1,787**
124,136	**119,524**	**113,551**	**(4,612)**	**(10,585)**	**5,996**	**976**	**117,164**	**2,360**	**Total Expenditure**	**248,249**	**238,642**	**223,169**	**(9,607)**	**(25,080)**	**10,707**	**2,063**	**235,479**	**3,163**
(5,652)	**(4,471)**	**(6,191)**	**(1,182)**	**539**	**(502)**	**(976)**	**(4,174)**	**297**	**Net result**	**(8,272)**	**(7,053)**	**(7,980)**	**(1,218)**	**(292)**	**(943)**	**(2,063)**	**(5,266)**	**1,787**
(2,922)	(3,495)	(1,705)	573	(1,217)					Funder	(7,915)	(8,681)	(4,725)	766	(3,190)				
8	(0)	73	8	(65)					Governance	35	(0)	135	35	(100)				
(2,738)	(976)	(4,559)	(1,762)	1,820					Provider	(392)	1,628	(3,389)	(2,020)	2,998				
(5,652)	**(4,471)**	**(6,191)**	**(1,182)**	**539**					**Net result**	**(8,272)**	**(7,053)**	**(7,980)**	**(1,218)**	**(292)**				

Note one 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 deficit year to date is ($8.3m) compared to a budget deficit of ($7.1m).
- Included within this result is recognition of the adjustment to an estimated net impact of COVID-19 of ($3.0m).
- Excluding the COVID-19 above this brings the year to date deficit to ($5.3m) being $1.8m favourable to budget.
- Revenue is favourable by $8.6m YTD, after excluding COVID-19 revenue, this is on budget.
- Personnel costs including outsourced is ($1.9m) YTD, excluding COVID-19 related costs of ($3.2m) the net favourable variance is $1.3m. Currently the DHB has a large number of vacancies which has been offset by ($2.3m) of vacancy savings targets for August.
- Treatment related clinical supplies is $2.1m favourable including favourable variances for Implants/Prostheses & Treatment disposables as volumes were down through the COVID-19 level 4 lockdown.
- Outsourced clinical services is favourable YTD by $409k; favourable movement due to outsourced surgical service delayed compared to plan, also partly due to the COVId-19 level 4 lockdown.
- Non treatment related costs ($2.9m) YTD unfavourable, however after excluding COVID-19 related costs of ($2.0m), the unfavourable variance was due to additional depreciation on 30 June building revaluation & seismic assessments costs.
- The funder arm is favourable YTD due to additional revenue from spend requirements for the community COVID-19 response which may not all be 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 $8.4m favourable YTD
- The variance is due to revenue for special MHAIDS additional funding $517k, The funder arm is also favourable by $8.3m revenue however with offsetting community cost and COVID-19 related costs in the Provider.

Personnel (including outsourced)

- Medical Personnel is ($351k) unfavourable for the month, the unfavourable position for the month is driven by vacancies across other services, most notably Hospital Flow offset by centrally held vacancy savings targets.
- Nursing Personnel is ($530k) unfavourable to budget for the month. Operationally nursing across the hospital is on budget, however the variance is a result of COVID-19 related costs and front loading of vacancy savings.
- Allied Personnel labour is $229k favourable to budget for the month, as a result of vacancies.
- Support Personnel labour month is on budget.
- Management/Admin Personnel is unfavourable in the month by ($519k), Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings.

Section 4

Financial Position

Cash Management – 31 August 2021

Month : Aug 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Aug 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
116,970	**116,074**	**110,917**	**895**	**6,053**	**Receipts**	**238,866**	**232,148**	**221,750**	**6,718**	**17,116**
					Payments					
47,359	54,654	42,073	7,296	(5,286)	Payments to employees	101,493	109,309	104,437	7,816	2,945
67,694	60,941	62,274	(6,753)	(5,420)	Payments to suppliers	139,755	122,880	124,343	(16,875)	(15,411)
0	0	0	0	0	Capital Charge paid	0	11,102	12,110	11,102	12,110
1,508	0	303	(1,508)	(1,205)	GST (net)	1,766	0	(1,749)	(1,766)	(3,515)
116,561	**115,595**	**104,650**	**(965)**	**(11,910)**	**Payments - total**	**243,013**	**243,291**	**239,142**	**277**	**(3,871)**
409	**479**	**6,267**	**(70)**	**(5,858)**	**Net cash flow from operating Activities**	**(4,147)**	**(11,142)**	**(17,392)**	**6,995**	**13,245**
					Investing Activities					
4	**16**	**73**	**12**	**69**	**Receipts**	**41**	**31**	**170**	**(10)**	**128**
					Payments					
7,283	11,255	3,660	3,972	(3,623)	Purchase of fixed assets	15,003	22,509	8,269	7,506	(6,734)
7,283	**11,255**	**3,660**	**3,972**	**(3,623)**	**Payments - total**	**15,003**	**22,509**	**8,269**	**7,506**	**(6,734)**
(7,279)	**(11,239)**	**(3,586)**	**3,984**	**(3,554)**	**Net cash flow from investing Activities**	**(14,961)**	**(22,478)**	**(8,100)**	**7,496**	**(6,605)**
					Financing Activities					
0	0	0	0	0	Equity - Capital	0	39,815	0	(39,815)	0
590	7,730	674	(7,140)	(84)	Other Equity Movement	12,187	15,460	674	(3,273)	11,513
0	0	0	0	0	Other	0	0	0	0	0
590	**7,730**	**674**	**(7,140)**	**(84)**	**Receipts**	**12,187**	**55,275**	**674**	**(43,088)**	**11,513**
					Payments					
0	**0**	**0**	**0**	**0**	Interest payments	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**Payments - total**	**0**	**0**	**0**	**0**	**0**
590	**7,730**	**674**	**(7,140)**	**(84)**	**Net cash flow from financing Activities**	**12,187**	**55,275**	**674**	**(43,088)**	**11,513**
(6,280)	**(3,030)**	**3,354**	**(3,226)**	**(9,496)**	**Net inflow/(outflow) of CCDHB funds**	**(6,921)**	**21,654**	**(24,818)**	**(28,596)**	**18,153**
(16,094)	550	(9,936)	16,645	6,158	**Opening cash**	(15,452)	(24,134)	18,236	(8,682)	33,688
117,563	123,820	111,664	(6,233)	6,038	Net inflow funds	251,095	287,454	222,593	(36,380)	28,758
123,843	126,850	108,310	3,007	(15,533)	Net (outflow) funds	258,016	265,800	247,411	7,784	(10,605)
(6,280)	**(3,030)**	**3,354**	**(3,226)**	**(9,496)**	**Net inflow/(outflow) of CCDHB funds**	**(6,921)**	**21,654**	**(24,818)**	**(28,596)**	**18,153**
(22,374)	**(2,480)**	**(6,582)**	**(19,894)**	**(15,792)**	**Closing cash**	**(22,374)**	**(2,480)**	**(6,581)**	**(19,894)**	**(15,792)**

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD Aug 2021		
	Actual $000	**Budget $000**	**Variance $000**
Net Cashflow from Operating	(4,147)	(11,142)	6,995
Non operating financial asset items	8	-	8
Non operating non financial asset items	(569)	-	(569)
Non cash PPE movements	(6,209)	(7,116)	907
Working Capital Movement			
Inventory	480	-	480
Receipts and Prepayments	22,207	-	22,207
Payables and Accruals	(20,041)	8,430	(28,471)
Total Working Capital movement	**2,645**	**8,430**	**(5,784)**
Operating balance	**(8,272)**	**(9,829)**	1,557

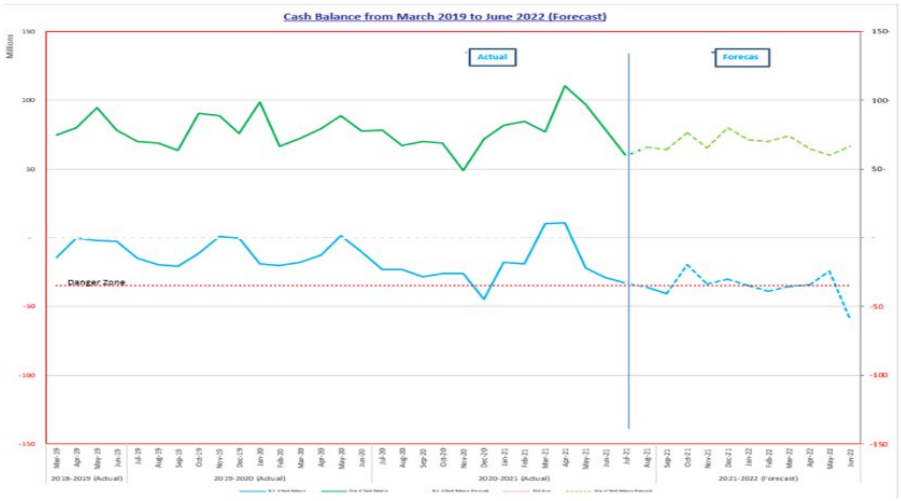
Net inflow cash: Aug $28.5m (Unfavourable)

1. The net cash flow from operating activities is favourable to budget due to COVID-19 revenue for the month. Higher than expected payments to suppliers.
2. The net cash flow from investment activities is unfavourable to budget due to less spend on Capital activity then budgeted;

Debt Management / Cash Forecast – 31 August 2021

Accounts Receivable
31-Aug-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	22,863	3,676	17,262	40	218	1667	22430
Other DHB's	3193	882	261	558	188	1304	5058
Kenepuru A&M	218	41	14	29	134		217
ACC	125	38	-32	-32	-15	166	196
Misc Other	2728	766	89	168	16	1689	4612
Total Debtors	29,127	5,403	17,594	763	541	4,826	32,513
less : Provision for Doubtful Debts	(4,107)						(4,093)
Net Debtors	25,020						28,420



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 $1.25m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $116k

4. 'Misc Other' debtors includes non resident debt of approx. $1.88m. About 86.8% 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.

Note: that the monthly actual cash balance exceeds the monthly forecasted cash balance due to a high buffer being maintained over the holiday period, release payment for construction projects.

Balance Sheet / Cashflow – as at 31 August 2021

Jul-21	Month : Aug 2021			Variance		Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Aug 2020	Actual vs Budget	Actual vs Aug 2020	YTD Aug 2021
31	31	31	31	0	0	Bank
50	50	824	(5)	(774)	56	Bank NZHP
13,177	13,237	13,561	12,685	(324)	553	Trust funds
77,167	79,009	63,930	55,348	15,079	23,661	Accounts receivable
9,261	9,873	9,466	9,826	407	47	Inventory/Stock
7,745	10,550	7,902	5,839	2,647	4,711	Prepayments
107,430	**112,751**	**95,714**	**83,723**	**17,036**	**29,028**	**Total current assets**
504,875	502,632	524,409	519,051	(21,777)	(16,420)	Fixed assets
16,058	5,875	5,875	14,796	0	(8,920)	Work in Progress - CRISP
95,879	112,805	103,005	60,510	9,800	52,295	Work in progress
616,812	**621,312**	**633,290**	**594,357**	**(11,977)**	**26,955**	**Total fixed assets**
1,150	1,150	1,150	1,150	0	0	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**0**	**0**	**Total investments**
725,392	**735,213**	**730,154**	**679,229**	**5,059**	**55,983**	**Total Assets**
29,352	35,693	16,896	19,291	(18,796)	(16,401)	Bank overdraft HBL
80,462	80,501	72,575	73,611	(7,926)	(6,890)	Accounts payable, Accruals and provisions
1,508	3,016	3,701	3,534	685	518	Capital Charge payable
593	593	593	593	0	0	Insurance liability
9,895	10,269	123,911	102,750	113,642	92,482	Current Employee Provisions
178,617	181,115	67,997	62,398	(113,118)	(118,717)	Accrued Employee Leave
14,324	18,440	22,515	11,296	4,075	(7,144)	Accrued Employee salary & Wages
314,751	**329,627**	**308,188**	**273,475**	**(21,439)**	**(56,152)**	**Total current liabilities**
90	97	92	100	(5)	2	Restricted special funds
605	605	605	605	0	0	Insurance liability
6,222	6,222	6,564	6,563	343	342	Long-term employee provisions
6,916	**6,924**	**7,262**	**7,268**	**338**	**344**	**Total non-current liabilities**
321,668	**336,551**	**315,450**	**280,743**	**(21,101)**	**(55,808)**	**Total Liabilities**
403,724	398,662	414,704	398,486	(16,042)	175	Net Assets
829,962	858,191	877,507	814,173	(19,316)	44,018	Crown Equity
0	0	0	0	0	0	Capital repaid
28,229	590	0	0	590	590	Capital Injection
130,659	130,659	130,659	130,659	0	0	Reserves
(585,126)	(590,779)	(601,193)	(543,989)	10,413	(46,790)	Retained earnings

Balance Sheet

1. The DHB's cash overdraft balance at the end of August 2021 is unfavourable due to a budgeted claim on the children's hospital not yet being received ($16.0m);
2. Accounts receivable is higher than budget due to timing differences;
3. Accounts payable, accruals and provisions is higher than the budget mainly due to timing differences but a large drop on the end of June figures;

Cash flow

1. Cash on hand is below budget due to changes in the opening balance and a budgeted claim on the children's hospital not yet being received ($16.0m);

Financial ratios

1. Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities. DHB's current ratio is 0.34 (July - 0.34);
2. Improved Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 46:54 (July - 44:56).

Note

1. Balance Sheet subject to change due to Revaluation of Land and Buildings currently in progress as at 30 June, which will be reflected through Comprehensive Income

Capital Expenditure Summary on Prior Year Approved August 2021

			Actual spend on live projects				Forecast spend on approved projects						
Asset Category	Approved Capex Budget	PY Spend to 30 June 2021	July actual spend	August actual spend	Actual YTD Spend	Actual LTD Spend	To spend	September forecast spend	December Quarter forecast	March Quarter forecast	June Quarter forecast	Forecast cash spend to June 22*	Carry forward to FY22-23
Buildings	27,456,044	16,017,443	268,499	217,153	485,652	16,503,096	10,952,948	1,360,836	3,800,316	2,549,594	1,426,092	9,136,838	1,816,110
Clinical Equipment	58,062,831	42,615,125	2,346,010	1,553,816	3,899,826	46,514,950	11,547,880	1,370,599	5,199,855	2,416,805	1,158,583	10,145,842	1,402,038
ICT	11,882,523	9,546,425	556,583	284,579	841,162	10,387,587	1,494,936	341,859	775,859	121,265	-	1,238,982	255,954
Prior Year projects	**97,401,398**	**68,178,993**	**3,171,092**	**2,055,548**	**5,226,640**	**73,405,633**	**23,995,765**	**3,073,294**	**9,776,030**	**5,087,663**	**2,584,675**	**20,521,662**	**3,474,102**

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

- $29.2m in approved but incomplete projects was carried forward from the previous year to FY2020/21
- Total cash spend in August 2021 was $2.1m with a further $20.5m is forecasted to be spent by 30 June 2022, leaving an estimated $3.5m to be carried forward to FY2022/23
- The forecast is based on cash phasing with the December 2021 quarter expected to be high due to the high spending in ICT and Clinical Equipment
- 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 August 2021

				Quarterly forecast					
Row Labels	Capital Plan 2021/22	Approved	Actual LTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Forecast cash spend to June 22	Carry forward
Clinical Equipment/Non Clinical Equipment	15,280,105	563,742	100,000	571,418	2,765,987	3,090,111	6,308,215	12,835,731	2,444,374
Facilities or Building	37,378,945	8,736,015	201,123	205,192	2,481,847	3,517,126	11,769,680	18,174,968	19,203,977
ICT	5,199,917	3,100,000	19,975	563,061	2,038,199	1,487,077	726,237	4,834,549	365,368
Small capex pool	10,796,925	2,416,144	528,578	722,383	2,699,231	2,699,231	2,699,231	9,348,654	1,448,271
Grand Total	68,655,892	14,815,901	849,676	2,062,054	9,985,264	10,793,545	21,503,363	45,193,903	23,461,989

Key highlights to FY2021/22 Capital plan:

- $68.7m was approved by the Board in the FY2021/22 Capital Plan
- The development of business cases from the 2021/22 Capital Plan are at various stages with $14.8m having been approved by August 2021
- Spend to August 2021 $850k and reflects the changes. The COVID-19 level 4 lockdown impacted the spending rate
- Business units have indicated when business cases will be submitted and a high level cash forecast has been projected from this with $45m to be spent by 30 June 2022, and $23.5m 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

3 November 2021

2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report – Quarter 1 (2021/2022).

Action Required

The Boards note:

(a) the ongoing change process for the establishment of the 2DHB Māori Health Directorate

(b) the update on the Iwi Māori Partnerhsip Boards (IMPBs)

(c) the developments in the Whānau Care (CCDHB) and Manaaki Whānau (HVDHB) teams

(d) the Tāngata Whaikaha Community engagement programme is in progress

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
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Director Māori Health Services
Purpose	Provide an update on the progress and performance of the two DHBs against the two Māori Health strategies.
Contributors	Māori Health Services across the two DHBs
Consultation	Not applicable

Executive Summary

1. In August 2021, the Māori Health Directorate implemented structural changes to our teams at Hutt Valley and Capital & Coast DHB's. Though we have had a few challenges caused by being locked down and responding to the COVID-19 outbreak, we have recruited to most positions and have dotted line reporting and support from other Directorates. The changes to the Directorate structure align with both Māori Health strategies, Te Pae Amorangi and Taurite Ora, as well as the wider 2DHB programme.
2. Iwi Māori Partnership Boards (IMPBs) are a new feature of the Health System Reforms and will be hosted by the newly established Māori Health Authority. IMPBs must be iwi led and will operate predominantly at a locality level supported by a dedicated core team who will carry out the work required to deliver on the IMPB's six key functions.
3. The Whānau Care (CCDHB) and Manaaki Whānau (HVDHB) services are currently undergoing incremental changes that are operational in nature. The only significant change to these teams is the creation of a 2DHB Manager role across both services. The staff that report to this role remain in place with no changes to terms and conditions of employment.
4. The Tāngata Whaikaha Community Engagement is a new research project to identify gaps and barriers in disability support for tāngata whaikaha Māori and their whānau. One of our early responses to improve Māori health outcomes including co-design and patient experience led to contracting the Foundation for Equity and Research New Zealand (FERNZ) to undertake

research with the tāngata whaikaha community to identify the gaps and barriers in disability supports for tāngata whaikaha Māori and their whānau. The research will help 2DHB planning for service for tāngata whaikaha so that we focus on achieving equitable outcomes.

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.
People	The ongoing change programme for the 2DHB Māori Health Directorate is underway.
Financial	Baseline funding remains, Taurite Ora - $500k and Te Pae Amorangi $350k.
Governance	Te Ūpoko o te Ika Māori Council

Engagement/Consultation

Patient/Family	Not applicable
Clinician/Staff	Not applicable
Community	Not applicable

Identified Risks

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

Attachment/s

1. 2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report – Quarter 1 (2021/2022).

Attachment 1: 2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report (2020/2021 Quarter 1)

This paper provides an overview of progress made on the key outcomes of the 2DHB Māori Health Strategies, *Taurite Ora* and *Te Pae Amorangi*, and includes:

- Background information on the Māori health equity context and associated 2DHB strategies
- A high-level progress report on the status of the broader activities that the 2DHB Māori Health Strategies encompass
- A high-level Dashboard and explanation of indicators that have been developed to measure progress in relation to Māori health equity
- A Table showing the alignment of the 2DHB Māori Health Strategies to *Whakamaua, the Ministry of Health Māori Health Plan.*

Contents

1. Changes to the Māori Health Directorate

In August this year, the Māori Health Directorate implemented structural changes to our teams at Hutt Valley and Capital & Coast DHB's. Though we have had a few challenges caused by being locked down and responding to the COVID-19 outbreak, we have recruited to most positions and have dotted line reporting and support from other Directorates.

The changes to the Directorate structure align with both Māori Health strategies, Te Pae Amorangi and Taurite Ora, as well as the wider 2DHB programme. It focuses on three key enablers:

1. Redefining our core functions as a directorate.
2. Building a fit-for-purpose team.
3. The establishment of a structure that strengthens cultural, strategic and operational capabilities across both sites.

The Whānau Care (CCDHB) and Manaaki Whānau (HVDHB) services are currently undergoing incremental changes that are operational in nature. The only significant change to these teams is the creation of a 2DHB Manager role across both services. The staff that report to this role remain in place with no changes to terms and conditions of employment.

1.1 Key changes

1.1.1 Redefine core functions

While there is strong alignment between the two Māori Health strategies we will align key deliverables into a combined HVDHB and CCDHB action plan, so effort and our limited resources can be focused more deliberately. Parallel to the development of a combined action plan, we are winding back slowly on the things that do not align with our strategic objectives. This means lowering expectation across the organisation that MHD can and should fulfil all Te Ao Māori related requests. We will have the action plan available for the next quarterly meeting.

1.1.2 Measurable contribution to Māori health outcomes

We have strong baseline data measuring our performance in relation to five key measures of Equity[1]. To help us interrogate data at a local level, we created the position of Senior Insights Analyst in the Directorate. This role supplements the analytics team in SPPP by concentrating wholly on Māori and Pacific health improvement as the key objective for all analysis. We believe we can build smarter, more purposeful Māori and Pacific analytics to help us prioritise the projects we support. One of the ways we think we can do this is by ensuring data matches the needs of Māori communities and that tangible action/s are identified which will improve Māori health.

[1] Baseline data measuring the performance of HV and CCDHB is gathered from a number of national sources, including Ministry of Health and is attached to this report as Appendix one.

1.1.3 Strengthen cultural leadership within Māori health and the wider organisation

The COVID-19 pandemic highlighted another key weakness across the organisation - a formally established cultural leadership role. As a default position, the organisation does not pay sufficient attention to maintaining relationships with hapū, iwi and Māori organisations. It became clear that the only connections into Māori communities were via contracted kaupapa Māori providers (there are less than 10 across CCDHB & HVDHB), or personal relationships held by the Director Māori and members of the Māori Health team and the SPP Directorate. During the COVID-19 pandemic, the Director Māori Health had only one other team member to help lead engagement with these groups and distribute funding from the Ministry of Health. As part of our Change programme, our intention was to create the role of Pou Tikanga. However, this has been put on hold pending the establishment of the interim Māori Health Authority. In the new look Health Sector, we expect to gain a better understanding of how 2DHB can best support the relationship between iwi-Māori partnership boards and the new authority.

1.1.4 Supporting the organisations commitment to pro equity

The Māori Health Directorate continues to work closely with Strategy, Planning and Performance to support the establishment of a pro equity agenda across the organisation, specifically taking a leadership role regarding what this means for Māori. While an equity lens is an integral component of all roles within the proposed structure, three roles in the new directorate are dedicated to working in the areas of workforce, commissioning and equity.

1.1.5 Strengthened relationships with key directorates

One of the key objectives of the changes is to strengthen our working relationships with other directorates, especially those who have signed up to deliverables within both strategies. It has been heartening to note that as a result of the 2DHB reviews that have taken place across most directorates, five Māori/equity focused roles have been committed to, with a dotted reporting line to the Director Māori Health. In effect, this level of commitment embeds champions and creates additional capacity for Māori Health focused projects.

1.1.6 Impact of the Health and Disability System Review

The changes set out here are consistent with the direction set out by government in its Health reform proposal, and the Ministers Letter of Expectations to the Board. I intend to continue implementing our focus on improved Māori health outcomes.

1.1.7 Health System Reforms - Establishment of an Iwi Māori Partnership Board

Iwi Māori Partnership Boards (IMPBs) are a new feature of the Health System Reforms and will be hosted by the newly established Māori Health Authority. IMPBs must be iwi led and will operate predominantly at a Locality level supported by a dedicated core team who will carry out the work required to deliver on the IMPB's six key functions. While these statutory functions and powers are yet to be confirmed in legislation it is envisaged they will include the following:

- Undertake locality assessments by engaging with whānau and communities
- Determine local priorities based on information collated and data analytics

- Review draft locality plans and negotiate changes
- Agree/approve locality plans with the MHA and HNZ
- Monitor implementation and impact of approved locality plans
- Provide regular reporting to whānau and hapori Māori on whether anyone is better off as a result of the services and changes implemented at a local level (accountability to Māori whānau).

A process to establish the IMPB for this rohe has started within the Māori Health Directorate. Following two initial hui with the Transition Unit a hui was held with the existing Te Upoko o te Ika Māori Council (TUI MC) on the 16th of September. While an initial set of agreements were made at this meeting not all iwi were present, so it was decided to call a further hui to engage iwi leaders. In the meantime, it was agreed that an Establishment Steering Group should be formed to continue progress and stay aligned with the ongoing developments within the Transition Unit and Ministry of Health. Cherie Seamark and Kuini Puketapu were nominated as the founding members on the interim Establishment Group, while awaiting further nominations from iwi. A hui with iwi leaders is currently being arranged before the end of October. This hui will test thinking to date and seek endorsement on the previous agreements made on 16 September.

Ministry of Health have released the first tranche of funding to support the writing of the implementation plans which are due to MOH by the end of November 2021. CCDHB will hold these funds as the nominated legal entity. The second tranche will be released once the implementation plans have been received and approved by MOH. IMBs need to be in place by 1 July 2022.

In parallel to this process which will be led by iwi, TUI MC will continue to deliver on their obligations in partnership with the DHB until 30 June 2022.

2. Te Pae Amorangi

Te Pae Amorangi: Hutt Valley DHB Māori Health Strategy, 2018-2027 aligns with the eight principles of the DHB's Strategy *Our Vision for Change* of equity, needs focused, co-design, partnership, people centred, stewardship of resources, outcomes focused and system thinking. Drawing on these principles, *Te Pae Amorangi* set out to:

- Expand on the framework provided by Our Vision for Change.
- Better understand our DHB's approach to equity and Māori health and where improvements can be made.
- Provide leadership across our DHB to eliminate inequity of health for Māori.
- Further interrogate our own data to get a better picture of our current reality, of how we provide health services to Māori and how our services support their wellness.

2.1 Te Pae Amorangi Tuatahi – Increasing our Māori Workforce across the System

We continue to partner with directorates to ensure robust procedures are in place to enable the development and recruitment of our Māori workforce. This work will be supported within the Allied professions with the appointment of the Director of Allied Professions- Māori.

3. Taurite Ora

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

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

3.1 Tāngata Whaikaha Community Engagement Programme

One of our early responses to improve Māori health outcomes including co-design and patient experience led to contracting the Foundation for Equity and Research (FERNZ) to undertake research with the tāngata whaikaha community to identify the gaps and barriers in disability supports for tāngata whaikaha Māori and their whānau. The research will help 2DHB planning for service for tāngata whaikaha so that we focus on achieving equitable outcomes.

3.2 Service Delivery

There are two teams in Service Delivery one at the Hutt Valley (Whānau Manaaki) and one at CCDHB (Whānau care services). Over the next three months the focus for both teams is on Data collection and development of measureable KPIs that align with the relevant Health Strategy.

The CCDHB Whānau Care Team

The team is now aligned to the strategy with one FTE dedicated to Maternal and Child health.

A newly appointed social worker focused on hapū māmā has completed orientation and is starting to build internal and inter-agency relationships including with community groups, professional agencies and other client groups that relate to practice area. She is also building a client load and while her focus is on connecting with Māmā early in pregnancy she is also making a difference when hapū māmā are admitted into the hospital.

This is an example of the type of work the team is doing in this area:

> *31yr old wahine presented to hospital with complex health needs and hapū with third child. According to hospital records, historical Oranga Tamariki involvement re drug use when hapū with two older children. Substance abuse since age of 18yrs and complex mental health issues. The wāhine had refused to engage with the ward social worker. One of the Whānau Care Manaaki Whānau met with her and as a result she agreed to meet with the WCS social worker. After some intervention and a whole lot of work from the māmā , she was discharged with pēpi in her care, a safety plan in place, and good community supports for Māmā, Pēpi and whānau. Oranga Tamariki closed the case.*

This was a good outcome for the whānau and future of this pepi. The aim the WCS social worker is to engage early in the pregnancy and had that happened in this case may of enabled these supports to be put in place earlier.

The new Childrens Health Nurse has also completed orientation and is starting to build the service engage with whānau. She is having early success with getting whānau to re-engage with services with success with supporting whānau to engage with the hospital and attend appointments.

For example:

> *When referred to the team, a whānau had missed numerous outpatient appointments for their tamariki and the service had lost contact with them. Our nurse made contact through their next of kin and was able to update contact details and talk to the Māmā. The nurse has been able to build a positive relationship with māmā who felt able to ring when she knew she was going to be late to the appointment. Although the whānau could not be there until after the clinic ended the WCS nurse was able to negotiate for the tamariki to be seen by a consultant. A win for the tamariki.*

The manaaki whānau focus on supporting adult inpatients. In recent months the team has also started to text Māori whānau who attend ED but are not admitted. Recently, we received the following feedback:

> *"You don't need to reply to this, just wanted to share a positive vibe and tautoko the work. I think this is the first time I've had a positive experience from any kind of social sector that's picked me purely for being Māori and it couldn't be more perfectly timed I have to leave my current medical centre and GP and I have been putting off finding another practice because I'm dreading that I won't be able to find somewhere that understands te ao Māori. So your touching base is significant to me it's restored a little faith that there might be changes happening in medical services."*

The Hutt Valley DHB Manaaki Whānau team continue mahi as usual and we are working on the best ways for collecting data and identifying key priorities based on Te Pae Amorangi.

4. Strengthening our commissioned services

4.1 Whare ki te Whare Kaiarahi – Navigation service

MHDG have been co-developing the Whare ki te Whare Kaiarahi – Navigation service to provide a community based service to support Māori:

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

The service supports Māori to be healthy at home, with a strong focus on prevention, improving access to existing health services, providing linkages to services, providing holistic community based care. It

works with primary care and hospital based teams to keep people stay well in their homes. The service team works with individuals and the whole whānau.

While the Māori Health group continues to be committed to this programme ongoing workforce issues has led to inconsistent development and delivery of the service. When a nurse was able to commit time there were clinics set up for whaiora and direct referral by GPs was supported. Prior to this, the service was reliant on Whānau Care Services referring patients. We continue to work with the provider to create a consistent and sustainable Whare ki te Whare service in Cannons Creek and Waitangirua.

5. Maternal, Child & Youth

5.1 Maternity Quality and Safety Programmes (MQSP)

- Hapū Wānanga, a Te Ao Māori focus ante-natal education class for Māori women will launch on 27 October 2021. These classes will replicate a successful model that was started in the Waikato.
- There has been a strong focus on a diversity project that seeks to create more welcoming spaces that reflect the communities of our DHB. New photos have been installed in the Kenepuru birthing unit and Ward 4 corridor at Wellington Regional Hospital. Initial feedback has been positive.
- A Noho marae focused on cultural training was held last year for midwives across the DHB to come together and learn from one another, there are requests for another to be organised within this financial year.
- The group was also presented with a new website from the Strategy, Planning and Performance team that collates all DHB information for whānau with new pēpe which launched Monday 18 October, www.pepeora.nz.

5.2 Maternal Wellbeing and Child Protection

The Child Transition into Care (formerly uplifts) Policy is in progress for sign off and completion. A more user friendly second draft has been completed following feedback and will be sent for consumer engagement and clinical feedback. Completion is aimed for end of November at the latest.

The Care of the Vulnerable Pregnant Person guidelines are undergoing cultural assessment to ensure appropriate supports of high and complex need parents during their maternity journey. This guideline will connect with the review of the Maternal Wellbeing and Care (MWC) group to ensure it is fit for purpose.

5.3 Children Clinics Service Improvement and Health Literacy

Progress in this space post November 2020 was minor due to the loss of project support however, a workshop was held in December and an e-Learning module has been published on ConnectMe, the staff training portal. The module outlines the importance of Health Literacy and small ways staff can take action to enable better engagement with consumers. A review of the Children's Services website update is also underway.

5.4 Commissioning Updates for Maternal, Child and Youth

Taurite Ora Outcome 1, points 6 – 10. These updates are provided to the Health System Committee by the Families and Wellbeing team.

6. SPOTLIGHT: Engaging Māori in Services – Ophthalmology Eye Clinic Did Not Attend (DNA) Rates

6.1 Background

In the Ophthalmology service, attending appointments is crucial for managing eye health. When a consumer is not engaged to attend appointments they are rebooked or eventually discharged to a GP. This may take a significant amount of time during which the eye health of the consumer could deteriorate, in worst case scenarios to the point of blindness. In 2020, the overall rate of DNA was 7.4% (2,857 DNAs out of 39,012 events) for Eye Clinics. The Did Not Attend rate for Māori consumers in 2020 was 18% (710 out of 3,981 Māori consumers) and for Pacific it was 17.2% (627). However of the 2,857 DNAs, Māori are 25% of all DNAs (710 out of 2,857) despite being 10.2% (3,981) of the overall eye clinic events.

Year	DNA Percentage Overall	DNA Number Overall	Total Number of Events
2021*	7.4%	2,563	34,667
2020	7.4%	2,857	39,012
2019	6.1%	2,409	39,857
2018	8.3%	3,171	38,131

Figure 1: DNA data for the last three years and current 2021 numbers as at 12/10/2021

Year	DNA Percentage Māori	DNA Number Māori	Total number of Māori Events
2021*	17.9%	616	3,458
2020	18.0%	710	3,661
2019	14.3%	540	3,809
2018	17.5%	633	3,622

Figure 2: Māori DNA Data for the last three years and current 2021 numbers as at 12/10/2021

6.2 Purpose and Alignment with Taurite Ora

The Engaging Māori in Services projects is focused on finding ways to enable Māori to attend their appointments in the Ophthalmology eye clinic service. This project aligns with two measures from the five measures for equity outlined in Taurite Ora, outlined below.

6.2.1 Accessible Appointments

- Enable Māori to attend eye clinic appointments.
- Seek to identify and minimise potential barriers for attendance e.g. parking or time of appointment.

6.2.2 Avoidable Hospital Admissions

- Ensuring Māori are able to attend their appointments will lead to earlier treatment and fewer admissions due to reduced degeneration overtime.

6.3 Process

The project uses the Quality Improvement "Model for Improvement" as the foundation and is currently coming to the end of Stage 1 – Defining and measuring the current state. Unfortunately, the project was impacted by the COVID-19 Alert Level 4 lockdown in August and timelines were pushed into November.

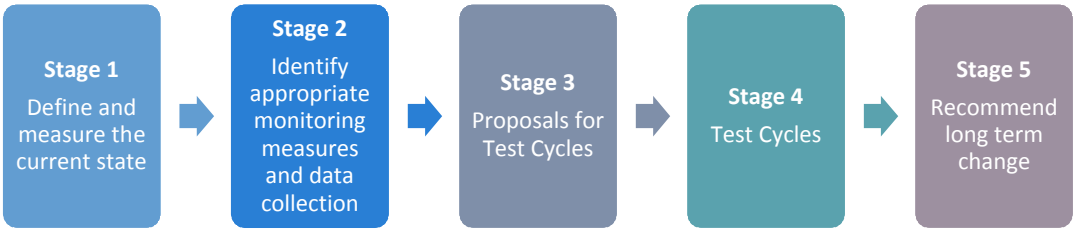


Figure 3: Quality Improvement Process Stages

6.4 Stage 1: Current State Assessment - Consumer Feedback

Two surveys for consumer feedback were completed, one by the Ophthalmology service and one by the Consumer Feedback team. Both were conducted in the eye clinic waiting room. A summary of the surveys is in Attachment 1. However, these surveys were not focused on Māori nor were they focused on the consumers who did not attend, as the respondents were already at the eye clinic.

A phone call survey focused on Māori consumers who have previously missed an appointment is currently underway and nearing completion. Survey questions focus on three main areas, Background and Notification, Rebooking and Contact and Attending the Appointment. Preliminary data shows 23 Māori respondents so far have taken part and key themes emerging are access – difficulty with transportation, the rebooking phone line and ability to select times of preference given life requirements and the long wait times.

6.5 Next Steps

Following completion of the consumer feedback calls, the project will shift to Stage 3 as Stage 2 has been completed concurrently to Stage 1. A full summary of the data will be reported including proposals for potential changes to test to Ophthalmology and Māori Health Services Leadership. As indicated above, the consumer feedback indicates the proposed tests should focus on solutions for transportation, the contact number for rebooking and consumer appointment selection. Tests will be constrained by funding, time and resourcing however, the project aims to have at least two testing cycles to be scheduled and completed before the end of 2021. Successful tests will have an implementation plan proposed with clear requirements to ensure long term sustainability.

In April 2021, a new Project Manager started in this area. Previous work is being re-assessed for continuation and completion, this has meant a delay in project timelines.

6.6 Maternity Quality and Safety Programmes (MQSP)

- The six month audit for the optimising birth project has been completed and a report on the results is being compiled.
- There has been a strong focus on a diversity project that seeks to create more welcoming spaces that reflect the communities of our DHB. New photos have been installed in the birthing units and have received positive feedback.
- A Noho marae was held for midwives across the DHB to come together and learn from one another, there are requests for another to be organised.
- Hapū Wānanga, ante-natal education classes for Māori women, are in development. A successful model in Hamilton has been studied and the group is seeking to replicate this for CCDHB.
- The group was also presented a new website from the Strategy, Planning and Performance team that collates all DHB information for whānau with new pēpe, www.pepeora.nz.

6.7 Women's Health Service Improvement Project – equitable access and acceptability of care

Survey work is a work in progress. There are iPads available to survey consumers utilising Maternity services, it is offered in both Te Reo Māori and English. The most recent data received for May had 18 respondents, two of whom were Māori. Of the 18, 15 said they were well cared for by staff "Yes, always" and the remaining three chose "Yes, sometimes". All 18 respondents said they felt culturally safe during their stay with only one choosing "Yes, sometimes". Overall, the feedback was positive regarding care and there were suggestions for limiting visiting (external and internal visitors), restricted quiet times and private space. This work has been realigned and is reported to the Maternal Quality and Safety Programs Governance group. The summary of survey responses for May is in Appendix Three.

6.8 Commissioning Updates for Maternal, Child and Youth

Taurite Ora Outcome 1, points 6 – 10. These updates are provided through the Health System Committee by the Families and Wellbeing team.

7. 2DHB Māori Health Dashboard: Measures of Equity

Taurite Ora highlights five key measures of equity that will be addressed by a multi-pronged approach. These five key measures are:

Given the parallel nature of the aims and objectives of the two Māori health strategies, these five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity in both the Capital and Coast and Hutt Valley regions.

These measures of equity are also aligned with the four key objectives of *Whakamaua: Māori Health Action Plan, 2020-2025*, which are:

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

The 2DHB Māori Health Dashboard (see Appendix One) notes how each of the key groups of indicators aligns with one or more of these national-level objectives for Māori health equity.

8. Appendix One: 2DHB Māori Health Dashboard

Systemic changes enable equitable health outcomes for Māori

Laying the foundations for a pro-equity organisation at all levels is important in promoting equitable health outcomes – these systemic changes are key enablers of equity. Accessible appointments are increased by improving access for Māori patients and whānau to culturally safe practices and cultural leadership, and reducing system barriers.

Areas of focus

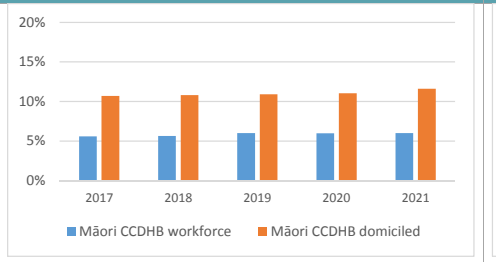
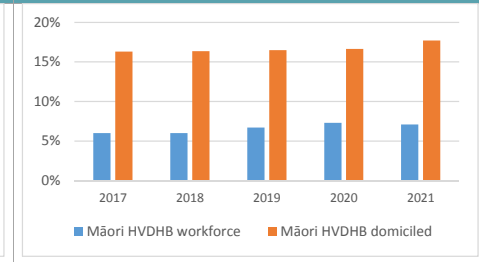
- DHBs as pro-equity health organisations
- Growing and empowering our workforce to have a strong Māori health workforce, and a workforce equipped to improve Māori health
- Strengthening commissioned services
- Accessible appointments

Links to Whakamaua: Māori Health Action Plan 2020-2025

- Objective 2: Shift cultural and social norms
- Objective 4: Strengthen system accountability settings

Sub-regional initiatives (2DHB)

- Developing and committing to an Equity Policy
- Māori stakeholder engagement plan and enhanced partnership board engagement (MPB / MWRB)
- Māori workforce plan and recruitment strategy
- Cultural competency workforce plan
- Equitable commissioning policy

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: Māori workforce is proportional to the regional working population	An increase in Māori workforce is expected to improve cultural safety in the by both Māori and non-Māori staff, for both Māori staff and patients. This is expected to have a positive impact on accessibility of appointments and cultural safety for Māori patients.	Māori workforce across all professions of the DHBs and their partners / commissioned services 2DHB: ≥13.0% *CCDHB: ≥11.1%* *HVDHB: ≥17.1%*			Targets are based on working population age (15-64) from 2018 Census, which is 11.1% for CCDHB and 17.1% for HVDHB. CCDHB: Baseline of workforce declaring Māori ethnicity is 6.9% as of November 2020. Note that 15% of staff have 'Other' or 'Unknown' ethnicity, and this number may decline with as data collection improves (one of the programmes of work).
Indicator 2: All current and future staff provide culturally safe and competent services to Māori	Ensuring our services prioritise Māori health is a key systemic change to support the foundations for equitable health care and they are applied across the 2DHB region.	Measure to be agreed with P & C and applicable across 2 DHB	Graph showing progress Under development	Graph showing progress Under development	Set core competencies and expectations for all staff to achieve health equity and improve Māori health outcomes. Implement a range of programmes and initiatives to support training of staff in culturally safe care and understanding Māori health equity challenges.

Māori live longer lives

Amenable mortality is one of the key measures of equity and is defined by the Ministry of Health as premature death that could potentially have been avoided given effective and timely care. As the Ministry of Health defines and measures amenable mortality data with a delay of up to 5 years, additional indicators of premature death that can be monitored and measured more frequently are included here.

Areas of focus

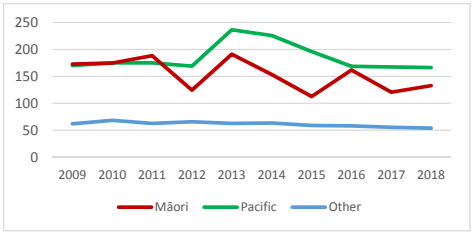
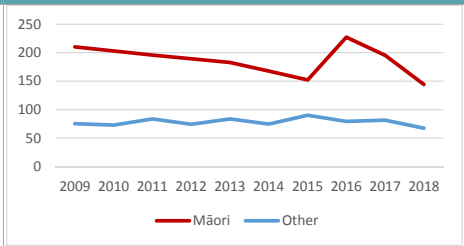
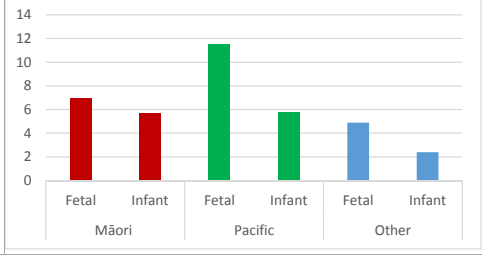
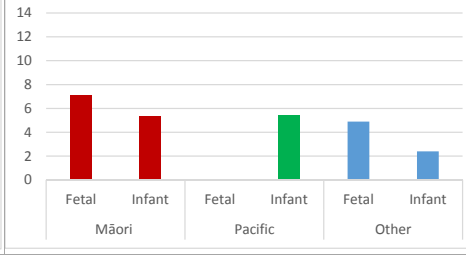
- Amenable mortality
- Maternal, child and youth
- Mental Health and Addictions

Links to Whakamaua: Māori Health Action Plan 2020-2025

- Objective 3: Reduce health inequities and health loss for Māori
- Objective 4: Strengthen system accountability settings

Sub-regional initiatives (2DHB)

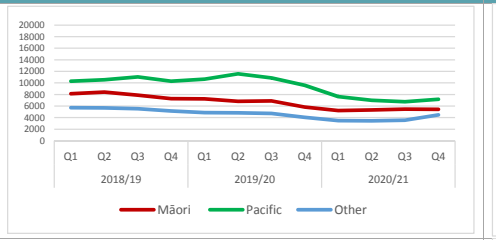
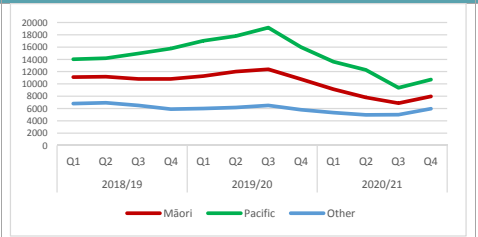
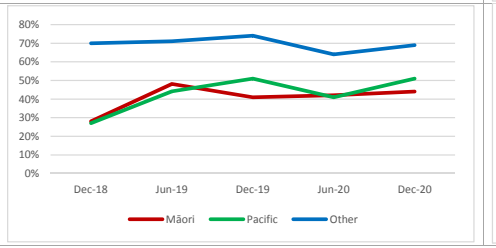
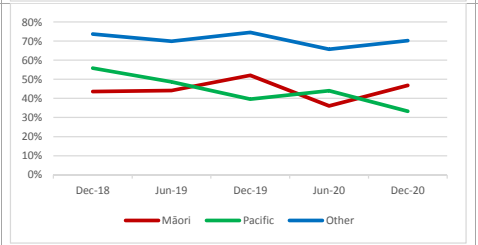
- Wahakura wānanga programmes to hapū māmā and whānau, including focused messages around safe sleep, immunisation, breastfeeding, and smoking cessation
- Co-designing MHA programmes with Māori
- Long-term conditions

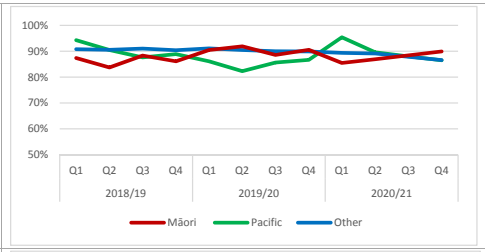
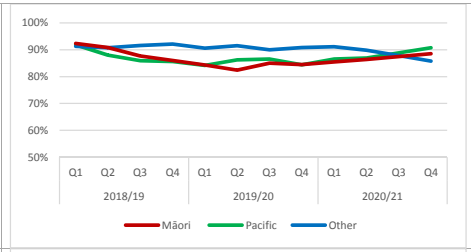
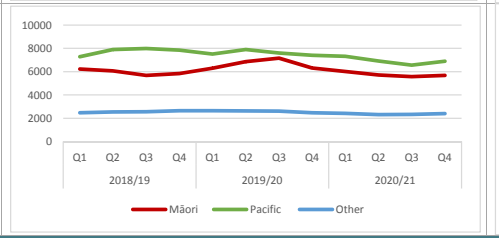
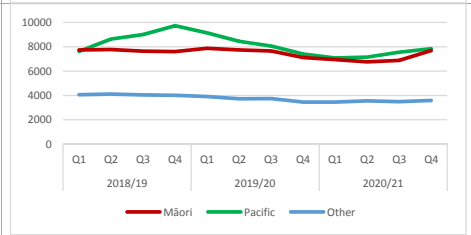
Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: Amenable mortality	Amenable mortality measures deaths that are potentially preventable given the appropriate effective health care and is an indicator of the performance of a health system.	Māori amenable mortality rates are equal to or lower than non-Māori rates			The potential positive impacts of the parallel Māori Health Strategies on this measure of equity will not be available for at least five years if amenable mortality is calculated by the Ministry of Health.
Indicator 2: Increase in life expectancy for Māori	A healthcare system that provides equitable outcomes should not show differences in life expectancy for different ethnicities.	Māori life expectancy rates are equal to or greater than non-Māori rates	❖ Baseline and future life expectancy as calculated by the Ministry of Health can be found here or here		Life expectancy has not been calculated in New Zealand on a DHB level, but rather for the whole Wellington region (including Wairarapa, Hutt Valley and all of the Kāpiti Coast).
Indicator 3: Lower rates of Māori infant and foetal mortality	A healthcare system that provides equitable outcomes should not show differences in foetal/infant mortality rates for different ethnicities.	Māori infant and foetal mortality rates are equal to or lower than non-Māori rates per 1,000 (2017)			This is connected to initiatives on breastfeeding, immunisations, smoke-free homes, and safe sleep devices.

Māori have fewer avoidable hospital admissions

There are different ways of looking at avoidable hospital admissions. The most common measure is 'Ambulatory Sensitive Hospitalisations' (ASH), which are admissions for conditions that are considered reducible through presentative and early intervention care. Other measures of avoidable hospitalisations available through the Ministry of Health databases are also included here.

Areas of focus • ASH • Long-term conditions • Maternal, Child and Youth • Mental Health and Addictions **Links to Whakamaua: Māori Health Action Plan 2020-2025** • Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services • Objective 3: Reduce health inequities and health loss for Māori	**Sub-regional initiatives (2DHB)** • MHA Services Review • Long-term conditions initiatives • Programmes with focused messages around safe sleep, immunisation, breastfeeding, and smoking cessation • Programmes with a focus on encouraging use of primary care **Local initiatives** • CCDHB: SLMs for youth • CCDHB: Zero Seclusion Project • HVDHB: Shift MHA services and care closer to home

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: ASH rates (ages 0-4)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care intervention and Māori have been found to have higher rates than non-Māori, pointing to inequitable healthcare outcomes.	Reduction in Māori child ASH rates by 6%			Other measures of avoidable hospitalisation are being explored and developed, but not yet available to use as a baselines, such as housing-related hospitalisations in children.
Indicator 2: Māori babies live in smoke-free homes	Babies living in smoke-free homes are expected to have greater health outcomes and reduced rates of hospitalisation.	At least 70% of Māori babies live in smoke-free homes			

Indicator 3: Māori babies are immunised	Children who receive immunisations can be protected from some illnesses that might result in hospitalisation. Māori tamariki are currently less likely to be fully immunised by age 5 than non-Māori children.	95% of Māori tamariki are immunised by age 5			WellChild data also includes data on breastfeeding and smoke-free homes and a range of other indicators by DHB.
Indicator 4: ASH rates (ages 45-64)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care intervention and Māori have been found to have higher rates than non-Māori, pointing to inequitable healthcare outcomes.	Reduction in Māori ASH rates by 6%			ASH data is not available for ages 5 to 44. While ASH rates may reduce comparatively for ages 5-44, we do not know how Māori are impacted in this age range. Acute hospital bed days data can be found here. Average inpatient length of stay data available here.

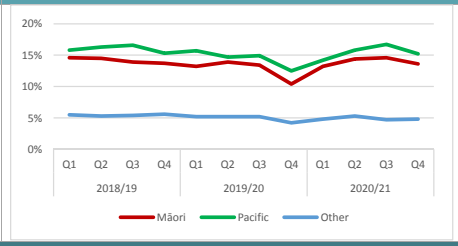
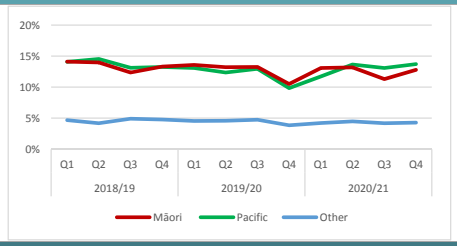
Māori have greater access to appointments

Accessible appointments in both primary and secondary care are generally measured by 'Did Not Attend' (DNA) rates.

Areas of focus
- Accessible appointments
- Did Not Attend (DNA) rates

Links to Whakamaua: Māori Health Action Plan 2020-2025
- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 2: Shift cultural and social norms
- Objective 3: Reduce health inequities and health loss for Māori

Sub-regional initiatives (2DHB)
- Cultural competency workforce plan and associated resources
- Project analysing DNA rates and how these can be addressed

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: DNA rates	'Did Not Attend' rates can be an indication of accessible appointments. Reasons for people not attending have previously been categorised as 'patient' and 'clinic' factors, thus attributing much of the blame to the patient. Most of the reasons attributed to the patient can be overcome by reframing the idea that the fault lies with the patient, and instead focusing on increasing accessibility to clinics for all patients.	Reduced DNA rates for 2DHB Māori			Rates for Māori appear to be stabilising after hyper activity in Q4, 2019/20 and we are observing gradual decreases on overall trend.

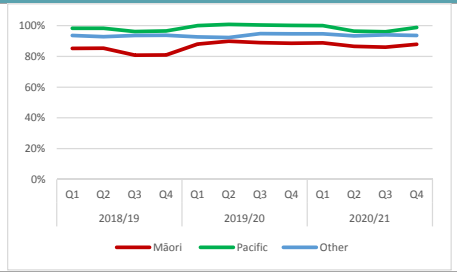
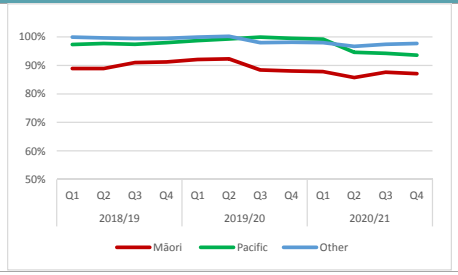
Māori have improved access to, and use of, primary care and community-based healthcare services

At the most basic level, primary care utilisation can be measured by the number of consultations divided by the number of people enrolled in a PHO. Measures of community-based services refer to the number and uptake of community-based services for/by 2DHB Māori.

Areas of focus
- Primary care and Māori health providers
- Community health services
- Co-design and partnership-based approaches

Links to Whakamaua: Māori Health Action Plan 2020-2025

Sub-regional initiatives (2DHB)
- Developing and providing simple and culturally safe PHO enrolment processes and care and following up with people using DHB services
- Supporting Māori health providers seeking to expand capacity and strengthen capability and review Māori Health funding portfolio to increase funding to Māori providers
- Co-designing ambitious targets with whānau, rangatahi and tamariki, set new benchmarks and put in place the infrastructure to deliver hospital and community-based services to achieve equity and improved health outcomes for Māori

• Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services • Objective 4: Strengthen system accountability settings					
Indicators	**Rationale**	**Targets**	**CCDHB Performance**	**HVDHB Performance**	**Comments**
Indicator 1: PHO enrolment rates	Enrolment in and utilisation of primary care is an important factor in reducing avoidable hospital admissions, managing long-term conditions, and improving health outcomes overall.	• All Māori are enrolled in PHOs • The Māori enrolment rate is equal to non-Māori enrolment rates?			
Indicator 2: Māori Health portfolio funding Increased funding to Māori health providers as a proportion of total funding	Māori health providers facilitate culturally safe access to community-based services and primary care, providing options outside of secondary care.	Increased Māori Health portfolio funding proportion			$1M has been approved for commissioning service delivery by kaupapa Māori service provider to Māori whānau on the basis that the service will have a clear alignment to one or more of the Equity Principles adopted by 2DHB.

9. Appendix Two: Strategic Alignment with Whakamaua: the Māori Health Action Plan, 2020-2025

	1: Māori-Crown Partnerships	2: Māori leadership	3: Māori health and disability workforce	4: Māori health sector development	5: Cross-sector action	6: Quality and safety	7: Insights and evidence	8: Performance and accountability
Objective 1: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services	Co-design with the community and take a partnership-based approach with local Māori in commissioning new projects/services.		Expand existing Māori health workforce initiatives aimed at encouraging Māori to enter health careers. Support workforce development specific to MHA relating to Māori Health equity.	Support Māori health providers seeking to expand capacity and strengthen capability, increasing access to and choice of kaupapa Māori services. Develop an equitable commissioning plan/policy with equity for Māori as a target for all new and renewing service contracts, obtaining Māori input to ensure contracts and agreements are also culturally appropriate.			Design and implement relevant Māori health and disability research in ways that contribute to achieving pae ora in partnership with Māori.	
Objective 2: Shift cultural and social norms		Increase knowledge of Board, CEO and ELT members regarding Māori and health equity issues and establish governance groups / additional Board seats for Māori as appropriate. Proactively support leadership networking opportunities for Māori staff at all levels of the organisation.	Develop an overarching Māori workforce plan and strategy with aspirations and targets for the recruitment, retention, and professional development of Māori staff.	Increase the percentage of Māori enrolled in a primary health organisation (PHO) to match that of the total population by, for example, developing and providing simple and culturally safe enrolment processes and care and following up with people using DHB services.	Where possible, look for opportunities to collaborate with the education sector in encouraging Māori to enter careers in the health sector (e.g., scholarships).	Develop a cultural competency workforce plan to set core competencies for all staff to achieve health equity and improve Māori health outcomes, as well as associated resources.		Develop and commit to an Equity Policy/Plan to implement changes to system accountability frameworks that assures ownership of Tiriti obligations and accountability for Māori health equity.
Objective 3: Reduce health inequities and health loss for Māori	Co-design with Māori in response to the Mental Health Inquiry.	Develop a Māori stakeholder engagement plan to work more closely with a range of Māori stakeholders in healthcare and the community in developing projects, initiatives, and strategies.		Develop and implement a DHB investment plan for long-term conditions. Invest in programmes focussing on education and messages around safe sleep, immunisation, breastfeeding, and smoking cessation. Invest in Maternal, Child and Youth, and MHA programmes with a focus on Māori health equity.	Prioritise the development of pathways of care for families experiencing violence, alcohol, drugs, and trauma (HVDHB).		Develop and commit to measures and indicators of Māori health equity to monitor progress. Stock take of Maternal, Child and Youth services available to meet the needs and aspirations of Māori and achieve health equity.	Develop and implement Māori health equity and Tiriti tools and resources to guide DHBs and staff in strategies, planning, monitoring and accountability.
Objective 4: Strengthen system accountability settings		Strengthen relationships and engage more frequently and meaningfully with relevant partnership boards (Mana Whenua Relationship Board / Māori Partnership Board).	Develop a Māori recruitment strategy by reviewing and strengthening current attraction, recruitment, hiring and 'on-boarding' practices. Implement a range of communications and a strategy to support, encourage and integrate pro-equity initiatives.	Review the Māori Health funding portfolios to identify gaps and opportunities to align to the Taurite Ora strategic direction, and track and increase Māori provider funding.			Data overhaul to ensure both DHBs have high-quality, complete, and consistent ethnicity data and reporting, and that progress on Māori Health is monitored and evaluated.	

Board Information – Public

3 November 2021

2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report April – November 2021	
Action Required **The Boards note:** (a) The Pacific Directorate are focussed on addressing the six priority areas defined in the Pacific Health & Wellbeing Strategic Plan 2020 – 2025. This paper provides a progress report from April – November 2021. (b) There are a number of initiatives that have occurred during the period to deliver on the actions outlined in the Strategic Plan. (c) The Covid-19 response for Pacific.	
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, Director Pacific People's Health, CCDHB & HVDHB
Endorsed by	Fionnagh Dougan, Chief Executive Officer, CCDHB & HVDHB
Purpose	Update the Boards in relation to the implementation of initiatives related to the Pacific Strategic Plan.
Contributors	Candice Apelu-Mariner, Integration Lead Pacific Sam McLean – Principal Analyst & Team leader - Analytics
Consultation	2DHB Strategy, Planning & Performance

Executive Summary

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 (Pacific Health Strategy) outlines the strategies the Boards have supported to improve health outcomes and achieve equity for Pacific communities across Wairarapa, Hutt Valley and Capital & Coast DHBs over the next five years.

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

- A high-level progress report on the status of the broader activities that the Pacific Health Strategy encompasses
- A progress report on Covid-19 response for Pacific
- 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 Rachel Haggerty	Ensure approval of funding investment for out years are sought	3	Medium risk

Attachment/s

1. 2DHB Pacific Progress and Indicators Report

2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report April – November 2021

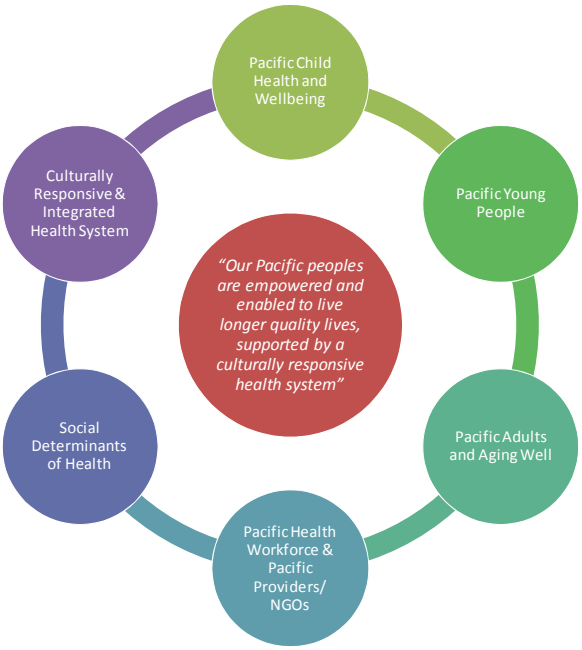
This report provides an overview of progress made in relation to the key outcomes of the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region, and includes:

- A high-level progress report on the status of the broader activities that the Pacific Health Strategy encompasses
- A progress report on Covid-19 response for Pacific
- A high-level dashboard and explanation of indicators that have been developed to measure progress in relation to Pacific health equity.

Contents

1. Background

Throughout the period of this progress report (April – November 2021) Pacific peoples in the greater Wellington region have experienced overwhelming challenges from the COVID-19 pandemic. This has encouraged the CCDHB and HVDHB (2DHB) to create a space for Pacific health providers, ethnic groups, churches and communities to implement innovative responses for health service delivery. While significant effort and time of all relevant stakeholders has been directed towards testing and vaccinations, attention on the 2DHB Pacific Health and Wellbeing Strategic Plan has remained a priority.



The six priority areas in the Strategic Plan follow a life-course approach to health with a strong focus on systems change and collective impact

Equity investments of $1,000,000 have enabled the 2DHB to commission funding to existing Pacific health providers to strengthen programmes that are already underway and also create new opportunities to meet the targets set out in the Strategic Plan. The table below reflects the distribution of funds:

Distribution of Commissioning for Pacific Health Providers	
Pacific Health Services Hutt Valley	$300,000
Taeaomanino	$50,000
NET Pacific	$20,000
Vaka Atafaga	$200,000
Catalyst Pacific	$50,000
Pacific Health Plus	$200,000
Stroke Foundation	$100,000
Vaka Tautua	$80,000
Total	**$1,000,000**

2. 2DHB Pacific Strategy Work Programme and Status

The Strategic Plan outlines activities and actions under the six priority areas to monitor progress of the broad activities. The table below provides an update on activities that have taken place in the period of the report (April – November) and the following colour coding has been used to describe progress on each activity:

Good progress – on track.	*Started – but not yet fully developed.*	*Work has not started on this yet.*

Specific projects and activities related to each general area of the work programme are noted in the Comments/ details column.

The dashboard in Appendix 1 provides a more detailed picture for three priority areas: Pacific child health and wellbeing; Pacific Young People; Pacific Adults and ageing well.

Priority One: Pacific Child Health To give Pacific children and their families the best possible start in life and ensure they meet key childhood developmental milestones through culturally responsive and safe services and support.		
Action	***Progress Status***	***Comments/ Details***
Support family-centred initiatives to reach pregnant mothers, parents, babies, and families.		An investment of $200,000 to an existing contract to Pacific Health Services Hutt Valley has been commissioned to support 'Thriving Cores Well Child Tamariki Ora Service for 0-4yrs to reach 200 more babies per year (a total of 300 babies will be supported) We have commissioned $100,000 to Naku Enei Tamariki (NET) Pacific 'Anofale Antenatal Programme' specifically for Pacific pregnant women. Taeaomanino have received a further $50,000 towards an existing contract ($45,000) to support antenatal work for Pacific mothers throughout Wellington. The 2DHB Maternal and Neonatal Strategy currently being developed will have a strong focus on enabling culturally responsive maternal services for Pacific mothers, children and families.
Collaborate with appropriate stakeholders to promote safe environments for bringing up Pacific children including warm homes, smoke free homes, good nutrition, safe sleeping, reducing smoking and alcohol consumption		Ongoing partnerships and joint initiatives between the 2DHB and Smoking Cessation service. The Senior Pacific Advisor for 'Takiri Mai Regional Smoking Cessation Service' a partnership with Kokiri Marae, is currently vacant and recruitment is underway and the position will be hosted by the 2DHB Pacific Directorate. MoH funding for smoking cessation services will also be commissioned in early 2022. We continue to work with Well Homes; Sport Wellington; and Healthy Families Hutt Valley to support social determinants of health. Ongoing support to Pacific Health Services Hutt Valley for their Community wellbeing programme that has engaged Church clusters and ethnic specific lifestyle programmes across the Hutt Valley.
Work collaboratively with Bee Healthy Regional Screening Services and key stakeholders on projects and initiatives to improve coverage of screening and preventative oral health interventions		While there is an ongoing partnership with Bee Healthy Oral health Regional Service, with the lockdowns it has meant that there is a significant backlog in this area. Promotions of oral services on the ethnic specific radio stations have taken place to strengthen this service. Ongoing support by the Pacific Units across 2DHB to reduce DNAs for appointments by nurses actively calling families ahead of schedule, translating, providing education and working with Bee Healthy to follow up high risk families.

Priority Two: Pacific Young People		
Action	***Progress Status***	***Comments / Details***
Support and strengthen initiatives that encourage young Pacific people to adopt healthy lifestyles, make informed choices about sexual health, smoking, and risk-taking behaviours		Funding has been commissioned to the Vaka Atafaga nursing service to broaden the scope of their practice to include beyond Porirua ($200k). A 2DHB Pacific Youth "Brainstrust" is in the final stages of being established. This group will be an advisory group to the 2DHB Pacific Directorates, and will help engage, develop and design "youth by youth for youth" Pacific specific programmes and services.
Accelerate strategies and innovations that focus on Pacific young people's mental health, self-harm and violence.		Taeaomanino and Pacific Health Services Hutt Valley have received funding through an Alcohol and Other Drugs funding stream (Strategy, Performance and Planning) to support mental health for young Pacific people. An evaluation has been completed on the Ta'iala mo le ola manuia mental health programme with Hutt Valley Samoan Churches. Recommendations will assist in delivering more bespoke programmes for Pacific youth.
Strengthen and promote partnerships with youth specific health, social and educational service providers.		Covid-19 vaccination funding allowed for an investment into a targeted Pacific youth event in Porirua during Super Saturday 16 October. The partnership developed with Porirua youth created pathways to promote youth specific health messaging already underway through the 2DHB Youth One Stop Shop initiative.
Leverage Technology to promote health messages and campaigns that reach and resonate with Pacific young people		Funding has been commissioned to Catalyst Pacific ($50k) who has been instrumental in promoting health messages and campaigns during the Covid-19 pandemic. Catalyst Pacific has strengthened the Positively Pacific Facebook page and website to provide one source of truth for all Pacific health messages in the Wellington region. It works in tandem with the 2DHB social media platforms.

Priority Three: Pacific Adults and Aging Well		
Action	***Progress Status***	***Comments / Details***
Work in partnership with key stakeholders to increase and encourage participation in screening programmes (cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).		The Pacific National Network for Bowel screening is a network of providers specifically targeting participation in bowel screening. This group is looking at broadening to include other areas to strengthen the low uptake of screening by Pacific peoples. Funding is being sought for an FTE to sit within Pacific Health Services Hutt Valley to increase the screening statistics. Pacific Health Services Hutt Valley and Atamu Trust in Porirua hold Breast and Cervical screening contracts with the Regional Screening services for Pacific women. They continue to engage and reach the hard to reach Pacific women overdue for their breast and cervical screening and enable appointments to be completed. A 2DHB Pacific Nurse Led Integration project funded under the DHB Sustainability innovation funding for hospital services will focus on strengthening work that includes increasing participation in screening programmes.

Priority Three: Pacific Adults and Aging Well		
Action	***Progress Status***	***Comments / Details***
		2DHB were one of the sponsors of the 'Pinikilicious Breast Screening' event held in Porirua on 20 May 2021.
Continue identifying change levers in programme and service design that will make the greatest impact on health conditions including cultural competency training for non-Pacific workforce that support Pacific people.		Pacific Cultural Competency Trainings rolled out across 2DHB to ensure a pro equity approach is taken when meeting with Pacific patients and their families. Planning for development of a Regional Cultural Competency Training Package to include Wellington and Keneperu Hospitals.

Priority Four: Pacific Health & Disability Workforce and Providers		
Action	***Progress Status***	***Comments / Details***
Influence HR recruitment policies and processes across the 3DHBs to improve Pacific employment opportunities including increasing number of Pacific on shortlisting, interview panels, steering groups and governance		• Nursing & Midwifery Recruitment and Retention Strategy encourages the engagement of Pacific nurses • Appointment of the Allied Professions Lead for Pacific Peoples Health • Agreement of the appointment of the Pacific Lead MHAIDS to sit on ELT • Appointment of Pacific Covid-19 Response Lead (x 2) • Appointment of the 2DHB Senior Advisor (Pacific) • Promotion of Integration Lead (HVDHB) and Systems Services Manager (CCDHB) to 2DHB Principal Advisor Pacific • Porirua Locality role to be hosted by 2 DHB Pacific Directorate
The 3DHBs and PHOs demonstrate their commitment to funding and supporting "Pacific by Pacific" Pacific health service providers in the community and recognise the crucial part they play within the health system and the achievement of health outcomes.		Funding Pacific Health Plus After hours service – ($200k) Funding for Pacific FTE to support Stroke Foundation ($100k) Funding for Vaka Tautua to support mental health and disabilities ($80k) Covid-19 Funding from MoH to DHBs (Tranche 3 - $947,047, Tranche 4 - $1.9 million, has also been allocated to Pacific Health Providers to enable providers to scale up and deliver an equitable response to the outbreak by sustaining community led response and services, and maintaining capability to support post-lockdown recovery and vaccination roll out. Ongoing and regular Pacific Providers meetings are held with Pacific providers chaired by the 2DHB Director Pacific.
Increasing and attracting our Pacific workforce by targeting students via formal education settings, such as secondary schools and tertiary institutions. This pipeline needs to be socialised as well with the education sector.		Contractor employed to develop a Pacific Mentoring Programme (Kia Ora Hau Ora) and a Pacific Workforce Plan.

Priority Five: Social Determinants of Health		
Action	***Progress Status***	***Comments / Details***
Work closely with Local Councils, Housing NZ (Kainga Ora) and key stakeholders to advocate and influence decision making that will improve healthy housing for Pacific people.		Continue to liaise and partner with Well Homes, relevant organisations such as MSD, Pasifika Futures, and other Whanau Ora service providers, Housing NZ and local councils to address issues such as housing.

Priority Five: Social Determinants of Health		
		Well Homes program have been present at Church based Pacific Vaccination Festivals in Porirua and Hutt Valley where they engaged with Pacific families and were able to provide education and support for warm housing. Initial discussions have been held with a Pacific senior manager from Kainga Ora about working closely together, This will help feed into the overall focus on addressing healthy housing for Pacific people.

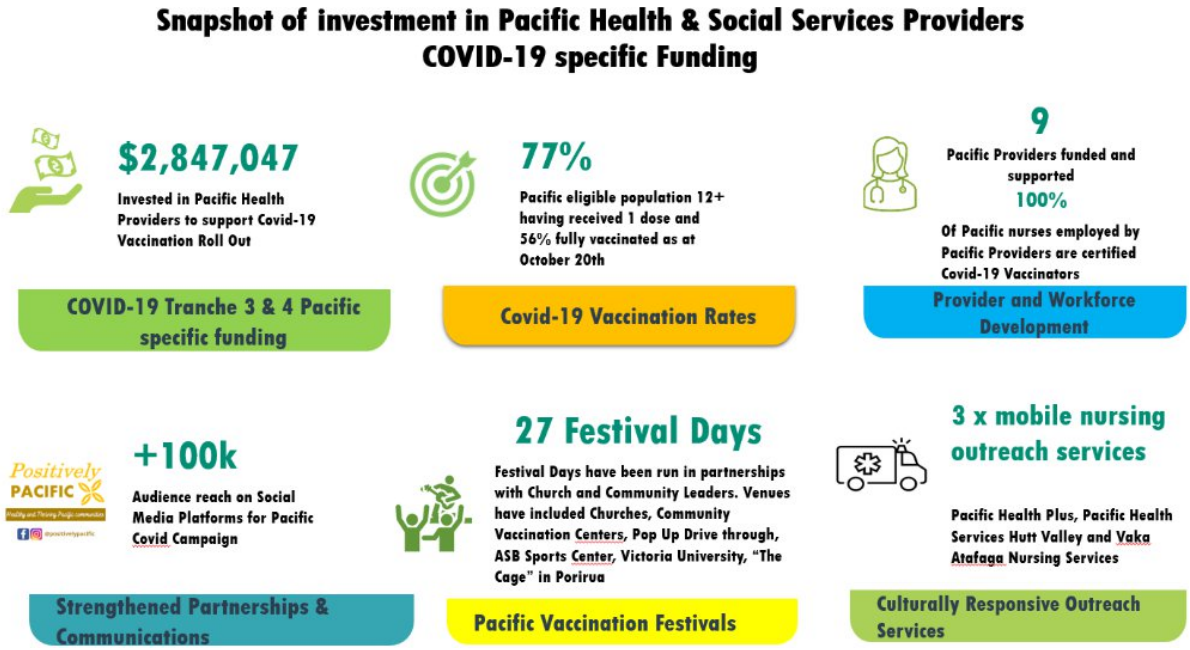
Priority Six: Culturally Responsive and Integrated Health System		
Action	***Progress Status***	***Comments / Details***
Develop and Implement a Sub-regional Cultural Competency Framework, Checklist and Training Package that nurtures a culturally responsive work environment and improve capacity of the health workforce to deliver culturally sensitive services.		Pacific Cultural E-Learning in place that is part of mandatory training for all staff. Ongoing Face to face two hour Pacific cultural training for the health workforce for HVDHB. This will be explored for CCDHB and WrDHB.
Continue to support integrated programmes in primary care and hospital/specialist services focused on early identification, treatment and support for individuals with risk factors such as the community integration initiative.		$83,380 investment in TatouTatou project to enhancing equity in specialist advice and ambulatory care (Strategy Performance and Planning initiative) A Respiratory and Sleep apnoea integration project is underway between HVDHB and Pacific Health services Hutt Valley to support high risk Pacific patients. Community Integration Steering Group work streams with a strong focus on connecting primary and secondary care and taking specialist services out to the community. This includes a localities approach that is focussed on Pacific, Maori and Disability communities. Patient Safety Group also focussed on safety of patients with a strong focus on Pacific.
Develop a Pacific communications strategy for the Greater Wellington Region		2DHB has developed this plan. Engage with Catalyst Pacific to ensure their work is aligned with this plan.

3. Covid-19 Response

The Ministry of Health allocated equity funding through their Pacific Directorate to the 2DHB Pacific team to support Covid-19 related activities within the Wellington region. The funding of $2,847,047 was commissioned in two tranches, the first on 1 June 2021 and the second on 13 September 2021. The allocation of the funding was at the discretion of the 2DHB Pacific team, and recipients were guided by the following objectives:

- 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 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.
- 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

The funding was distributed to nine existing Pacific health providers, and while their work continues, the infographic below demonstrates outputs and outcomes delivered as at 20 October 2021.



4. Next Steps

The Pacific team across 2DHB will:

- Develop a 2DHB Maternal and Neonatal Strategy
- Develop an 'Operational Plan' to implement the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region
- Complete the Pacific Workforce Plan and Pacific mentoring programme. Develop FTE role to deliver mentoring programme
- Further develop Porirua Locality work with FTE
- Work with Wairarapa DHB Planning & Performance and 2DHB Strategy, Planning & Performance to manage identified risks for 2021/22 and beyond.

5. Appendix One: 2DHB Pacific Health Dashboard

Pacific child health and wellbeing

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

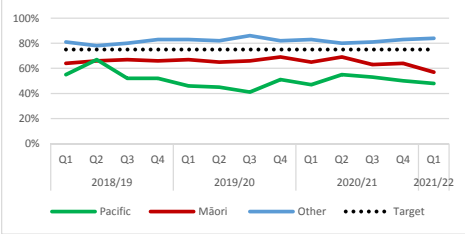
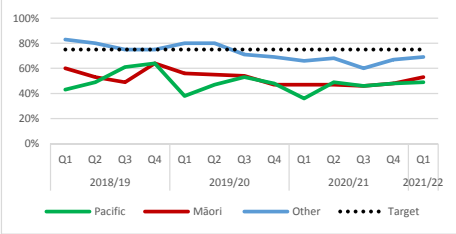
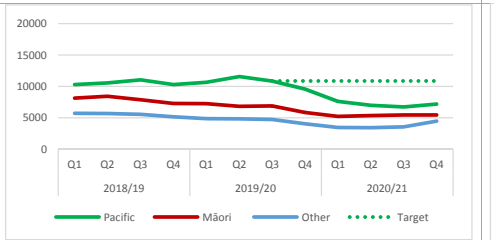
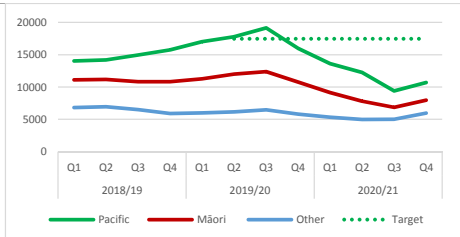
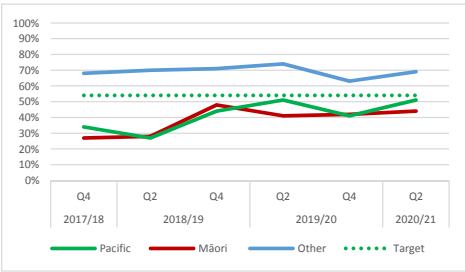
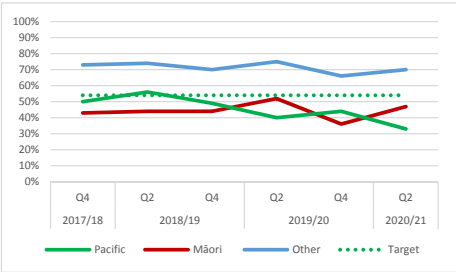
Ensure Pacific Children meet key childhood developmental milestones through culturally responsive and quality services and support

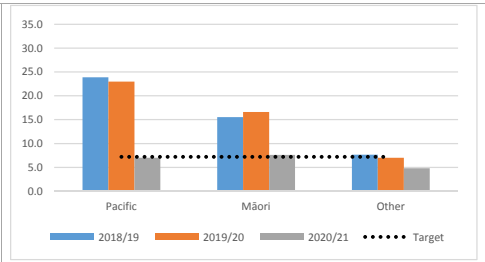
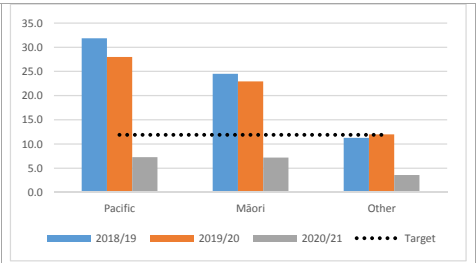
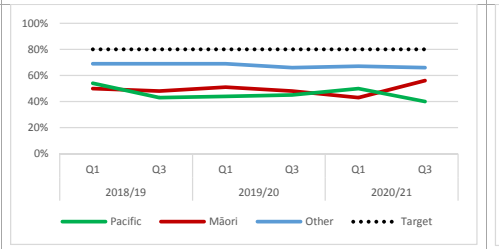
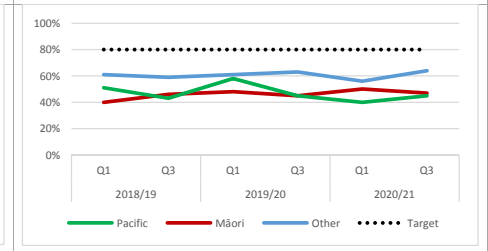
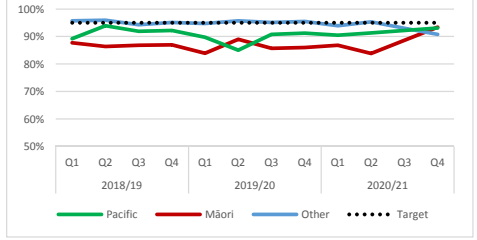
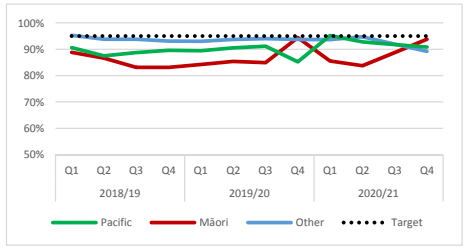
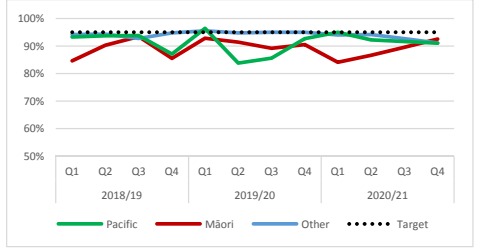
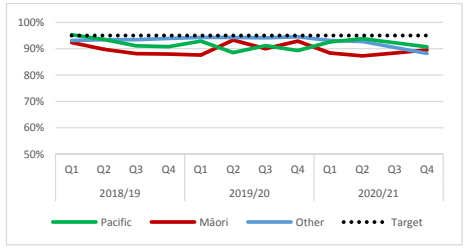
Areas of focus for next 12 months

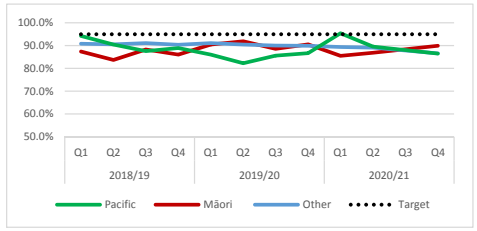
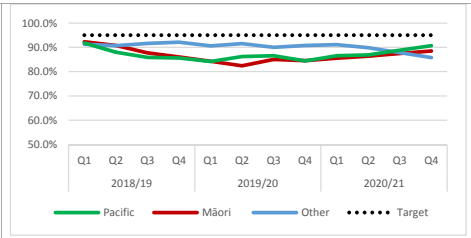
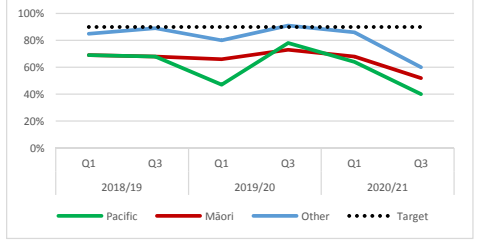
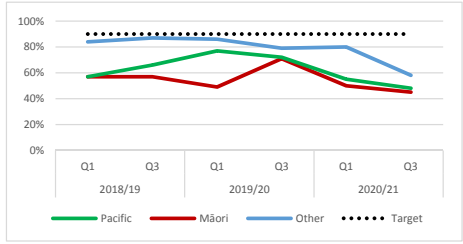
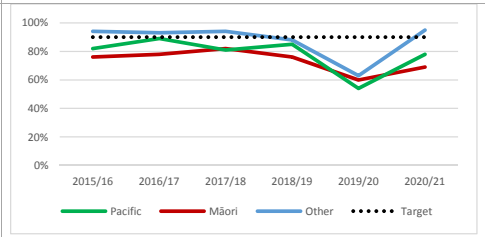
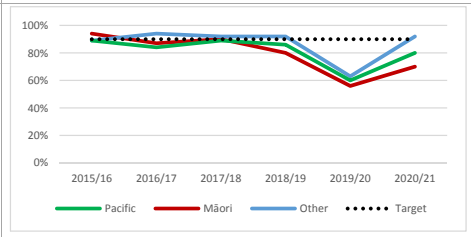
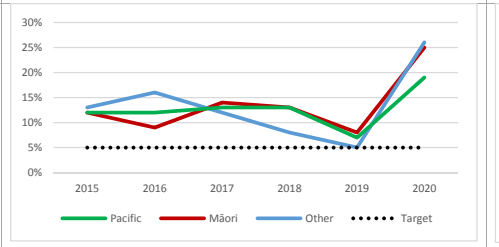
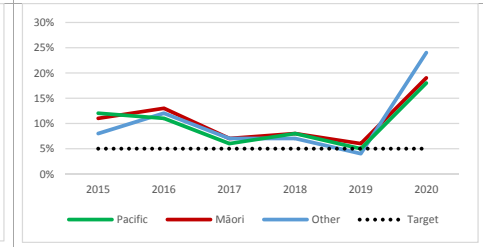
- More accessible and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.
- Increase the number of Pacific children living in healthy homes that are warm and smokefree

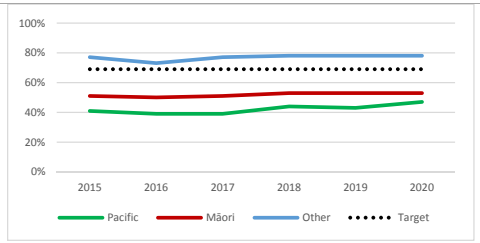
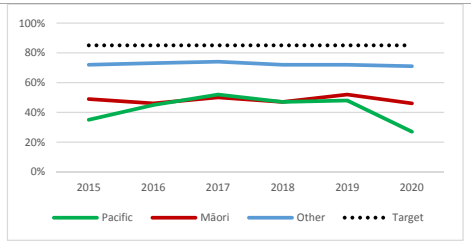
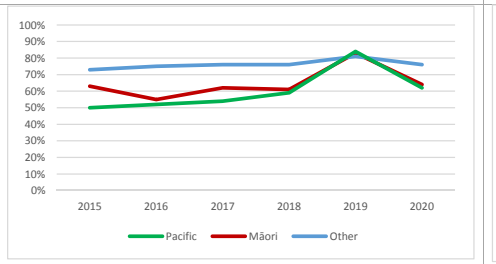
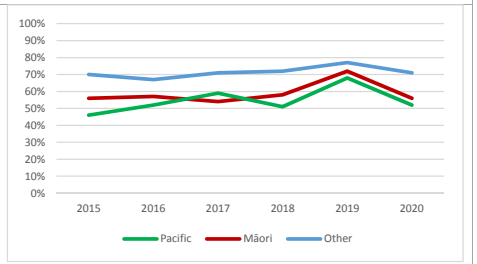
Sub-regional initiatives (2DHB)

- 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% (≤10,865) HVDHB: ↓2% (≤17,459)			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. The declining rates are driven by decreased respiratory illness in 2020. In mid-2021, RSV resulted in a small increase.
% 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 within which they will initially be raised.	CCDHB: 54% HVDHB: 54%			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.

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 completing the full schedule of vaccines but do 'catch up'.
% of Pacific children fully vaccinated at two years old		≥95%			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 (Maori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but will be

% of Pacific children fully vaccinated at five years old		≥95%			developed as the equity gains may be worth a small investment.
% 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 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	≤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.

% of Pacific children caries free at 5 years	by children in school Year 8 (12/13-year olds).	CCDHB: ≥69% HVDHB: ≥85%			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 12 years old		TBC			

Pacific Young People

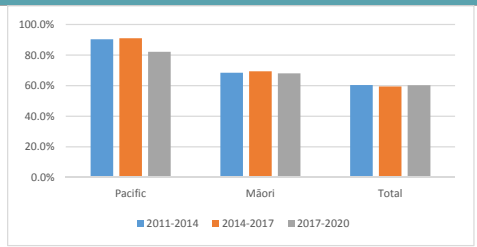
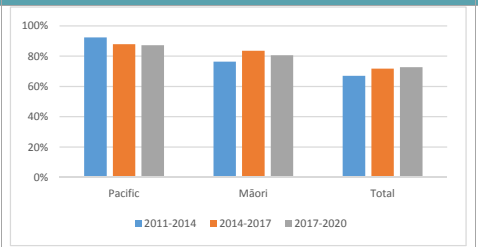
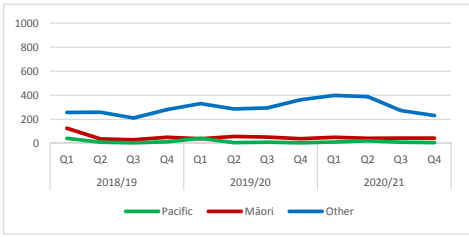
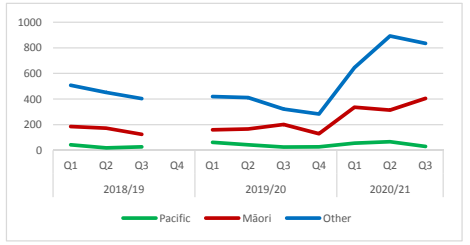
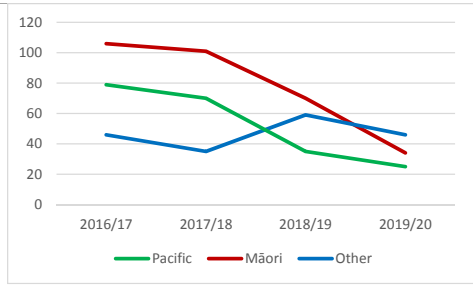
Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives

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

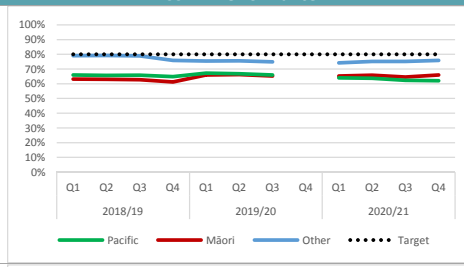
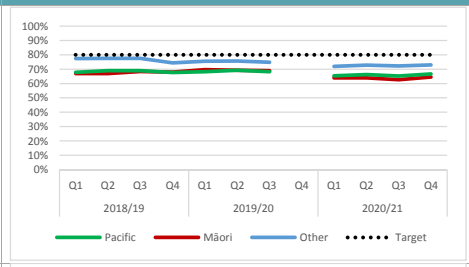
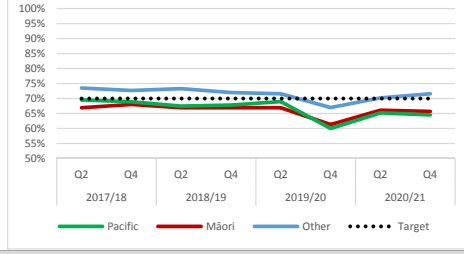
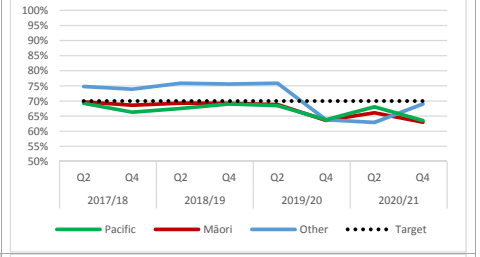
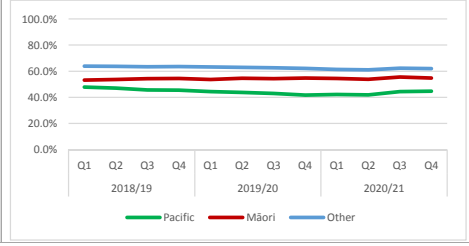
Pacific adults and elderly are actively engaged in their health care, live productive, active, culturally secure and quality long lives.

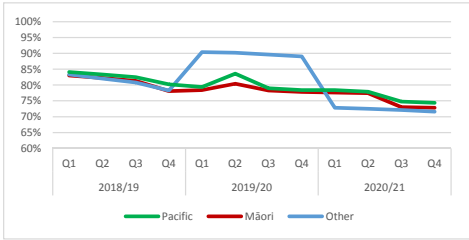
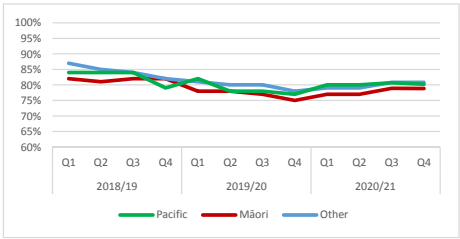
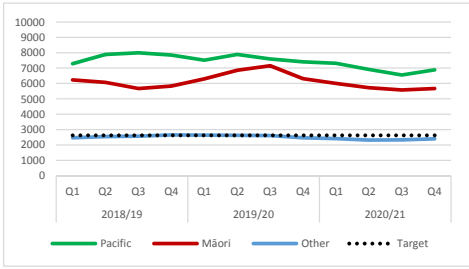
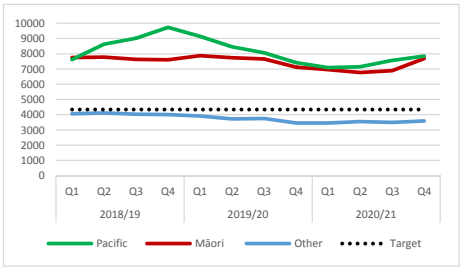
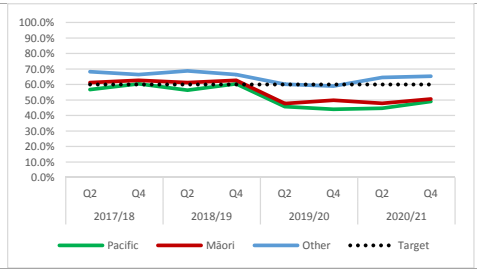
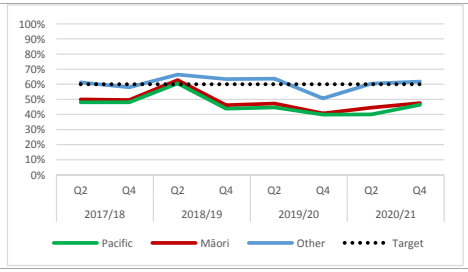
Areas of focus

- 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. We've identified a need to review and refresh our approaches for supporting Pacific women who are overdue or unscreened to attend screening clinics. We expect to identify opportunities to recommission services from a pro-equity perspective during 2021-22.
% of eligible Pacific women (50-69 years old) completing breast screening		≥70%			
% of eligible Pacific population (60+) completing bowel screening testing			-		

% 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) Regular clinics continue to be held in Wellington practices, with strong demand emerging from Porirua practices.
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			There are a range of Pacific Providers working collaboratively to address inequities and high unmet needs in Pacific communities. Vaka Atafaga, is a Pacific neighbourhood nursing service in Porirua to support Pacific families in improving their health and health outcomes. There is also a similar Pacific Nursing Service in the Hutt Valley. These services are focused on supporting Pacific families with complex health and social needs and access to primary health care services. ASH is one of the referral criteria for families, along with diagnosis of long term condition(s) which are high contributors to ASH admissions.
% 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			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.

Pacific Health and Social Services Providers

Goal: The Pacific health workforce and Providers have the capabilities, resourcing, aspirations, organisational structures, professional opportunities and potential to lead, support and contribute to achieving positive health and wellbeing outcomes for Pacific people.

Areas of focus

- The 3DHBs and PHOs demonstrate their commitment to funding and supporting "Pacific by Pacific" Pacific Health Service providers in the community and recognise the crucial part they play within the health system and the achievement of health outcomes.
- Strengthen and support Pacific Health Providers and align their work with General Practices and hospital services in particular with a focus on Health Care Homes and Integrated family health centres in primary care and the community.

Sub-regional initiatives (2DHB)

- Developing and committing to an Equitable Commissioning Policy
- Pacific Provider Forum in the Greater Wellington Region established and supported
- Community Localities, Neighbourhoods work.
- Regional Screening Services
- Mental Health Projects

2DHB Equity Investment for Pacific Health & Social Services Providers

$1,000,000 top up equity funding

Pacific Health Services Hutt Valley
- Strengthen Primary Nursing Service
- Well-Child Tamariki Ora Service
- Alcohol & Addictions Counselling Services
- Primary Mental Health Services

Taeaomanino Trust
- Strengthen Alcohol & Counselling Services
- Mental Health Services
- Antenatal Services

Pacific Health Plus
- Extend After Hours Medical Clinic GP Services

Vaka Atafaga
- Extend Mobile Outreach Nursing Service to Wellington

Naku Enei Tamariki (NET)Pacific
- Continue Anofale Antenatal Health Services

Catalyst Pacific, Samoa Capitol Radio & Pacific Broadcasters
- Communications via digital platforms, radio, strengthening Positively Pacific

Vaka Tautua
- Support mental health and disability services for Pacific

Board Information – Public

3 November 2021

3DHB Data and Digital update – Quarter 1	

Action Required

The Boards note:

(a) The content of the attached Data and Digital update report for Quarter 1 2021/2022.

(b) We continue to strengthen our security posture with targeted investment.

(c) The core clinical work programmes – single clinical portal and regional radiology information system are progressing on track

(d) 3DHB Digital are working closely with the Ministry of Health and the Transition agency to align digital direction, investment and architecture in preparation for Health NZ.

Strategic Alignment	Creating a sustainable and affordable health system
Author	Martin Catterall, Chief Digital Officer, Capital & Coast District Health Board
Endorsed by	Fionnagh Dougan, Chief Executive, Capital & Coast and Hutt Valley District Health Boards
Purpose	The purpose of the paper is to inform the board of the Q1 2021 performance of 3DHB ICT and the intentions for Q2 2021.
Contributors	n/a
Consultation	n/a

Executive Summary

1. The direction and workload has been refocussed around clinical workspace upgrades and clinical process improvements, improving service levels and operational efficiencies, risk management and remediation, and cyber security management and upgrades.
2. The work programme for FY 2021/22 is progressing well with ePrescribing going live in November, the Single Clinical Portal and Regional Implementation progressing to plan.
3. Business cases are under development or have been approved for the cyclical replacement programmes, though hardware orders are constrained due to high global demand.
4. Engagement regionally and nationally continues with a focus on alignment of technology direction across the six regional DHBs and the Ministry of Health.

Strategic Considerations

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

Identified Risks

Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
To achieve the proposed outcomes in the digital strategy investment is required.	Martin Catterall	We will signal through annual budget requests the required funding over the next four years.	Low	Low
Potential loss of access to ICT systems due to state of assets, limited resiliency, and resourcing.	Martin Catterall	Progressing strategic foundational initiatives and resilient systems work programme.	Medium	Medium

Attachments

1. 3DHB Data and Digital Quarterly Report – Q1 2021-2022

3DHB DATA AND DIGITAL
QUARTERLY UPDATE, OCTOBER 2021

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

The direction and workload of the department as a whole has been refocussed around

- clinical workspace upgrades and clinical process improvements
- meeting priority ICT needs across the three DHBs
- improving service levels and operational efficiencies
- risk management and risk remediation with a focus on technical upgrades
- cyber security management and upgrades.

Many of the upcoming challenges facing the ICT department concern change and organisational transformation of the DHBs. To meet these challenges we are collaborating closely with the digital teams in the other three DHBs within the central region, progressing plans to create a better continuity of service, sharing of data and leveraging ideas and systems to improve outcomes.

Likewise we are also participating with the nationwide health ICT network and with the Ministry of Health Data and Digital team. Doing so means we can represent our region in the programme of change as the move to Health New Zealand gains momentum.

A recent success for ICT in this regard is the move to a nationwide single contract for all DHBs for Microsoft licensing which will be more cost effective while also providing access to higher level products.

2. WORK PROGRAMME UPDATES

CLINICAL WORKSPACE

3DHB Clinical Portal

The single clinical portal project is underway, with current actions ensuring the right levels of assurance and governance. During the next few months a number key activities will be undertaken, being initiation of data migration and core functionality being stood up with regard to patient identify and dynamic patient summaries.

This activity will be on going with a current planned go live for Wairarapa DHB in October 2022, Hutt Valley DHB in December 2022, then Capital & Coast DHB in May 2023.

Regional Radiology Information System (RRIS)

This project remains in an overall amber status, meaning the project has some concerns, but they are under active management.

A review of Regional Clinical Portal (RCP) additional procedure code changes continues. There is a significant number of code changes and this work will continue for the next two months.

The delivery of the PACS reporting package was delayed due to the COVID-19 lockdowns. The Philips team have now completed training and handover to the Regional Digital Health Service team at TAS. The DHB is expecting the delivery of this package in the next month.

The DHB specific teams have been progressing the data migration activities and sign off by the region will be sought in October.

An issues paper for the Radiology Ordering solution for Hutt Valley and Wairarapa was completed in September 2021. Dr Brian Corley and the Hutt Valley Radiology team have taken a revised paper to the Hutt Valley Clinical Users Group. This paper will now progress to Steering Committee and finally to the DHB Executive Leadership Teams for a final decision.

It is still planned that the project will go live for Capital & Coast DHB in March/April 2022, with Hutt Valley and Wairarapa being delivered shortly thereafter.

ePrescribing

ePrescribing for outpatients is nearly complete, with an expectation that all three DHB's will go live in November 2021. This initiative will allow for outpatients to be prescribed medicines electronically, removing the need for paper prescriptions to be printed.

3. WORK PROGRAMME UPDATES

DIGITAL FOUNDATIONS

The digital foundations programme encompasses a number of core foundational projects which focus on underlying digital infrastructure on which our clinical and corporate systems operate.

Business cases for core activities have either been approved or are being reviewed internally prior to submission for approval. This includes annual server and network hardware replacement, the security improvement programme and equipment to enable Te Wao Nui.

DIGITAL WORKPLACE

The digital workplace programme has been limited to a few small deliverables as funding was not available this financial year to progress the full rollout across the DHBs.

3DHB ICT is progressing an early adopters pilot for Microsoft Teams. This pilot is engaging with small groups of users from within the DHB in order to test the approach planned through the design and planning phase. The pilot is expected to last for six weeks starting mid October 2021.

In parallel to the pilot, work is underway to configure Teams in a minimal viable product. This would allow voice, video and chat functionality, however restrict the use of the tool as an information store to ensure the DHB does not have an unmanageable document repository in breach of our Records Act requirement.

3DHB ICT have commissioned two reports into the current state of our PABX and contact centre systems. These reports are focussing on cybersecurity and equipment failure risks to indicate the level of risk being faced by the DHBs.

4. CYBER SECURITY

3DHB ICT recently responded to the Ministry of Health with regard to our annual information security assurance programme.

We have included the feedback provided for key areas below:

ASSURANCE ACTIVITIES

The following security controls and related initiatives to improve the security posture of the 3DHB's has been completed or initiated within the last year.

- We produced and published our 3DHB Cyber Security Strategy. This strategy included a horizontal view of the roadmap of work to support this strategy.
- The commitment of $750k Opex and $250k Capex 2021/22 budget to support the execution of the Cyber Security Strategy across the 3DHB.
- As a result of the Waikato incident and following a full security control review there were a number of pipeline initiatives deemed "shovel ready" which were accelerated under urgency. These included:
    - A threat hunt of all endpoints using a modern Endpoint Detection and Response (EDR) via All of Government (AoG) provider Inphysec. The results of this threat hunt were received in September 2021 and have revealed no evidence of threat actors either present or historically present at the time of the threat hunt. A number of vulnerabilities were identified which the security team are working with operational staff to remediate.
    - A review of Business Continuity Plan (BCP) and Cyber Security Incident Response processes was completed.
    - The urgent procurement and deployment of a modern EDR solution. (Crowdstrike). This is currently being implemented under urgency.
    - The procurement and deployment of a User Awareness and Training solution to coincide with Cyber Security week in October 2021.
- The implementation of controls to retrieve historical emails later flagged as malicious.
- An initiative to implement E5 Security tools in collaboration as early adopters with Ministry of Health (Itnewcom).
- The establishment of a "fit for purpose" Certification and Accreditation process which included collaboration with the Ministry of Health Security team.
- The upgrade and penetration testing of our Netscaler Reverse proxy Appliance which is the security control used to accelerate all internet facing systems. There were no upgrades of internet facing applications within this period warranting further penetration testing.

4. CYBER SECURITY continued

ASSURANCE ACTIVITIES CONTINUED

- Acceleration of the replacement of the IBM Security Operations Centre/ Security Incident Event Management (SOC/SIEM) solution scheduled to be completed in November 2021.
- Development of a phase one business case to initiate work to implement controls including DDOS , 802.1x , SOC/SEIM Replacement, Log Aggregation , VA Scanning Tool and Defender E5.

SECURITY MANAGER

3DHB ICT have undertaken the following people capability and capacity initiatives:

- The appointment of all roles to the dedicated Security team (4 FTE) including the appointment of two new roles, Security Team Leader and Security Engineer.
- The recruitment of a Regional Chief Information Security Officer (CISO).
- Exploring the opportunity of a 3DHB Virtual CISO (a VCISO is an outsourced security practitioner or provider.)
- The development of an operating model to support the newly created Security team.
- The formation of the Digital Foundations Programme including Programme and Project Managers to support the execution of the Security roadmap of work.
- Reorganising the process in which servers are patched to improve the compliance rate of patched servers.

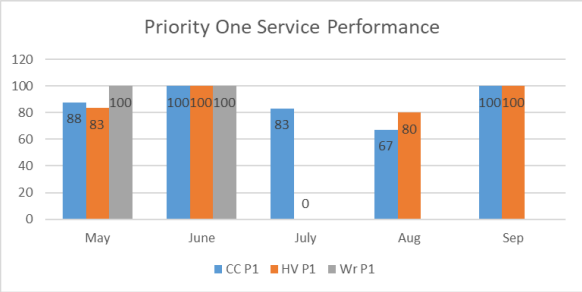
5. SERVICE ASSURANCE

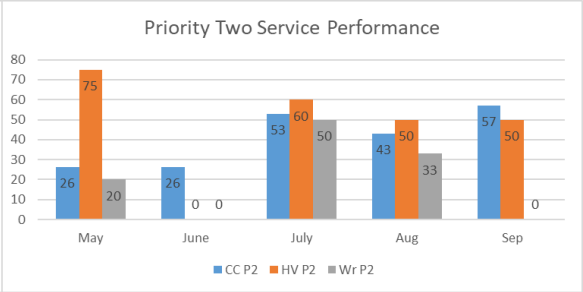
SERVICE LEVEL AGREEMENT METRICS

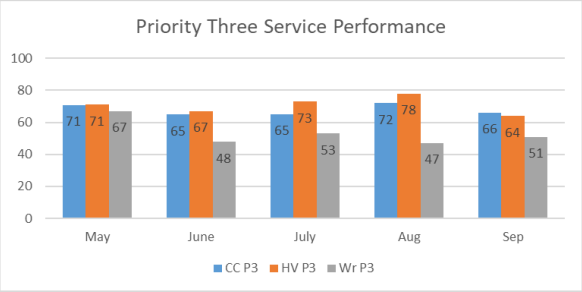
The following metrics have been agreed between Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB.

- Priority 1 (Critical) Incidents - Restoration in two hours
- Priority 2 (Urgent) Incidents - Restoration in four hours
- Priority 3 (Moderate) Incidents - Restoration in 24 business hours
- Priority 4 (Minor) Incidents - Restoration in five business days

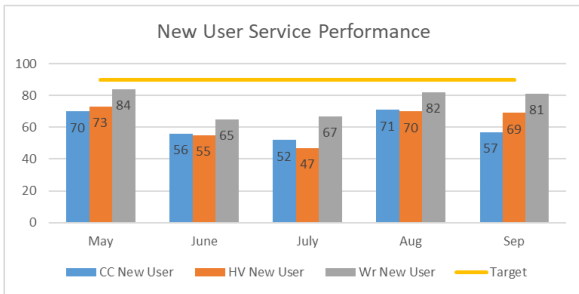
The following graphs details the service level achieved for April through to August. Further work is underway to improve this performance by clarifying definitions of work requests versus service improvements versus transformation.

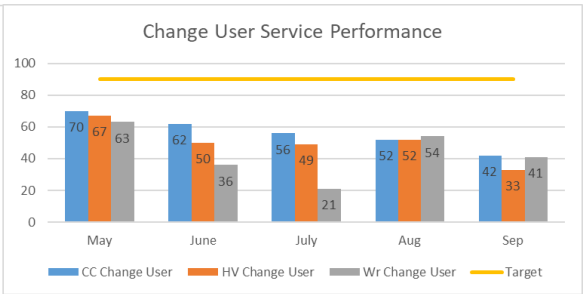


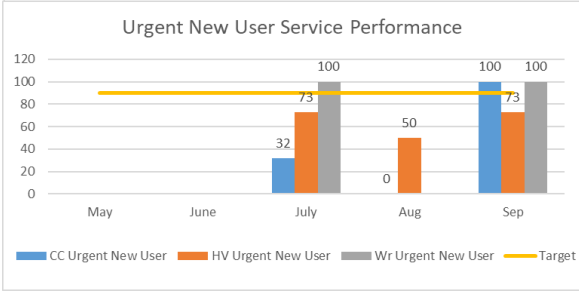




The other metrics currently being reported on reflects the speed at which user changes are being effected. Currently for all DHB's service level is below the required levels, however work is under-way to automate simple tasks such as these in order to improve service levels.







This paper discusses suicide and self-harm.

Need to talk? To talk to a trained counsellor:

1737

Free call or text 1737 to talk to a trained counsellor

Depression.org.nz

0800 111 757 or text 4202

Lifeline

0800 543 354

Suicide Crisis Helpline

0508 828 865

(0508 TAUTOKO)

HUTT VALLEY DHB

Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

Board Discussion – Public

3 November 2021

Suicide Prevention and Postvention – Statistics on suicide and self-harm, and the 3DHB Action Plan update

Action Required

The Boards note:

a) The release of the 2020/2021 national annual provisional suicide statistics and the launch of an interactive web reporting tool that provides a single source of information on deaths by suicide in Aotearoa

b) Current national and regional suspected suicides and self-harm data sourced from the web-tool, the 3DHB Suicide Notifications Database and 2DHB self-harm statistics.

c) The National Suicide Prevention Office (SPO) now requires all District Health Boards to develop 12 month regional suicide prevention action plans that implement actions from He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029

d) The 3DHB Suicide Prevention and Postvention Action Plan (presented to the 3DHB Disability Advisory Committee in July 2021) is a living document and has been revised to update the new national and 3DHB information

e) While many other DHBs will need to develop a plan, the 3DHB are well ahead as the *Action Plan* has already been endorsed and is being implemented. The plan only requires refinement to ensure it aligns with current data and the focus areas outlined by the SPO.

Strategic Alignment	He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction Services He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029 Living Life Well A strategy for mental health and addiction 2019-2025 Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 Taurite Ora Māori Health Strategy 2019-2030 Te Pae Amorangi Maori Health Strategy 2018 -2027 Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services.
Authors	Roxanne Leech, 2DHB Suicide Prevention and Postvention Co-ordinator
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Rachel Haggerty, Director, Strategy, Planning and Performance (SPP)
Purpose	This paper provides the Chief Coroner's Annual provisional suicide statistics and 3DHB suicide and self-harm statistics. It also provides an update on the 3DHB Suicide Prevention and Postvention Action Plan.
Contributors	Catherine Inder, Principal Advisor, Mental Health and Addiction, SPP Nathan Brown, Senior Health Insights Analyst, SPP
Consultation	Suicide Prevention and Postvention Governance Group

Executive Summary

1. The 3DHB Suicide Prevention and Postvention Action Plan (the *Action Plan*) was developed in 2020 in response to He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029 (*Every Life Matters*). The *Action Plan* aims to reduce suicide and improve people's well-being through well-being promotion and suicide prevention, intervention, and postvention.
2. While the *Action Plan* was endorsed by The Suicide Prevention and Postvention Governance Group and the Disability Support Advisory Committee in Q1 2021, the *Action Plan* is a 'living document' and has undergone several iterations whilst being implemented.
3. On 9 August 2021, The Suicide Prevention Office (the national leaders for the implementation of *Every Life Matters*), indicated that DHBs need to develop 12-month sub-regional action plans that implement the actions in *Every Life Matters*. Although our DHBs were well-ahead of schedule (as we had already started to implement our *Action Plan)*, we are currently reviewing our plan to ensure it meets the requirements.
4. The *Action Plan* is also being updated in response to recent data from the 2020/2021 annual provisional suicide statistics (from the Chief Coroner's office); the new suicide web-tool (launched by the Ministry of Health); as well as suicide and self-harm statistics from our DHBs. These insights have resulted in the *Action Plan* including a greater focus on equity, locality-based, trauma-informed, and community-led approaches; and ensuring our efforts are focussed on well-being promotion and suicide prevention for priority groups, including young Māori men, older men and female rangatahi.
5. Highlights in this report include:
    - Recent data on suicide and self-harm in the 2DHB region (see Attachment 1)
    - Updates to the *Action Plan* in response to the recent directive by the Suicide Prevention Office and to new suicide and self-harm data
    - The *Action Plan*'s alignment to the future direction described in the *Locality Community Mental Health Development (Strategic Priority: Community Mental and Addiction Networks)* endorsed by DSAC on 29 September, 2021.

Strategic Considerations

Service	Mental Health, Addiction and Suicide Prevention and Postvention services
People	There is a team of 3DHB Suicide Prevention and Postvention Co-ordinators
Financial	The resourcing schedule is part of the operating budget for 2021/2022.
Governance	The Governance of this work is supported by Strategy, Planning and Performance, and the Suicide Prevention and Postvention Governance Group.

Engagement/Consultation

Patient/Family	Lived Experience Advisory Group
Clinician/Staff	A wide range of clinicians are engaged in developing models of care and service delivery.
Community	Multiple community providers are engaged
Expert Review	Dr Annette Beautrais, Suicide Prevention Co-ordinator, Suicidologist, Researcher and Professor Dr Chris Bowden, Director of Research, Victoria University of Wellington

Attachments

- Suicide and self-harm in the 2DHB region – *Resource Centre*

Purpose

6. The purpose of this paper is twofold, it:
    - provides the latest annual provisional suicide data and regional suicide statistics, recently released by the Coroner and Ministry of Health, as well as the most recently available 3DHB self-harm data
    - describes how the 3DHB Suicide Prevention and Postvention Action Plan, which is a living document, has been reviewed and updated to align it with the Suicide Prevention Office's new requirements and responds to the most current statistics on suicide and self-harm.

Background

7. The 3DHB Suicide Prevention and Postvention Action Plan (the *Action Plan*) was developed in response to He Tapu te Oranga o ia Tangata: Every Life Matters – Suicide Prevention Strategy 2019–2029 (*Every Life Matters*). The *Action Plan* aligns with *Every Life Matters* in its aim to reduce suicide and improve people's well-being. There are four focus areas in the plan: promotion, prevention, intervention, and postvention.
8. The Action Plan was endorsed by the Suicide Prevention and Postvention (SPP) Governance group in June 2021 and presented to the Disability Support Advisory Committee (DSAC) on 21 July 2021.
9. On 9 August 2021, The Suicide Prevention Office (SPO), who provide national leadership for the implementation of Every Life Matters, advised the SPP Co-ordinator National Network that all District Health Boards (DHBs) need to:
    - deliver sub-regional SPP action plans that implement *Every Life Matters* actions
    - incorporate *Every Life Matters* focus areas for sub-regional programme delivery.
10. On 4 October 2021, the Chief Coroner released the annual provisional suicide statistics and together with the Ministry of Health, launched a new interactive web reporting tool that provides a single comprehensive source of information on deaths by suicide in Aotearoa.
11. Whereas many other DHBs will need to develop a plan in response to the SPO's requirements, the 3DHB are well ahead. We all already have an endorsed Action Plan which is currently being implemented. Our next step is review and refine the Action Plan to ensure it aligns with current data and the focus areas outlined by the SPO.

Rates of suicide and self-harm in Aotearoa and our DHBs

12. The attached slide deck presents the 2020/2021 annual provisional suicide data released by the Chief Coroner, and the data available on the new Ministry of Health suicide web-reporting tool, that together update both national and regional suicide statistics. This information is informing the updates to our Action Plan (see paragraphs 15 and 16 below).
13. We recognise that self-harm is a risk factor for suicide and that people who self-harm are in distress - whether or not their intentions are suicidal. The slide deck also presents 2DHB self-harm data.

14. Although one life lost to suicide is too many, the rate of suspected suicide deaths in Aotearoa and across the 2DHB region is relatively steady
    - From 2008/09 to 2017/18, the change in the rate of suicide deaths in Aotearoa was not statistically significant
    - Although the number of 2020/21 deaths by suspected suicide in the 3DHB is higher than previous financial years, the fluctuation caused by these two years is statistically insignificant and the pattern is consistent to previous years
        - 40 people died by suspected suicide in 2020/21 in CCDHB (11.6 per 100,000 people)
        - 19 people died by suspected suicide in 2020/21 in HVDHB (12.5 per 100,000 people)

15. There are inequities in our DHBs for suicide and self-harm:
    - 85% (53/62) of suspected suicide deaths across the 2DHB region were non-Māori (2020/21 financial year), however over the last 7 years, Porirua and Lower Hutt have had a higher proportion of deaths due to suspected suicide among Māori and Pacific people
    - Māori are overrepresented in self-harm presentations when compared with their population size.

16. Males are more likely to die by suspected suicide:
    - 73% of people who died due by suspected suicide are male, and males are overrepresented across all age groups
    - There is variation in the age of people who die by suspected suicide, however Māori men are younger while non-Māori, and non-Pacific men are older.

17. People who self-harm or suicide are only sometimes mental health service users:
    - Since 2015, 29% of people who have died by suspected suicide were current clients of an MHAIDS service
    - 44% of people who died from suspected suicide between 2014/15 and 2020/21 had at least one contact with an NGO or DHB mental health service in the previous year
    - Only 32% of people who had died by suspected suicide across 2020 and 2021 had interaction with secondary mental health services and were known to the sector, however, those not known to secondary mental health services had higher levels of interaction with primary care (however it is not known whether this was mental health-related)
    - 15% of all suspected suicides in the 2DHB had at least one self-harm presentation to ED in the two years prior to their death.

18. Self-harm presentations to emergency departments (ED) are greater for females
    - Wellington City and Lower Hutt EDs have experienced the greatest increase in presentations compared to other 2DHB EDs (2020/21)
    - Females represent 70% of self-harm presentations in the 2DHB region
    - Females under the age of 30 years old represent 45% of all self-harm presentations.

19. Our rangatahi are presenting for self-harm

    - Over the past five years, the number of self-harm presentations from youth to the Wellington ED has steadily increased by 17%.
    - 79% of self-harm related presentations occur during school terms
    - CCDHB EDs are seeing primarily seeing older youth from more affluent areas while HVDHB and WrDHB EDs are seeing a younger population from more deprived areas.

3DHB Suicide Prevention and Postvention Action Plan update

20. The *Action Plan* is a living document and we have continued to review and refine it, while delivering on it, to ensure it is well aligned to the SPO's requirements, and reflects and responds to the most recent data. The updates and improvements ensure we are taken a locality-based approach and that our actions are targeted towards priority groups, including young Māori men, older men and female rangatahi.
21. The key improvements since it was endorsed by both the SPP, Governance Group and DSAC are:

    i) Programme delivery prioritisation for the next 12 months, in line with the SPO's directive in response to the data review.

    ii) Another expert review by Dr Annette Beautrais, Suicide Prevention Co-ordinator, Suicidologist, Researcher and Professor.

    iii) Including the Equity definition, goal and principles, and describing how these and the Te Whare Tapa Wha Māori model of care inform the *Action Plan,*

    iv) Including an improved description of the *Action Plan*'s approach to better describe the locality-based, trauma-informed, and community-led approach to suicide prevention and postvention.

    v) Expanding the priority groups section in the *Action Plan* to better describe these and how we can best work alongside the priority groups to support their needs,

    vi) Ensuring an emphasis is placed on well-being promotion and suicide prevention initiatives.

Alignment to MHA strategic priority work programme

22. The Action Plan is aligned to the direction described in the Locality Community Mental Health Development (Strategic Priority: Community Mental and Addiction Networks) endorsed by DSAC on 29 September, 2021. The purpose of the change programme is to design and implement integrated, place-based MHA services that are more responsive to the diverse needs of people who are experiencing mental illness, mental distress and/or the issues related to the use of alcohol and other drugs – all risk factors for self-harm and/or suicide.
23. The Action Plan is taking a locality-based approach that will enable strong connections to be established with the planned integrated, place-based mental health and addiction services in the Hutt Valley, Wellington, Kāpiti and Porirua responsive to the people with MHA needs in those communities.

Next steps

24. The SPP team will complete its review of the *Action Plan* and continue to implement it. We will provide a copy of the updated *Action Plan* and a progress update as part of our 24 November 3DHB Mental Health and Wellbeing Strategy report to DSAC.

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Suicide and Self-Harm in the 2DHB Region

This presentation discusses suicide and self-harm.

Need to talk? To talk to a trained counsellor:

1737

Free call or text 1737 to talk to a trained counsellor

Depression.org.nz

0800 111 757 or text 4202

Lifeline

0800 543 354

Suicide Crisis Helpline

0508 828 865

(0508 TAUTOKO)

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“Suicide affects people from all communities and walks of life but some populations such as Māori, youth, men and people who [use or have used] mental health and addiction services [have relatively higher rates of suicide]. Pasifika and Rainbow communities, and people who are bereaved by suicide are also disproportionately affected.” (Ministry of Health, 2019)

- Suicide and suicidal behaviour is preventable
- We have a ‘zero-tolerance’ approach to suicide
- A range of factors influence a person’s risk of suicide
- Some people have multiple risk factors and experience the cumulative impacts of these
- There is no one way to prevent suicide
- A whole of system approach is required to protect people

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National and local directions

He Ara Oranga & Kia Manawanui

- The Government's view is clear

Every Life Matters

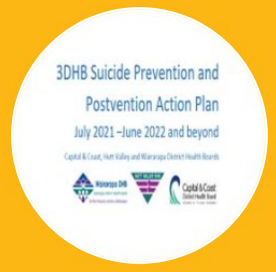
- Support local responses
- How our wider health services respond to suicide risk

MHAIDS

- A collaborative leadership model currently being implemented
- Increasing demand services
- Preparing for an integrated care approach

Developing Community Mental Health Networks

- Integrating care in our communities amongst NGOs, primary care and MHAIDS



3DHB Suicide Prevention and Postvention Action Plan

- Reducing suicide and improving well-being within the sub-region through wellbeing promotion and suicide prevention, intervention and postvention.

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*While the Suicide Prevention and Postvention Action Plan is a 3DHB plan, for purposes of this paper, only the Capital and Coast and Hutt Valley DHB data is included. The Suicide Prevention and Postvention team continue to work with the WDHB to ensure a locality-based approach is taken.

Data on suicide and self-harm

This information pack presents the:

- 2020/2021 Annual provisional suicide statistics
- Confirmed suicide deaths and suspected suicide deaths taken from the web-tool launched by the Chief Coroner and the Ministry of Health on 4 October 2021
- 3DHB Suicide Notifications Database
- Self-harm statistics in Capital & Coast and Hutt Valley District Health Board (2DHB)

Provisional and Confirmed data on suicide

In Aotearoa, a death can only officially be confirmed as a suicide by a coroner upon the completion of their inquiry. These deaths are classified as confirmed suicide deaths and are reported by the Ministry of Health. However, a provisional suicide classification may be made before the coroner has reached a finding. These are referred to as suspected intentionally self-inflicted deaths and are reported by the Chief Coroner.

Web-tool

The tool presents data about confirmed suicide deaths as well as suspected intentionally self-inflicted deaths in Aotearoa. This data is presented as trends over time, by age group, district health board of residence, ethnicity and sex. Both numbers and age-standardised rates are presented.

3DHB Suicide Notifications Database

The Capital & Coast, Hutt Valley and Wairarapa District Health Boards (3DHB) maintain a database of suspected suicides that occur in the 3DHB regions.

Interpreting suicide data and trends

The statistics on deaths by suicide reported here can fluctuate significantly from year to year. This is due to small counts, especially in smaller population groups. The statistics based on these numbers should be interpreted with caution. Understanding trends in rates is only possible over long periods of time (5–10 years, or even longer for small population groups).

Interpreting self-harm data

The motivation for intentional self-harm varies, and therefore hospitalisation data for self-harm is not a measure of suicide attempts.

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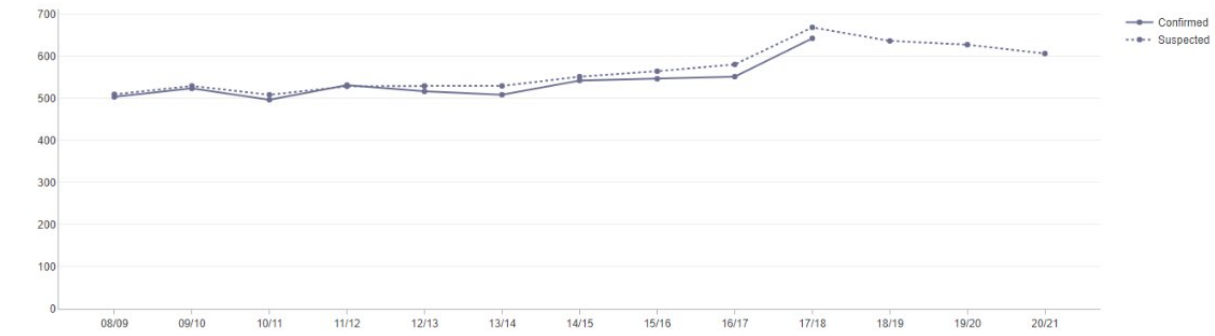
What we know

Suicide in Aotearoa

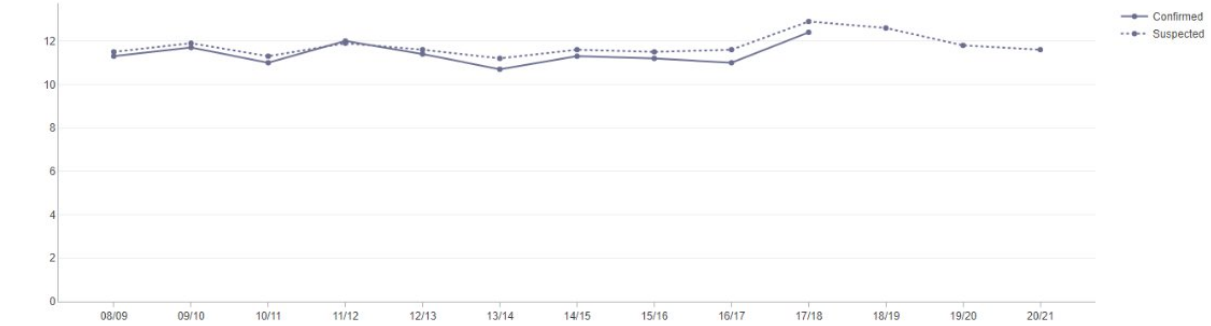
2008/09 to 2020/21

Number of suicide deaths in Aotearoa New Zealand, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).

Rate of suicide deaths in Aotearoa New Zealand, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).
Rates are per 100,000 and age-standardised to the World Health Organization's standard world population.

607 people died by suspected suicide in 2020/21, compared to 628 the year before – a decrease of 21 deaths.

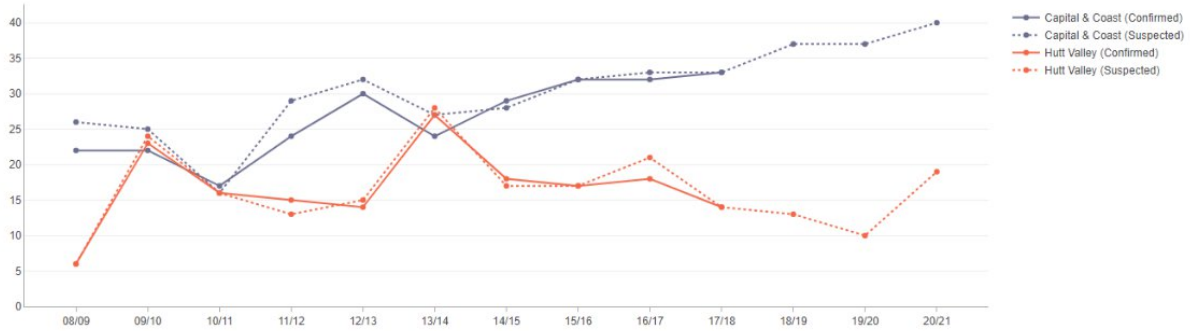
The rate of deaths from suspected suicide decreased from 12.9 deaths per 100,000 in 2017/18 to 11.6 deaths per 100,000 in 2020/21

From 2008/09 to 2017/18, the change in the rate of suicide deaths was not statistically significant.

Suicide across the 2DHBs

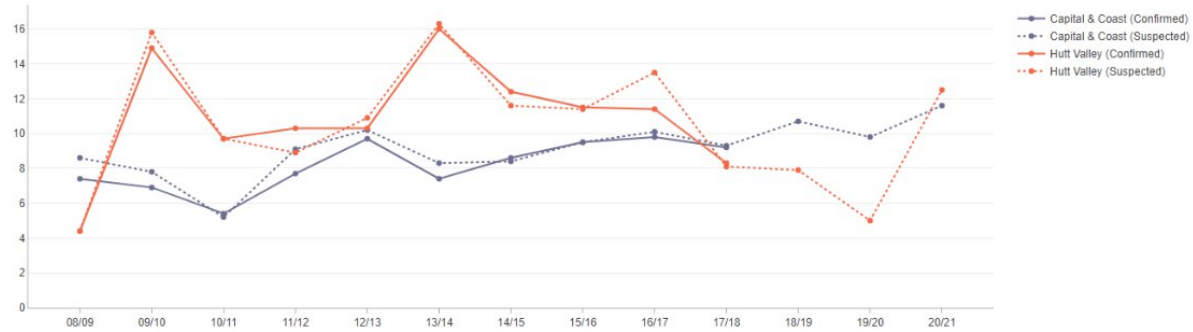
2008/09 to 2020/21

Number of suicide deaths across Capital & Coast, Hutt Valley District Health Boards, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).

Rate of suicide deaths across Capital & Coast, Hutt Valley District Health Boards, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).

In CCDHB, 40 people died by suspected suicide in 2020/21,

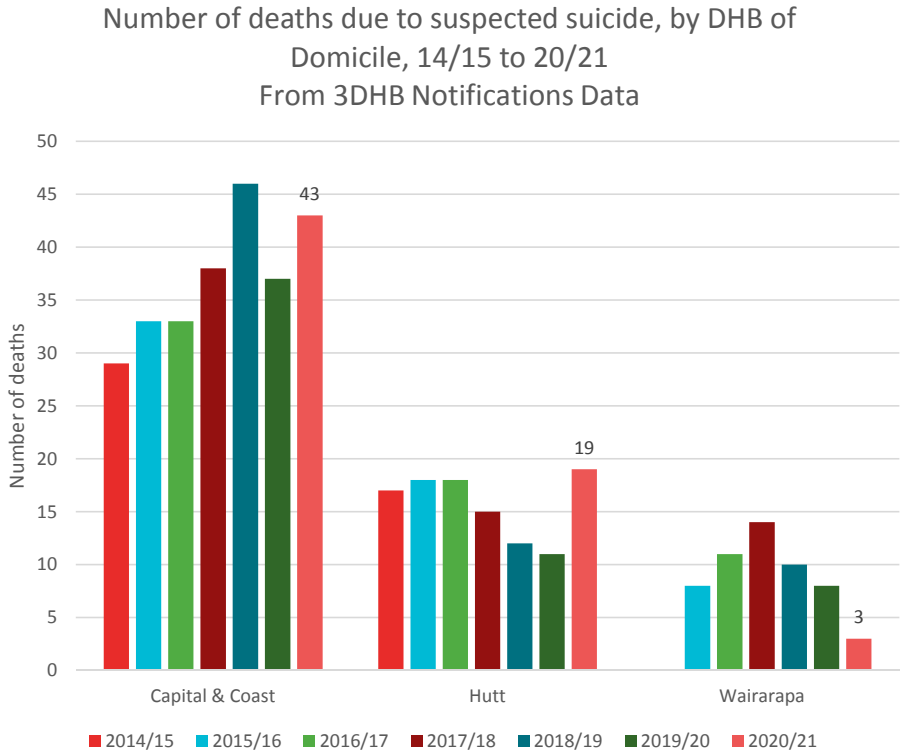
In HVDHB, 19 people died by suspected suicide in 2020/21

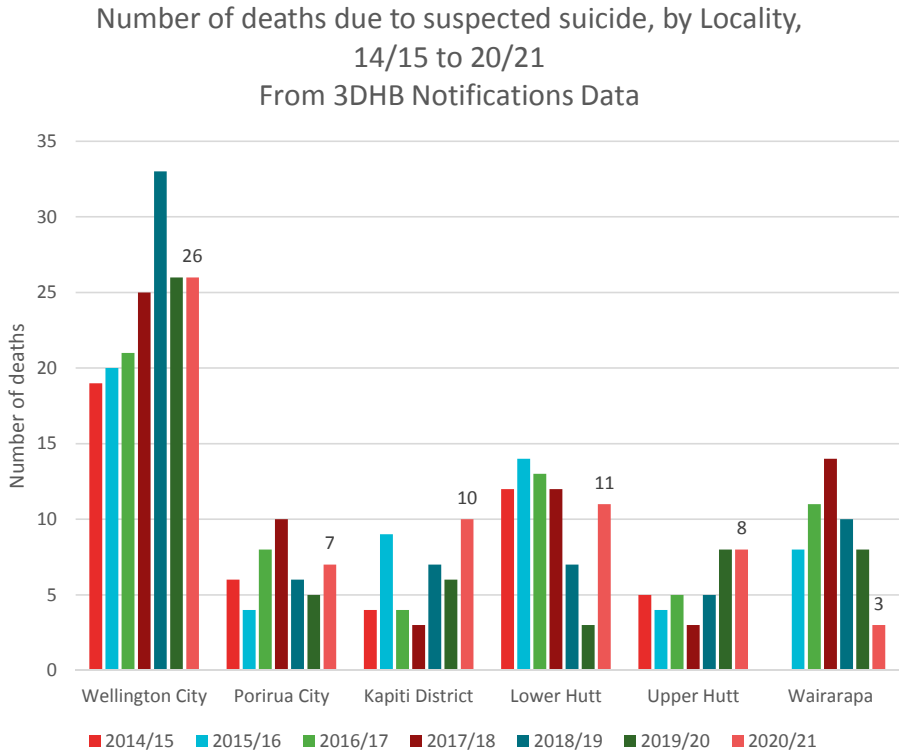
In CCDHB, the rate of suspected suicide deaths in 2020/21 was 11.6 per 100,000 people.

In HVDHB, the rate of suspected suicide deaths in 2020/21 was 12.5 per 100,000 people.

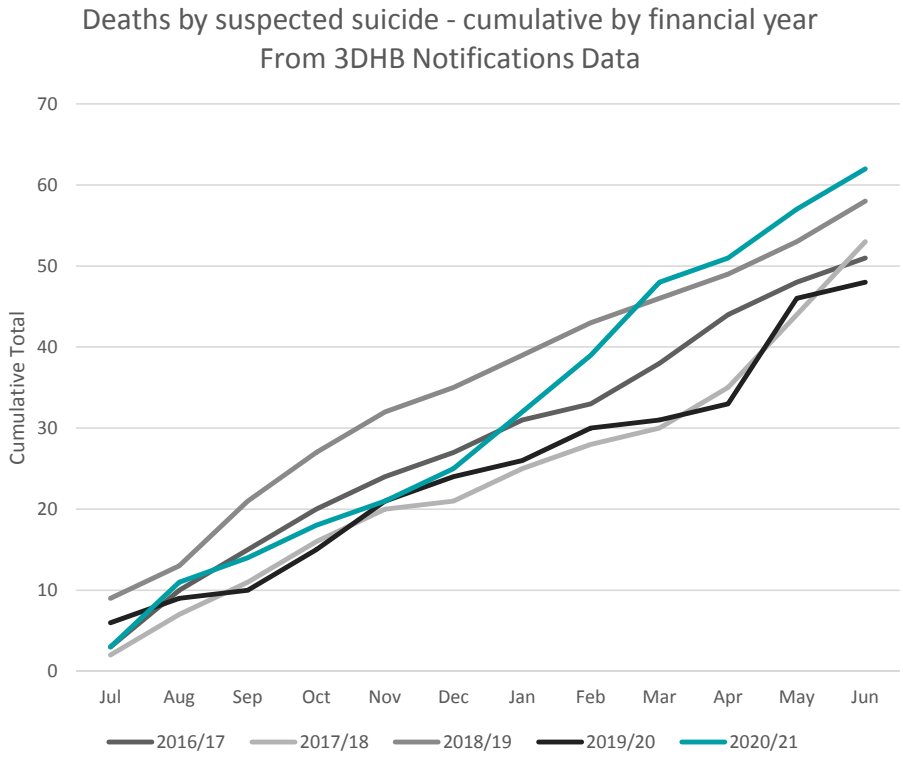
Rates of suicide may be influenced by differences in population age, ethnicity and deprivation across district health boards.

In the 2020/21 financial year, there were 62 deaths due to suspected suicide documented by the Suicide Prevention and Postvention team across the 2DHB sub-region. There have been 10 deaths due to suspected suicide in the 2020/21 financial year to date; all 10 in CCDHB.





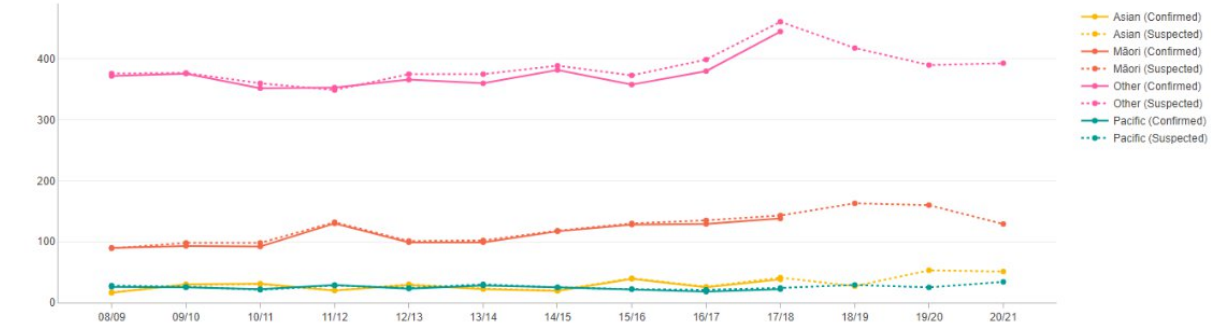
The number of deaths by suspected suicide in 2020/21 is relatively higher than previous financial years but remains on trend. 2019/20 was significantly lower than previous financial years, likely due to the Covid-19 lockdown.



Suicide in Aotearoa by ethnicity

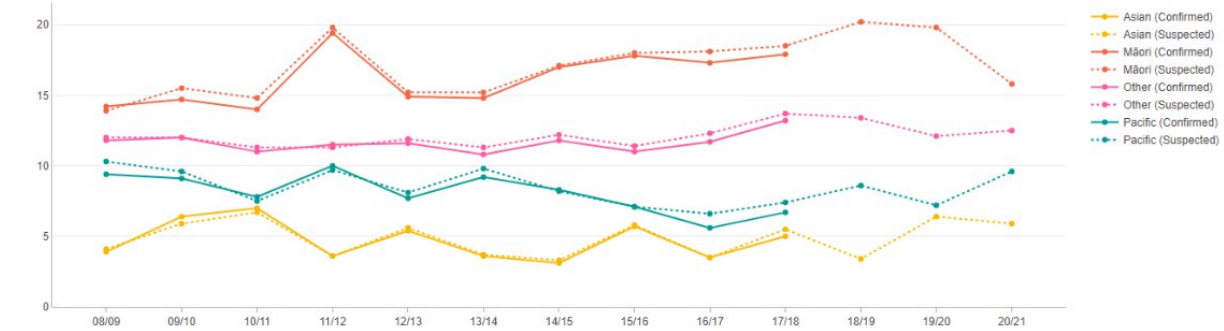
2008/09 to 2020/21

Number of suicide deaths for Māori, Pacific, Asian, Other ethnic groups, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).

Rate of suicide deaths for Māori, Pacific, Asian, Other ethnic groups, 08/09–20/21

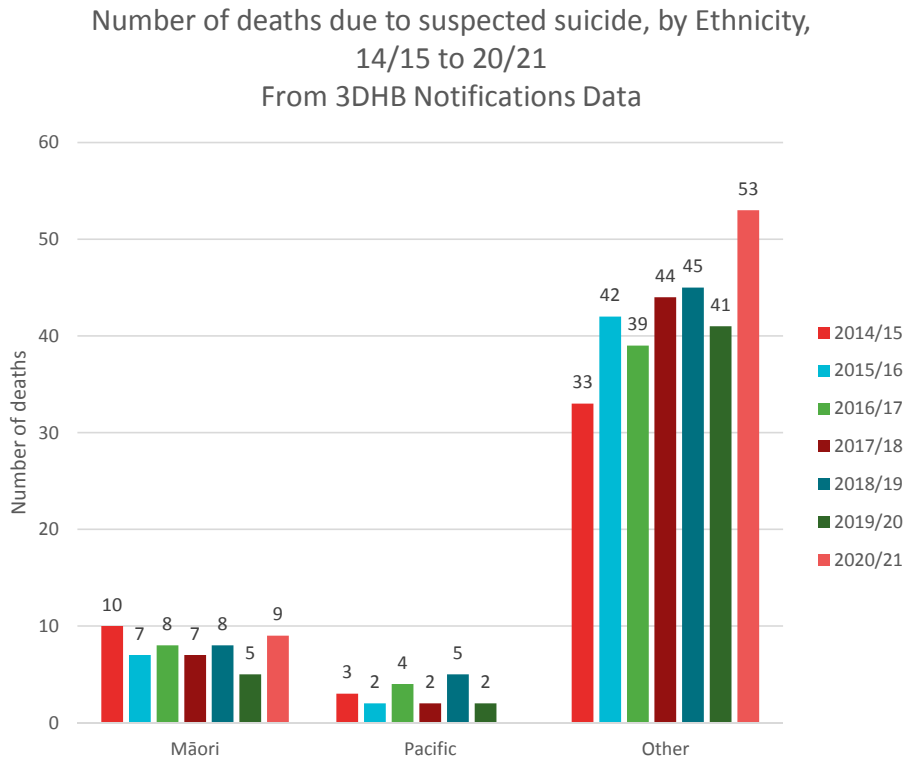


Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).
Rates are per 100,000 and age-standardised to the World Health Organization's standard world population.

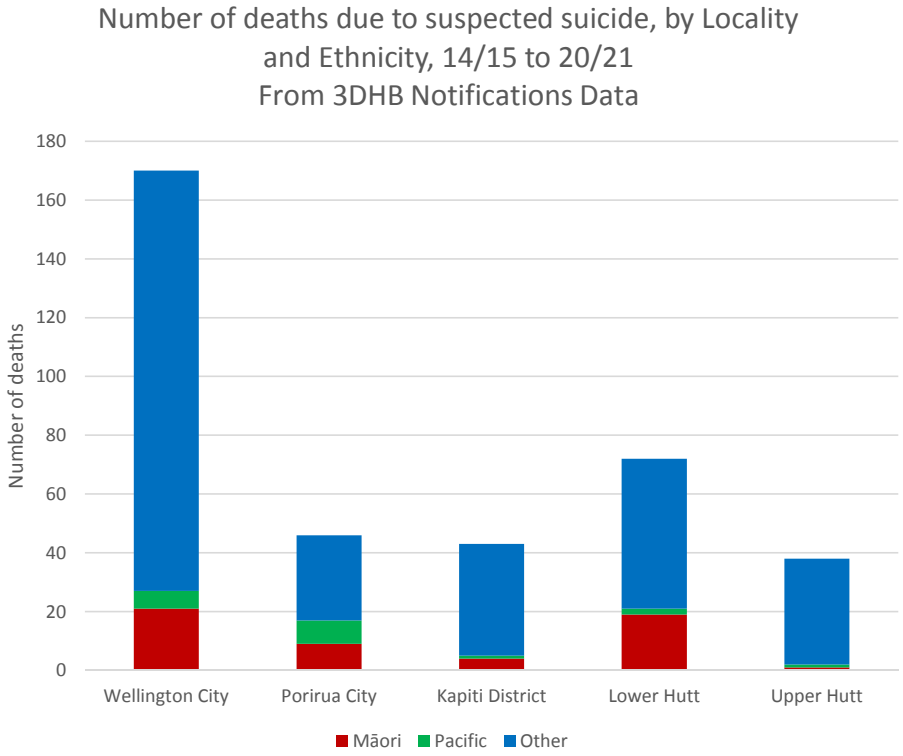
In 2020/21, the rate of suspected suicide deaths was higher for Māori than other ethnic groups, with a rate of 15.8 per 100,000

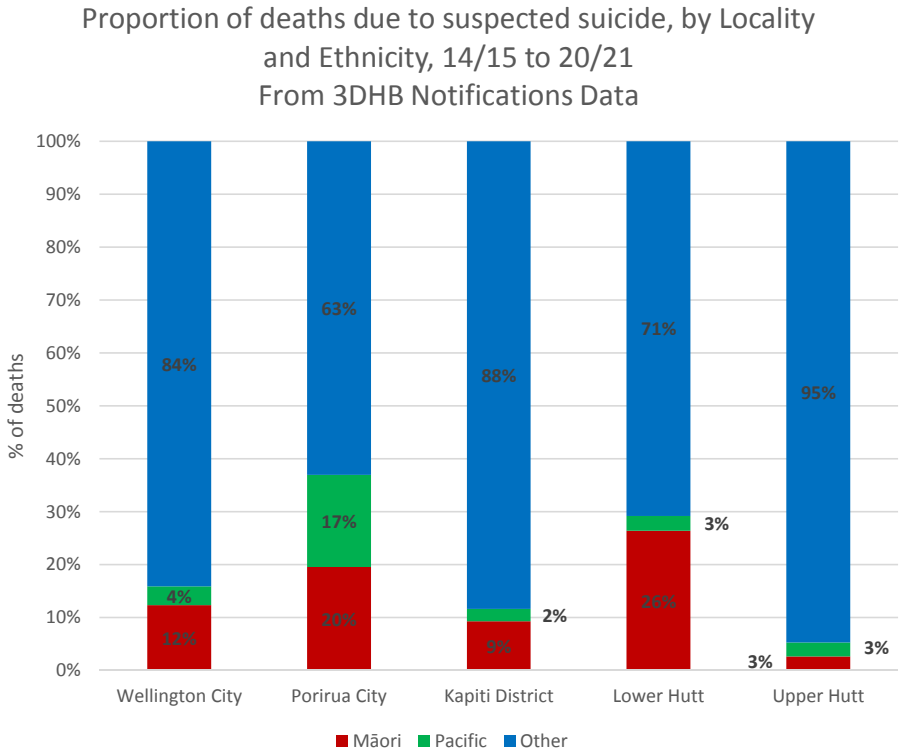
From 2009 to 2018, there were changes in the rates of suicide by ethnicity. However, for all prioritised ethnic groups, none of the changes were statistically significant

There have been 62 deaths due to suspected suicide across the 2DHB region in the 20/21 financial year. There have been 53 deaths for Non-Māori, Non-Pacific, 9 for Māori and 0 for Pacific.



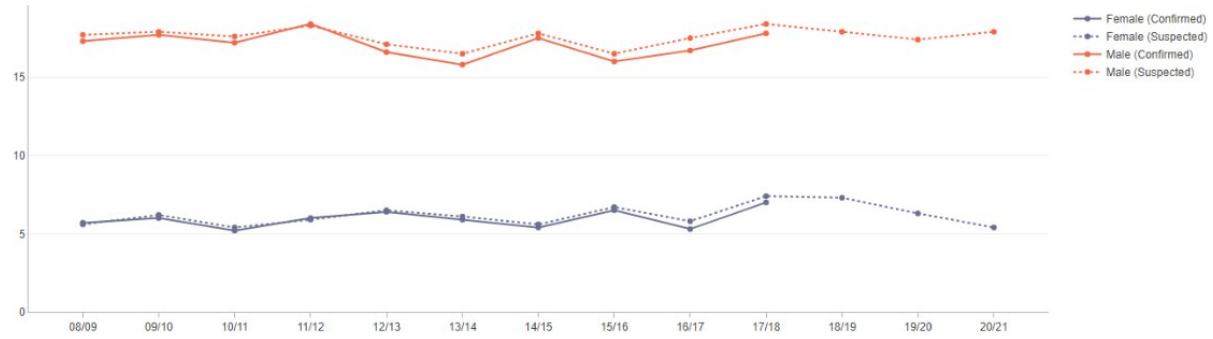
Over the last seven years, Porirua and Lower Hutt have had a higher proportion of deaths due to suspected suicide among Māori and Pacific people





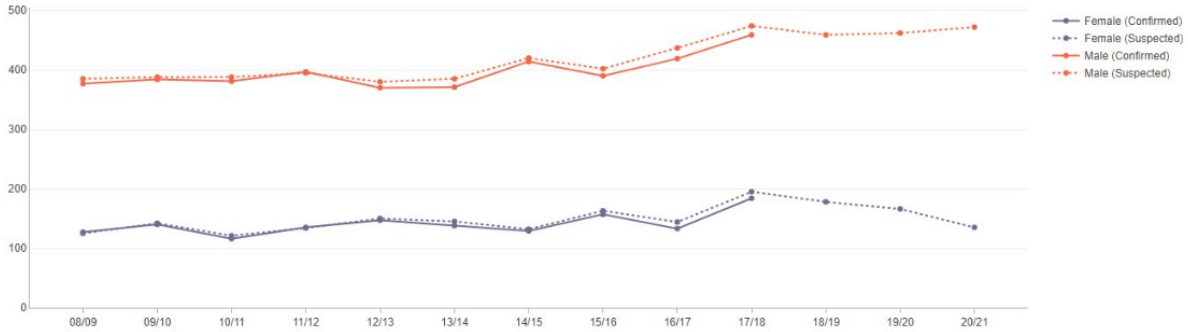
Suicide in Aotearoa by sex

Rate of suicide deaths for all ethnic groups and all ages, by sex, 08/09–20/21



Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).
Rates are per 100,000 and age-standardised to the World Health Organization's standard world population.

Number of suicide deaths for all ethnic groups and all ages, by sex, 08/09–20/21



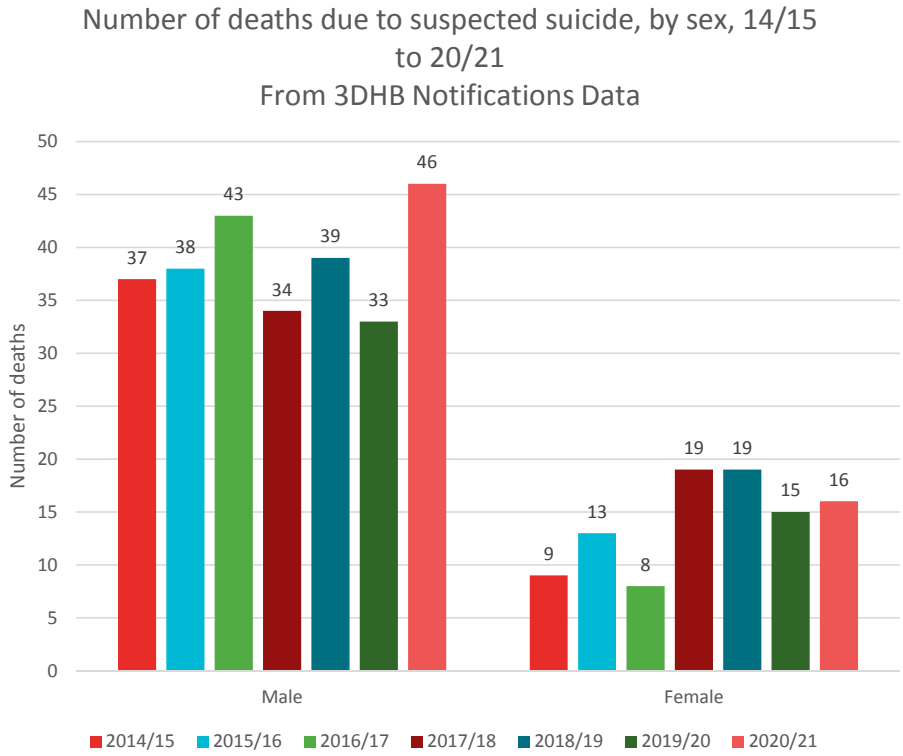
Source: New Zealand Mortality Collection (confirmed suicides); Ministry of Justice's case management system (suspected suicides).

In 2020/21, In 2018, there were 472 male suspected suicide deaths and 135 female suspected suicide deaths.

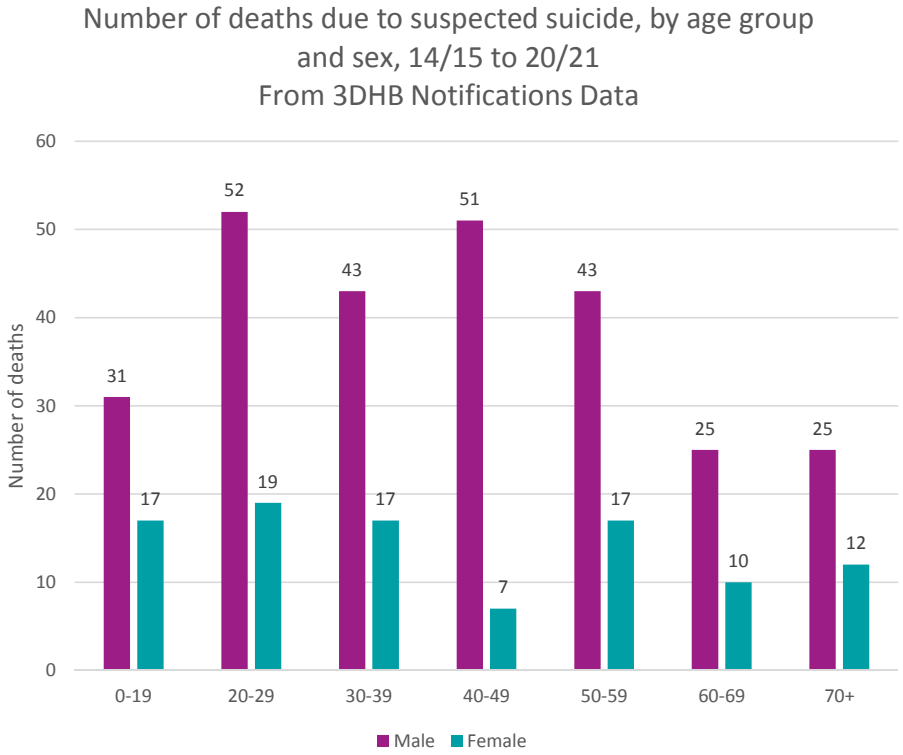
In that year, the rate of suicide for males was 17.9 per 100,000 males, and the rate for females was 5.4 per 100,000 females.

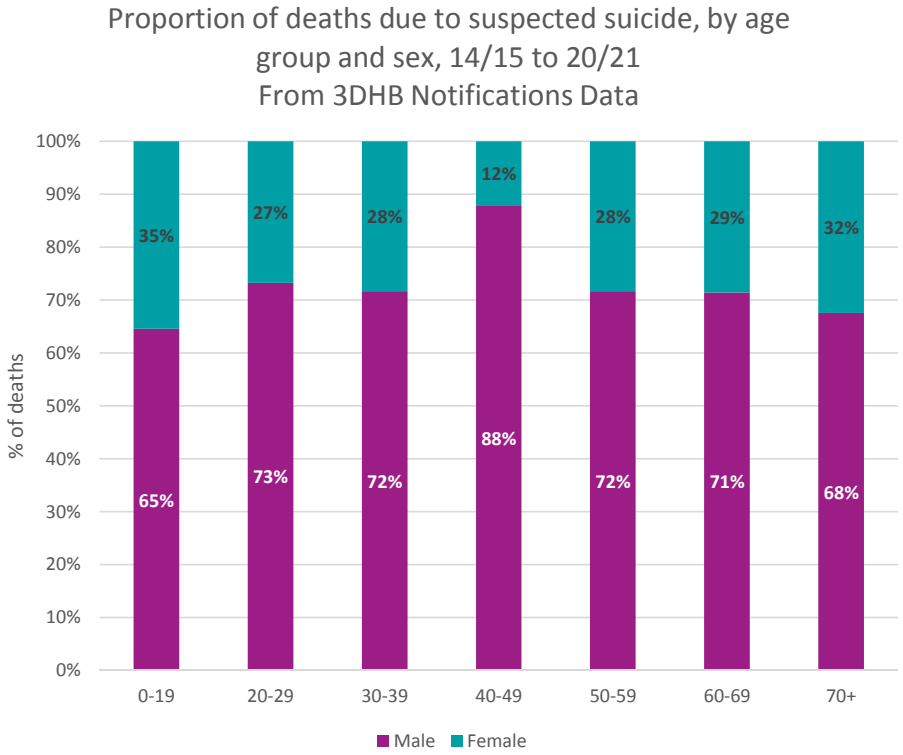
From 2009 to 2018, there were changes in the rates of suicide by sex. However, none of the changes were statistically significant

Within the 2DHB region, 73% of people who died due to suspected suicide were male.



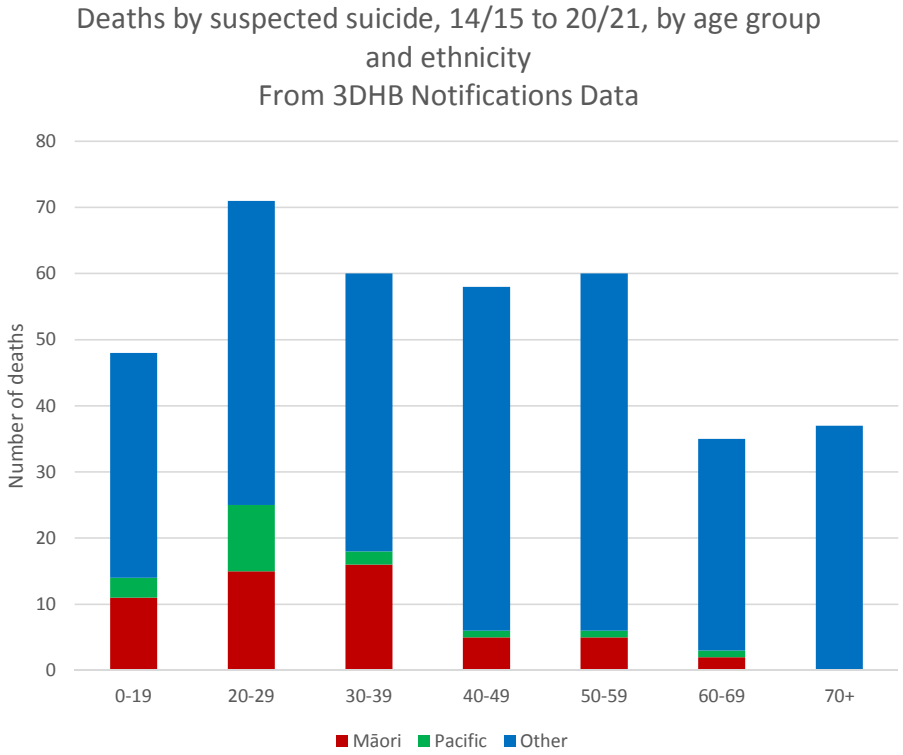
Males are overrepresented in suspected suicides across all age groups within the 2DHB region.

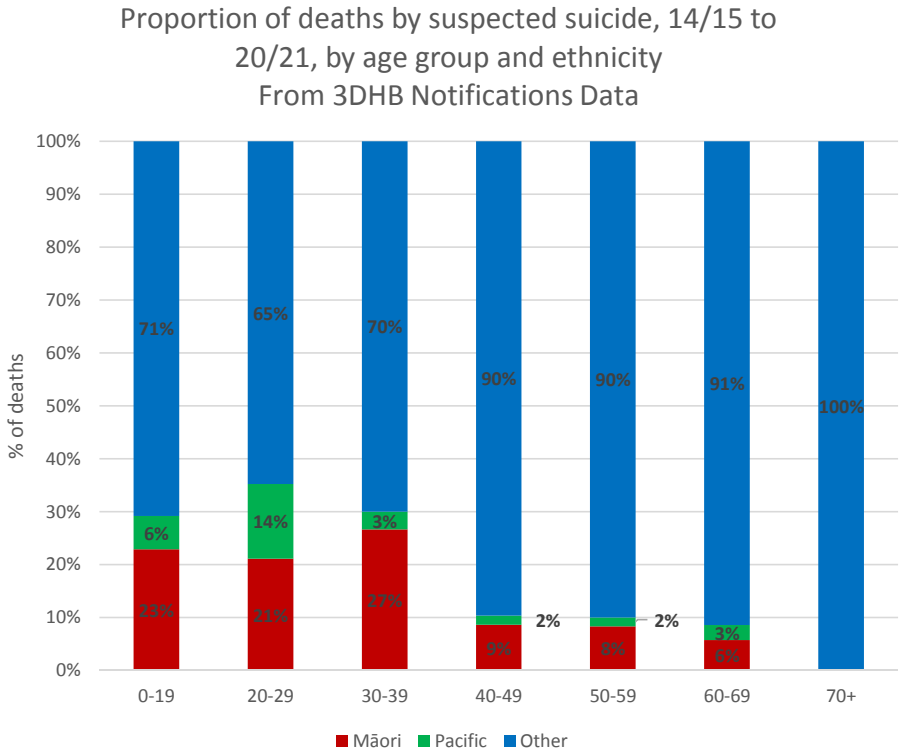




There is variation in the age of people who die due to suspected suicide over time.

Māori men who die due to suspected suicide are younger. Non-Māori, non-Pacific men who die due to suspected suicide are older

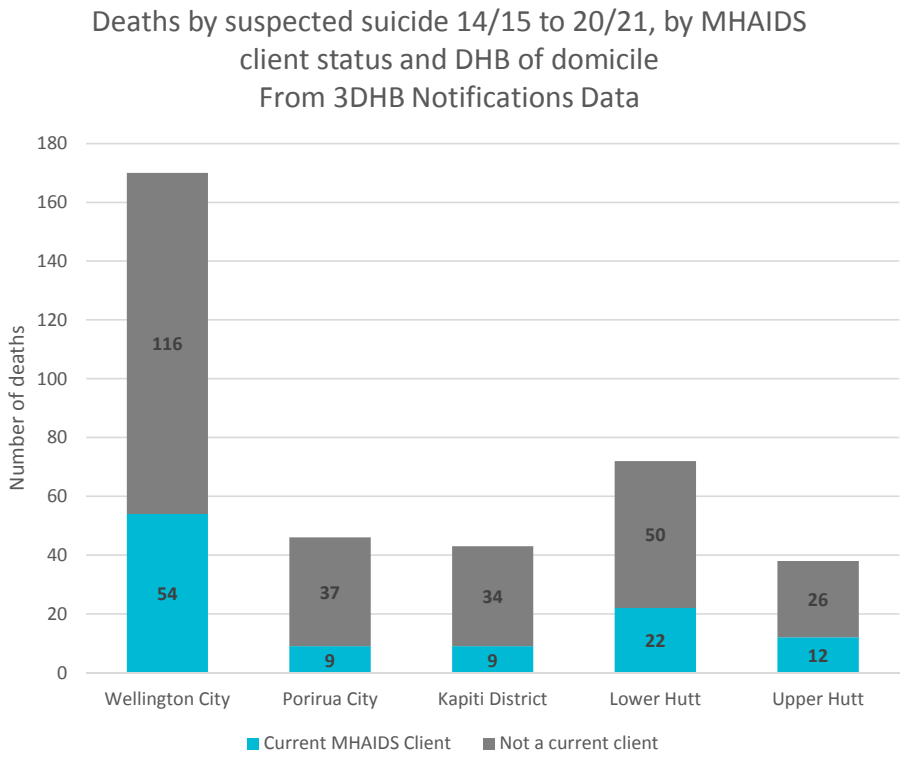


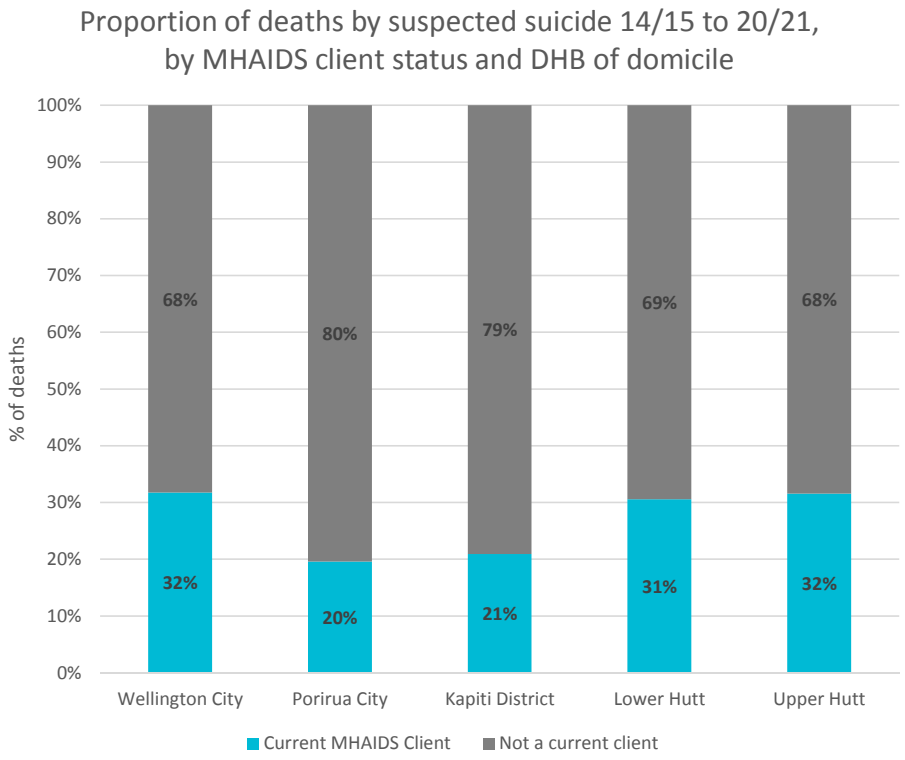


Not all people who die due to suspected suicide are known to our services

29% of people who have died due to suspected suicide between 2014/15 and 2020/21 were current clients of an MHAIDS service.

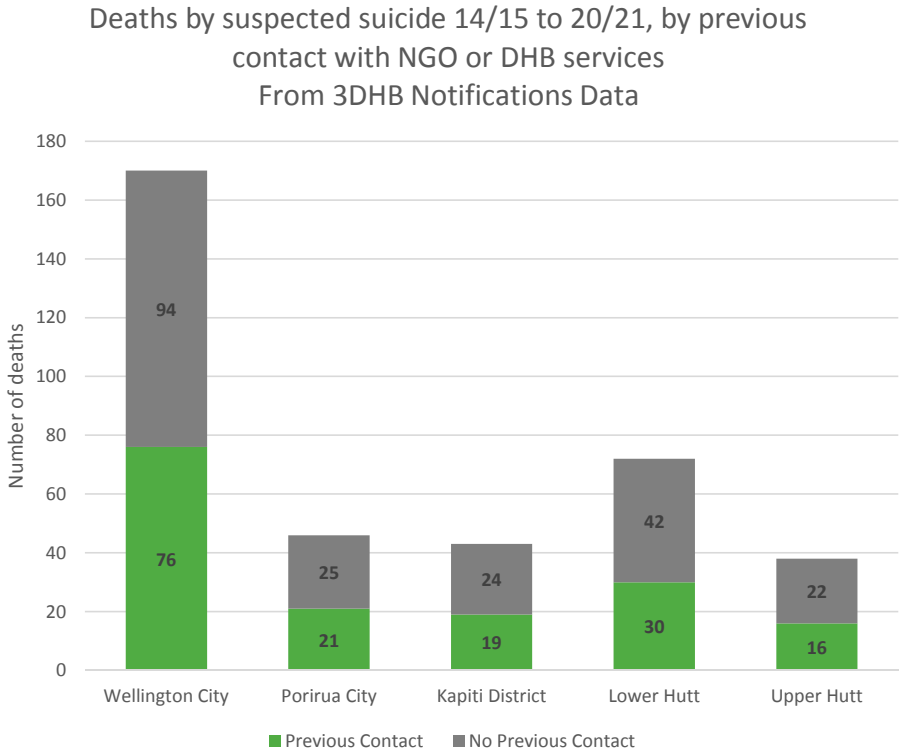
A current client is a person who has an active/open referral with MHAIDS at time of death.

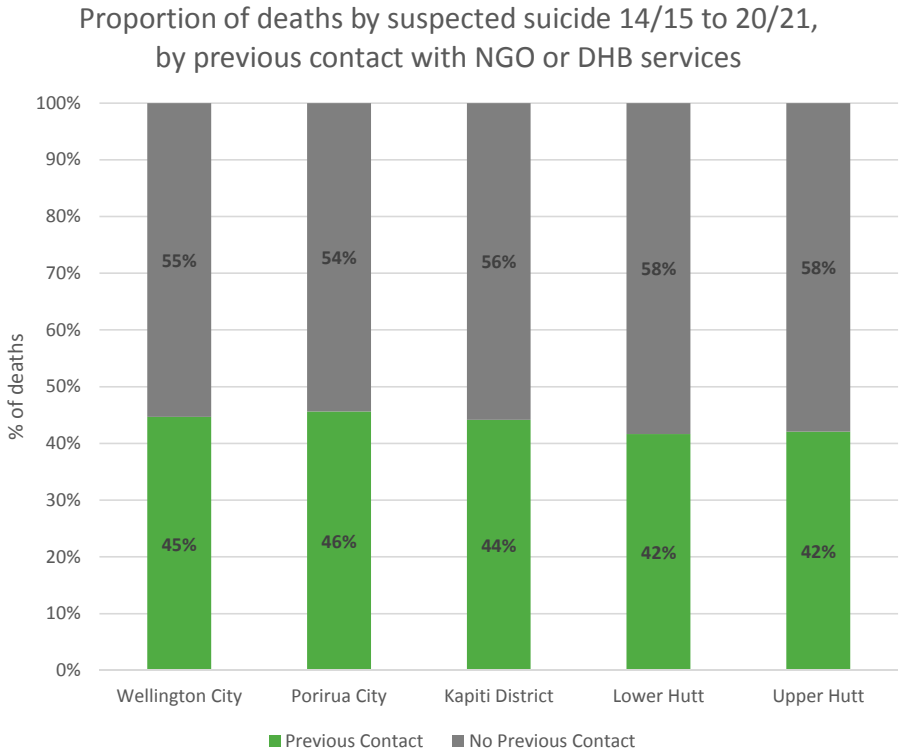




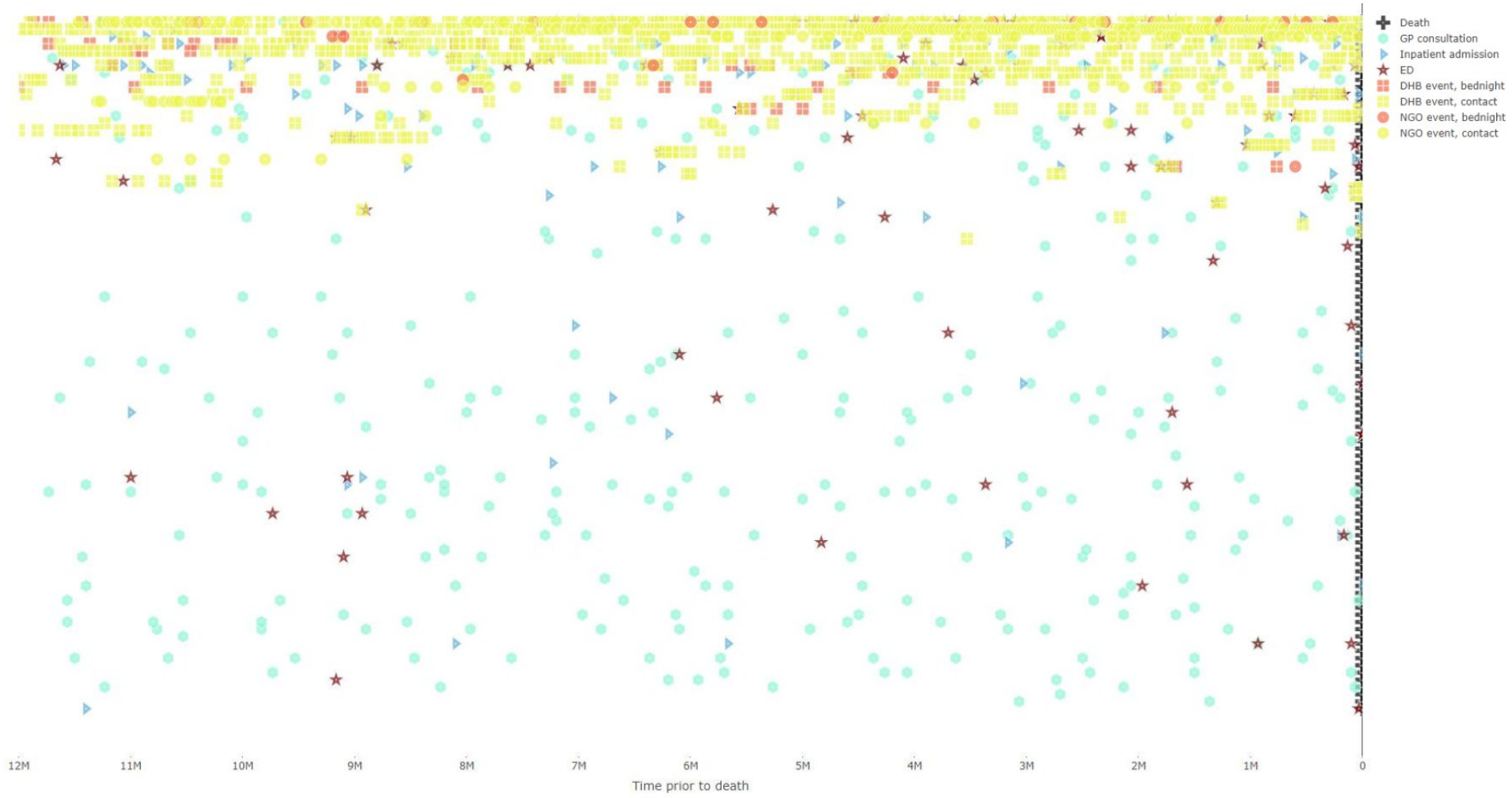
44% of people who died from suspected suicide between 2014/15 and 2020/21 had at least one contact with an NGO or DHB mental health service in the previous year

This group includes current and previous clients who have contacted MHAIDS services.

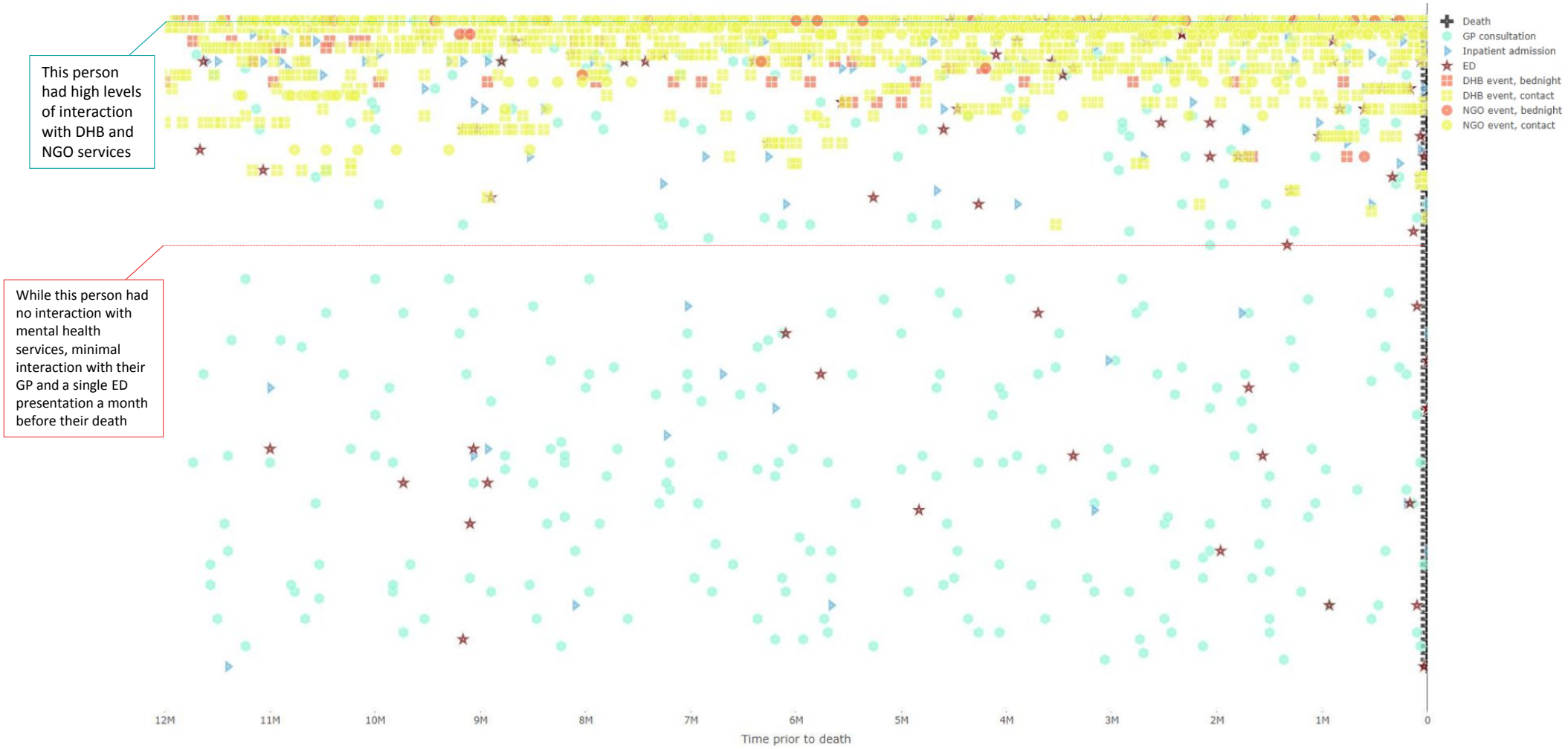




This visualisation depicts 96 people who died due to suspected suicide in 2020 or 2021, and their interactions with the health system in the year prior to their death



Each person is represented by a row where the far left hand side is 12 months prior to their death (12M) and the far right hand side is their date of death (0)

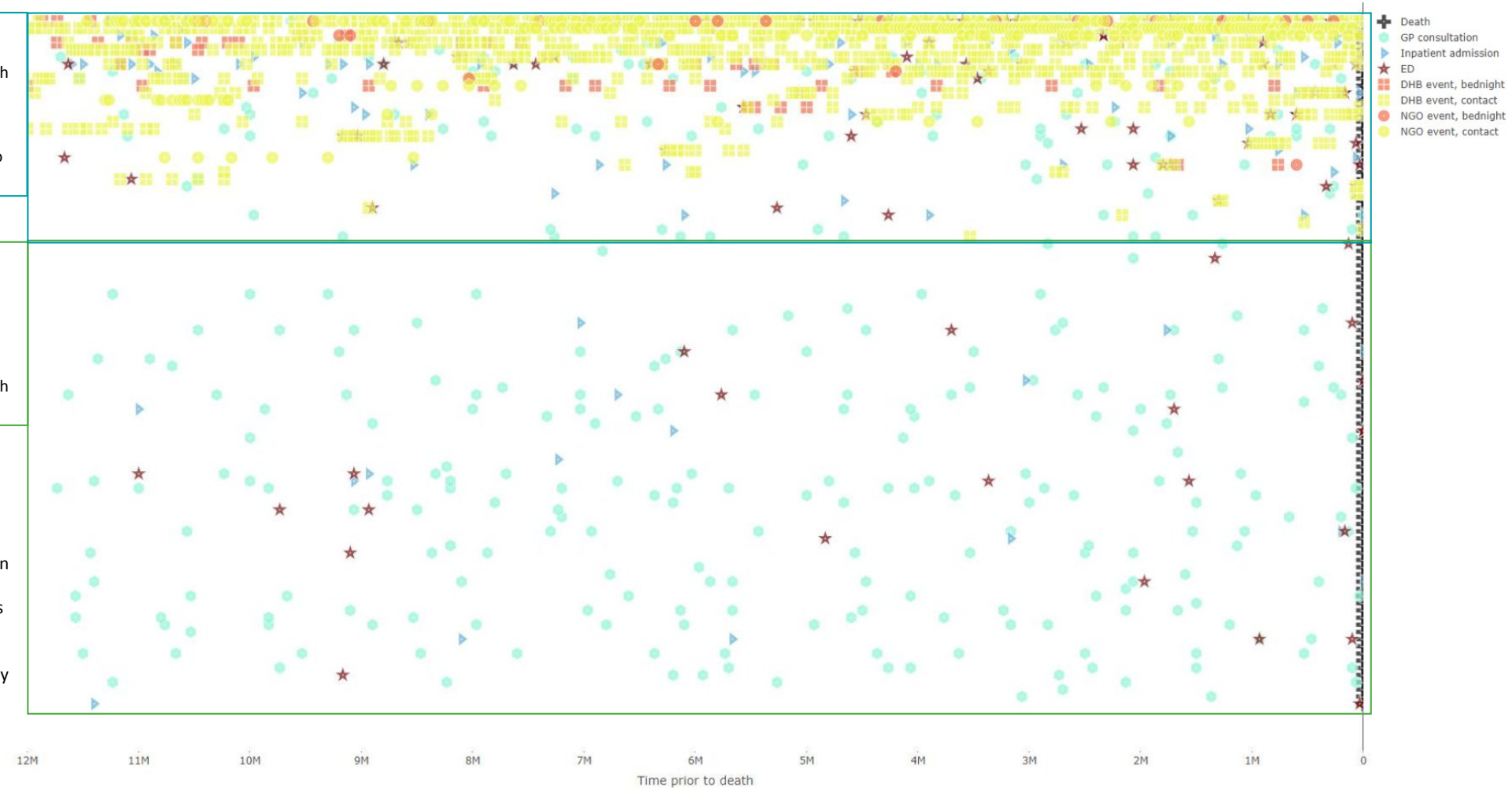


Every persons journey is different and there is no common pattern

Only 31 of the 96 people had interaction with secondary mental health services and were known to the sector

Those not known to secondary mental health services had high levels of interaction with primary care*

*we do not have detailed information on primary care activity so this will include non-MH related activity



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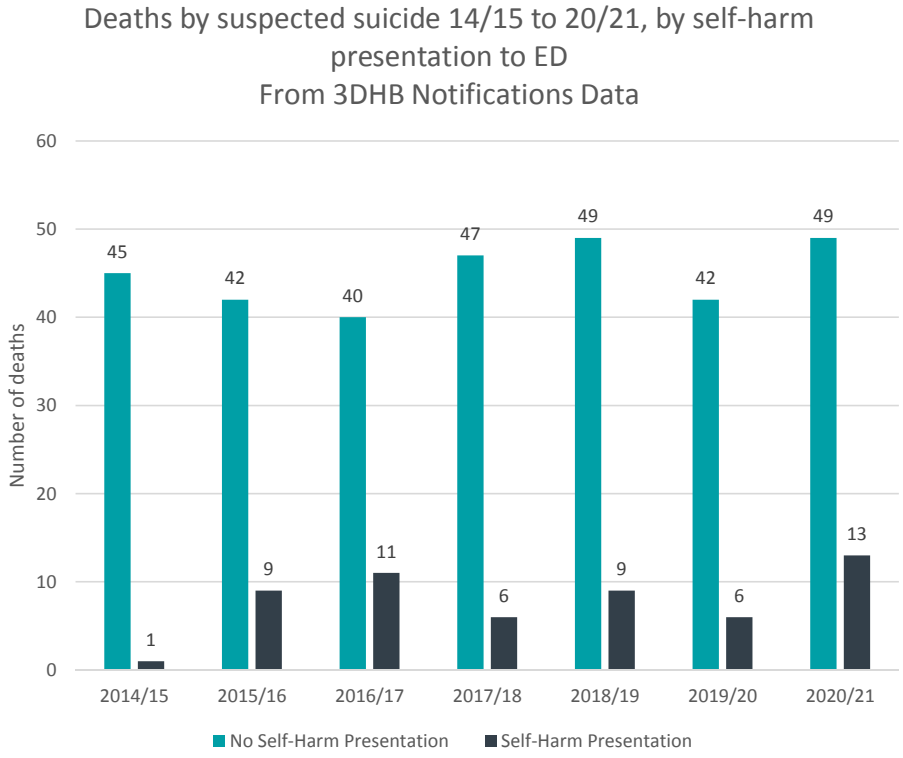
Self-harm is a risk factor for suicide

While people who self-harm may not intend to die, self-harm is an indicator of people in distress and is a risk factor for suicide. Since self-injury and suicide both indicate underlying distress it is important to assess whether people who self-injure are also suicidal and provide the necessary treatment for individuals in both of these categories. The following slides present self-harm data.

Self-harm is an indicator of distress

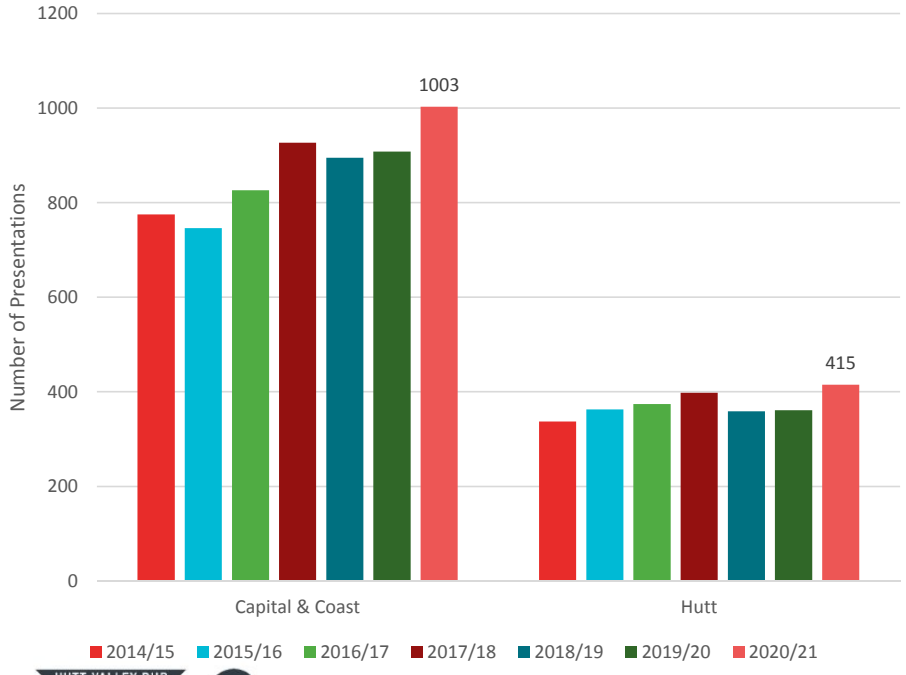
15% of all suspected suicides had at least one self-harm presentation to ED in the two years prior to their death



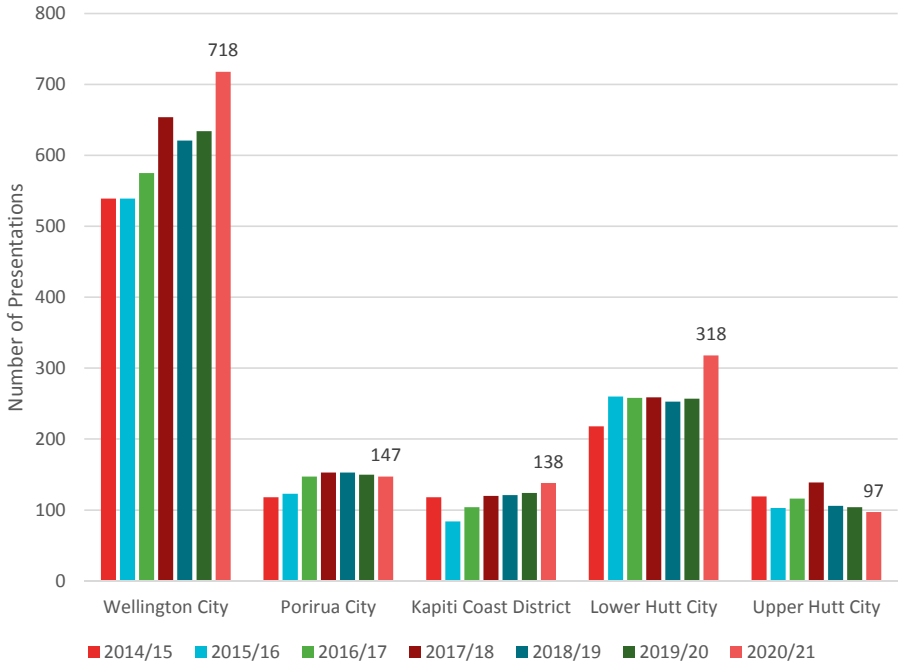
In the 2020/21 financial year, there have been 1,418 self-harm presentations to Emergency Departments (ED) in the 2DHB region.

Wellington City and Lower Hutt have experienced the greatest increase in presentations

Number of Self-harm Presentations, 14/15 to 20/21, by DHB of Domicile



Number of Self-harm Presentations, 14/15 to 20/21, by Locality



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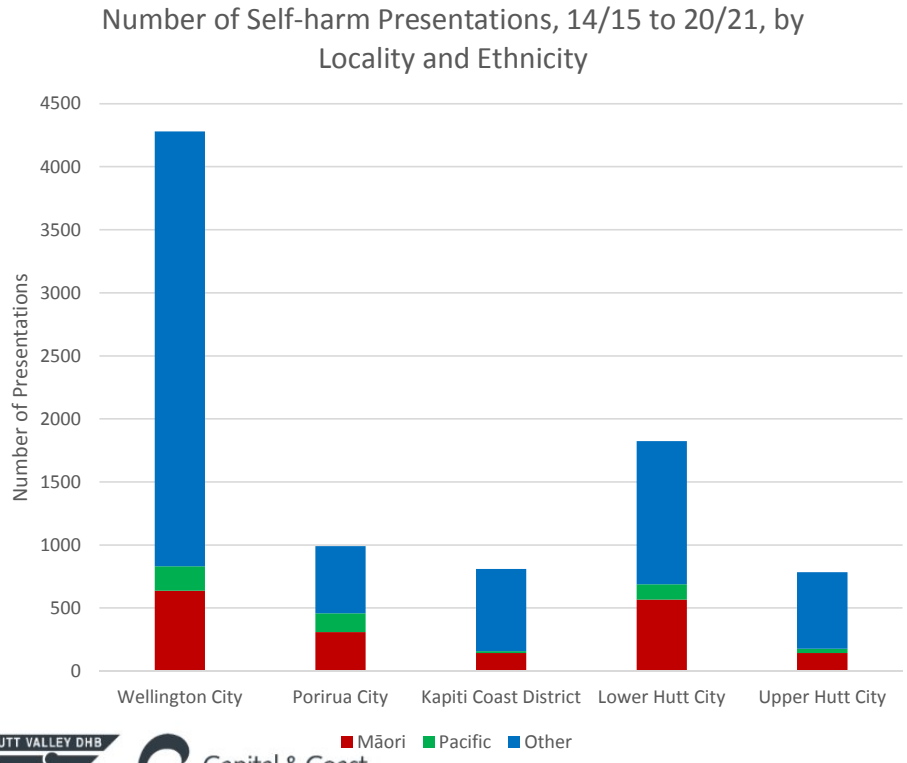
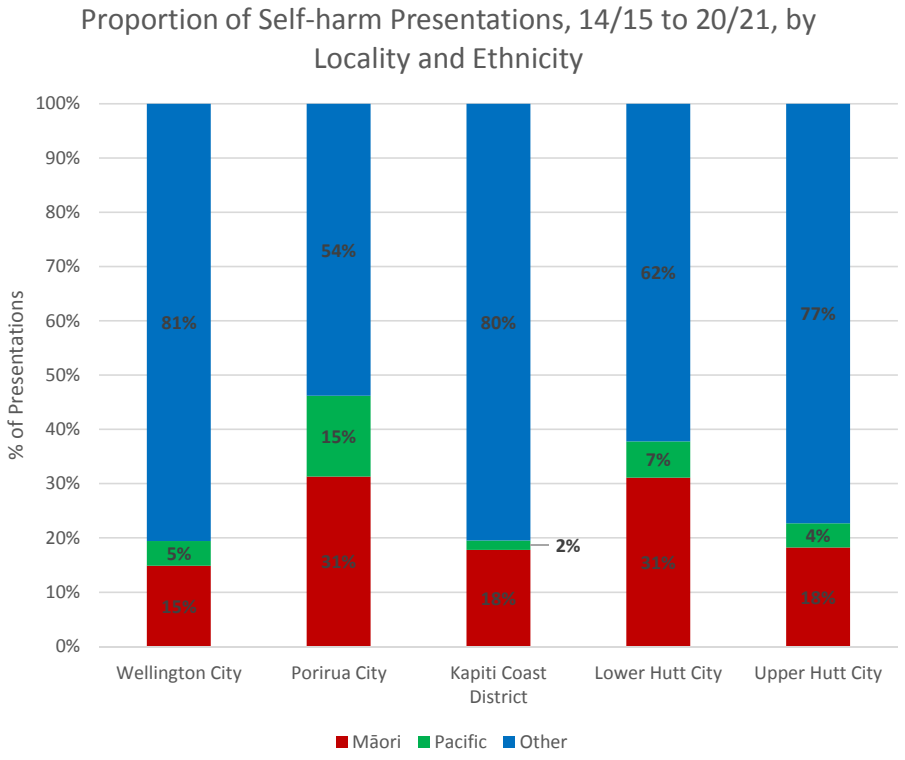
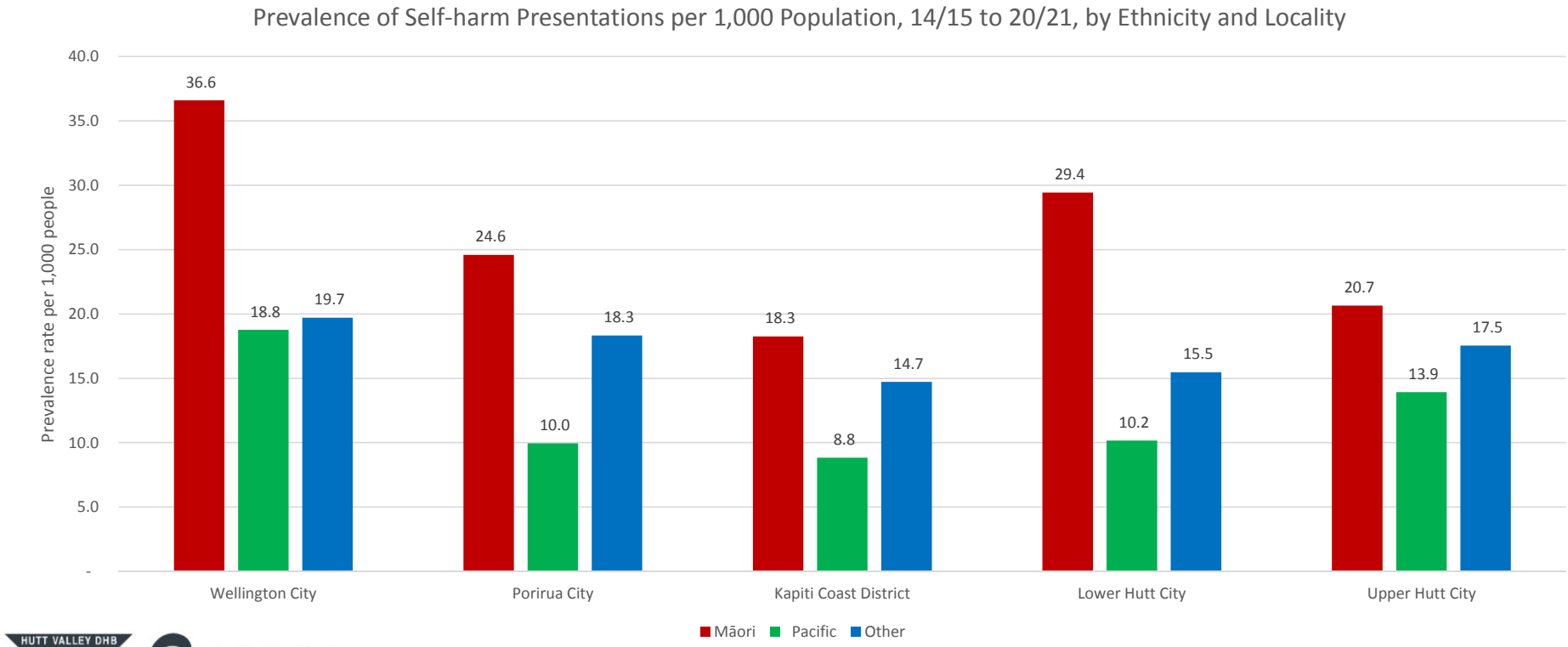
The majority of self-harm presentations were for Non-Māori, Non-Pacific people living in Wellington



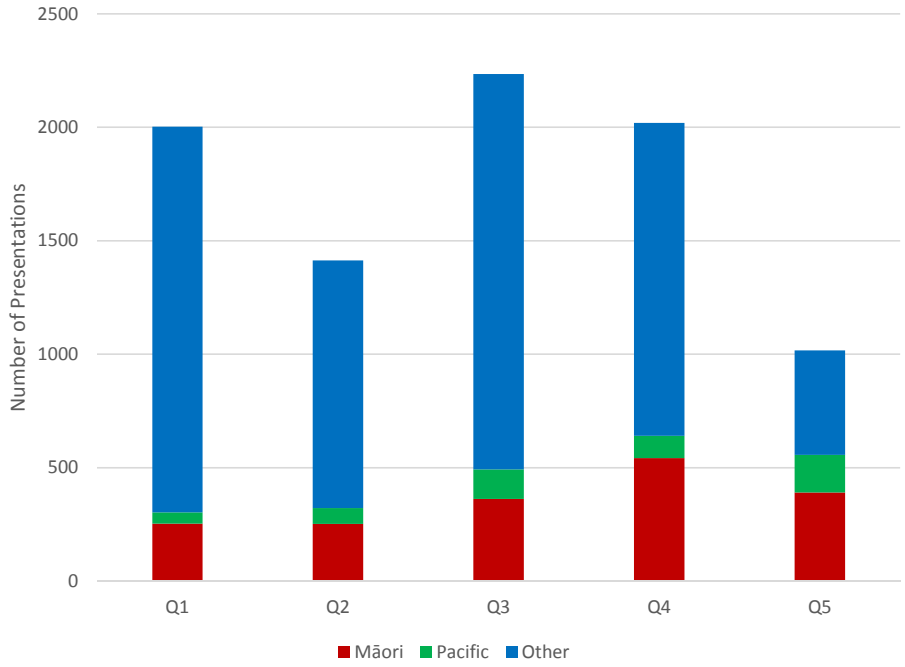


However, Māori are overrepresented in self-harm presentations when compared with their population size

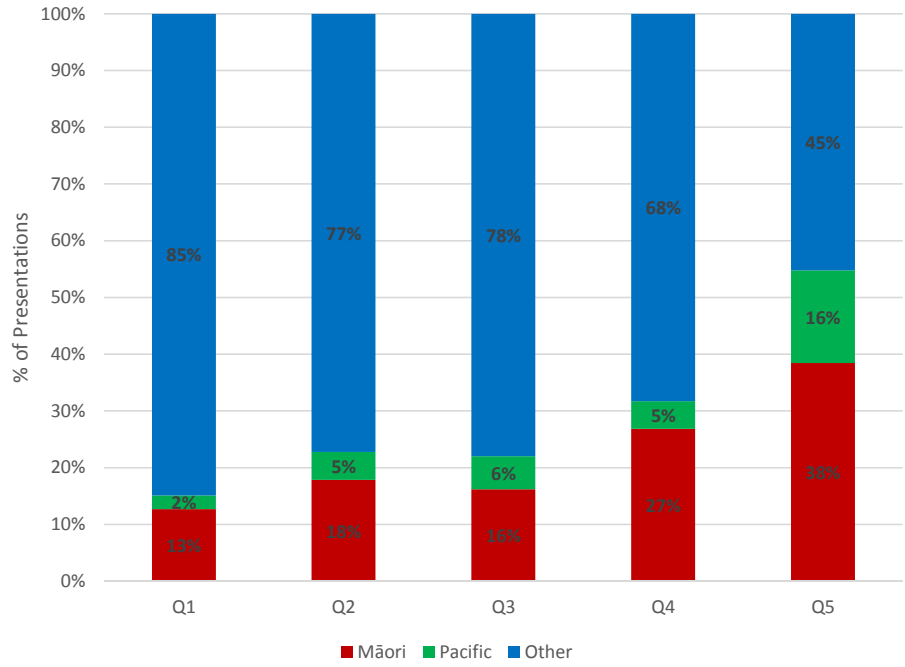


Self-harm affects people from all walks of life

Number of Self-harm Presentations, 14/15 to 20/21, by Ethnicity and Deprivation Quintile



Proportion of Self-harm Presentations, 14/15 to 20/21, by Ethnicity and Deprivation Quintile



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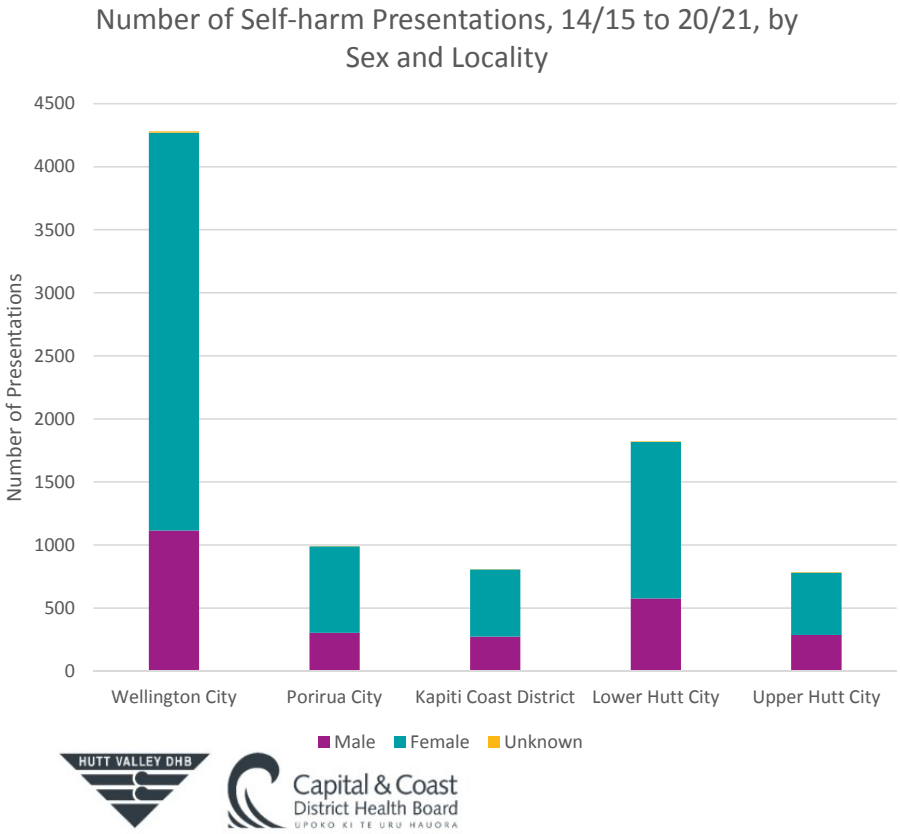
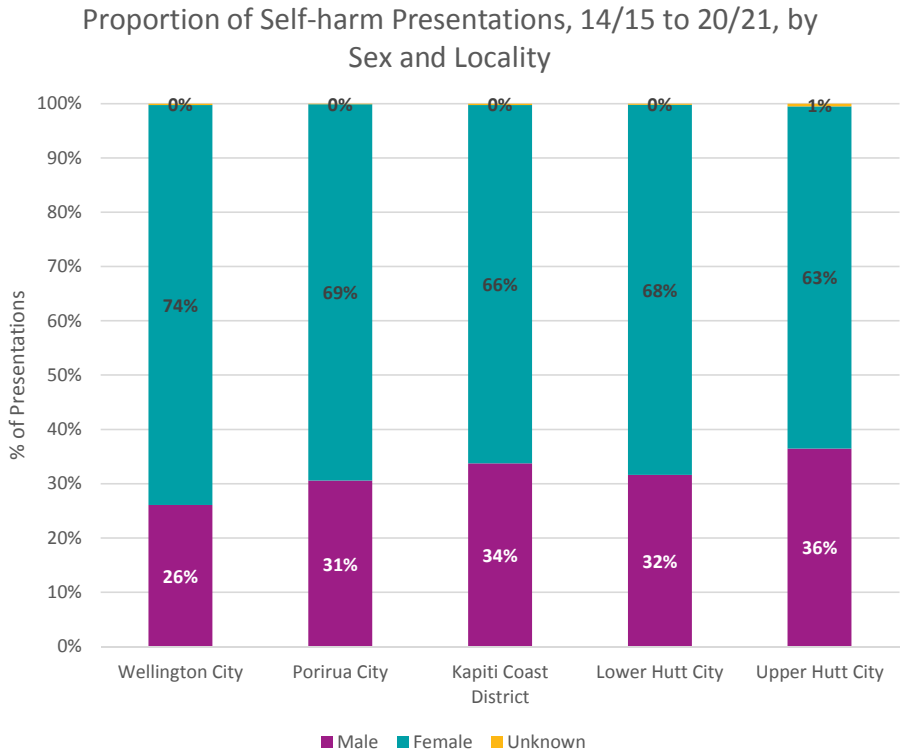
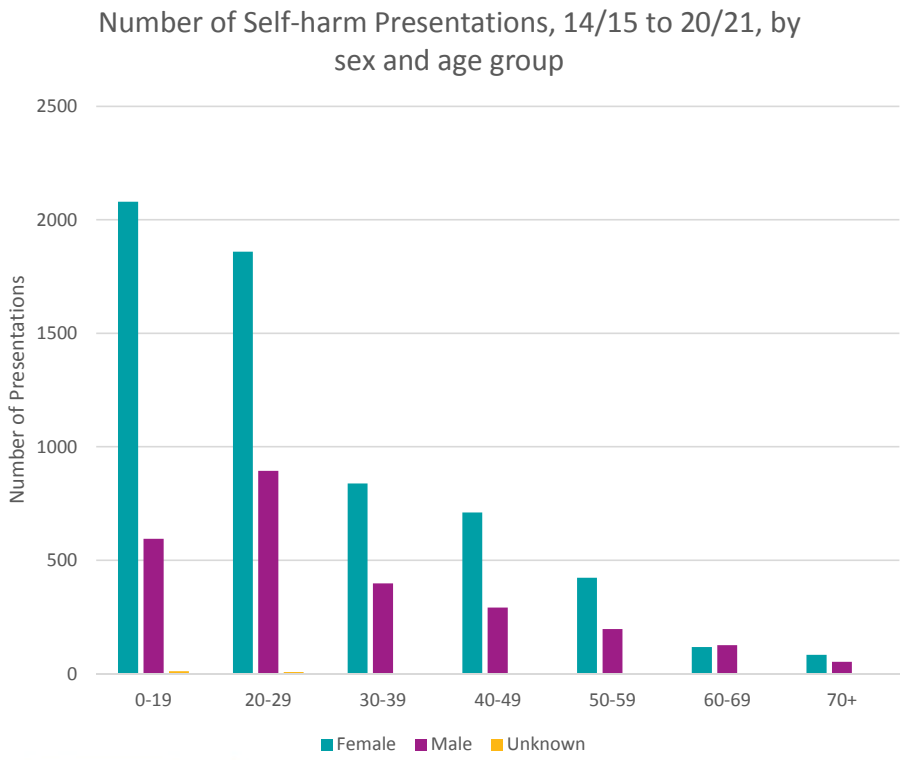
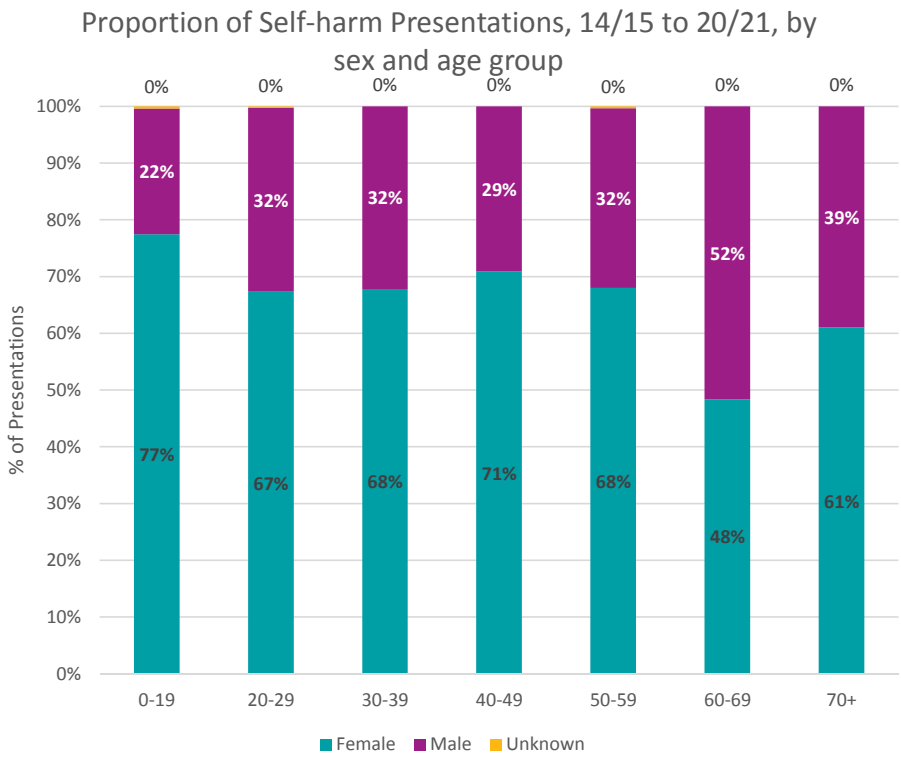
Although males represent 75% of suspected suicides in the 2DHB region, females represent 70% of self-harm presentations





Females under the age of 30 years old represent 45% of all self-harm presentations





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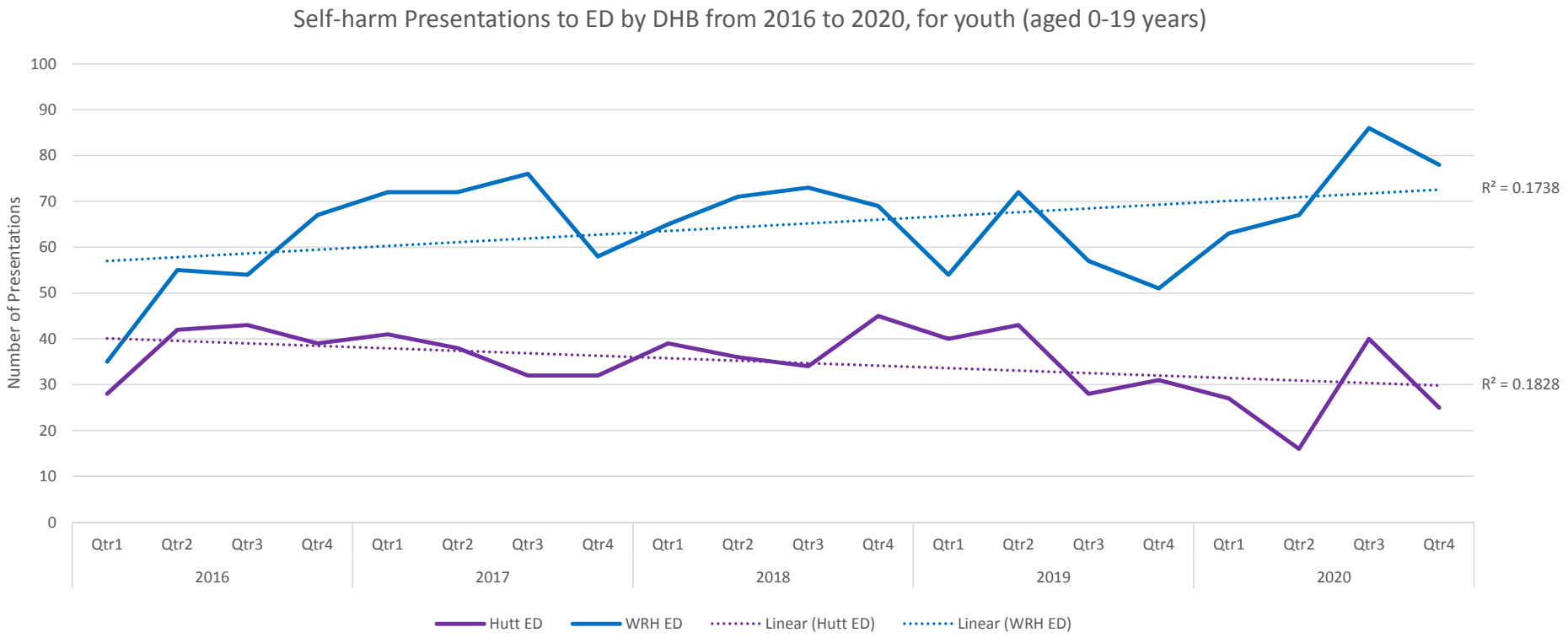
Self-harm in our rangatahi

The following slides are from previous analysis on self harm among rangatahi (0-19 years old)

Problem Statement

Over the 2020 calendar year, 3DHB emergency departments saw an increase in youth presenting for self-harm. This prompted the following analysis to determine driving factors for youth self-harm.

Over the past five years, the number of self-harm presentations from youth to the Wellington Regional Hospital Emergency Department (WRH ED) has steadily increased by 17%. Nearly the same rate that self-harm presentations to Hutt Valley ED (Hutt ED) have decreased over the same timeframe.



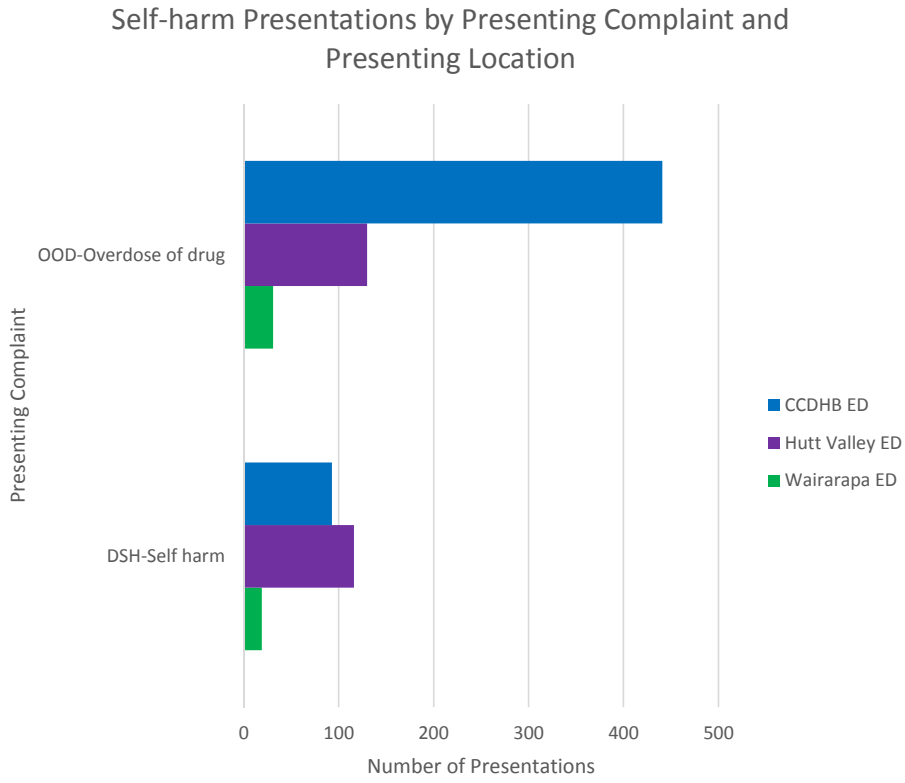
Self Harm is presenting in two primary forms: deliberate self-harm, and overdose of drug

Deliberate Self-Harm (DSH)

- Deliberate self-harm covers any self-inflicted physical harm. Most commonly in the form of cuts, this extends to self-injurious behavior such as attempted hanging and intentionally putting oneself in harms way.

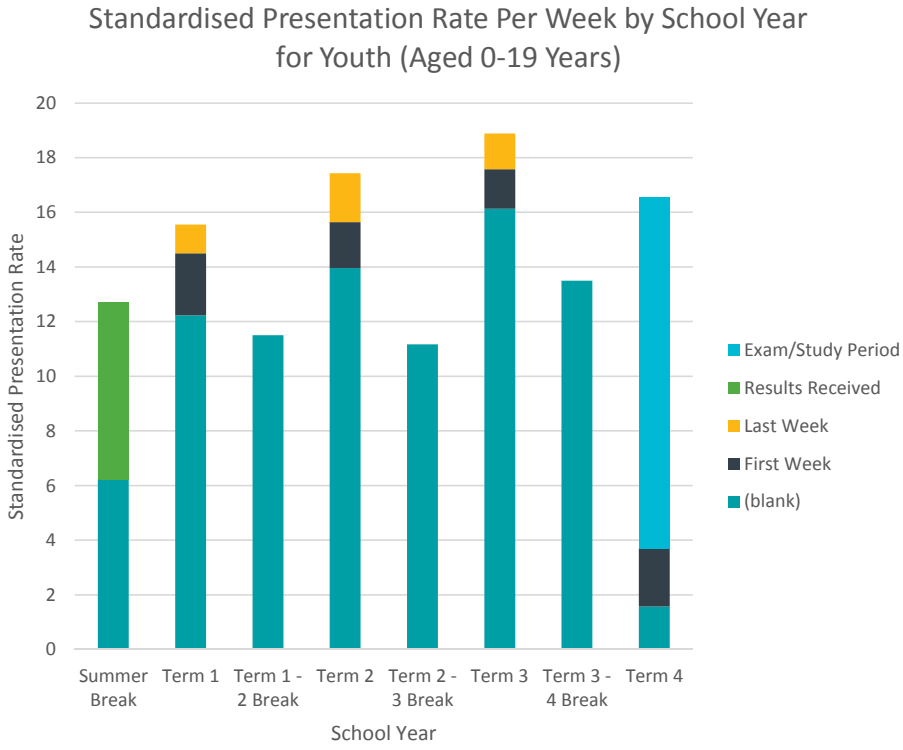
Overdose of Drug (OOD)

- Deliberate self-poisoning or overdosing accounts for 73% of all self-harm related presentations. Drugs most commonly used for overdosing were paracetamol and anti-depressants.

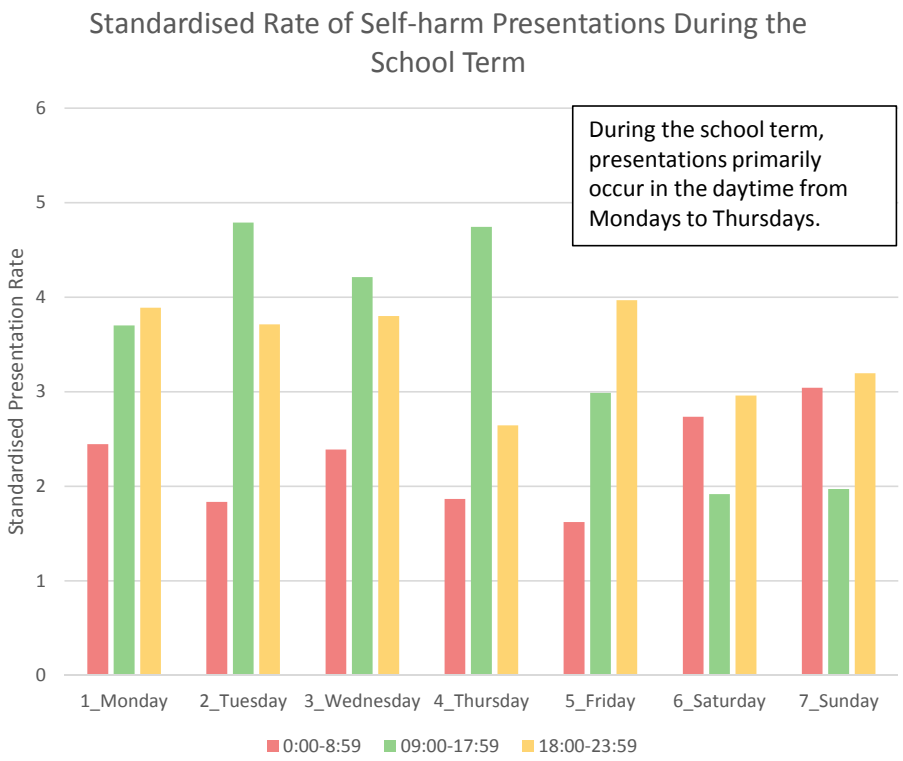


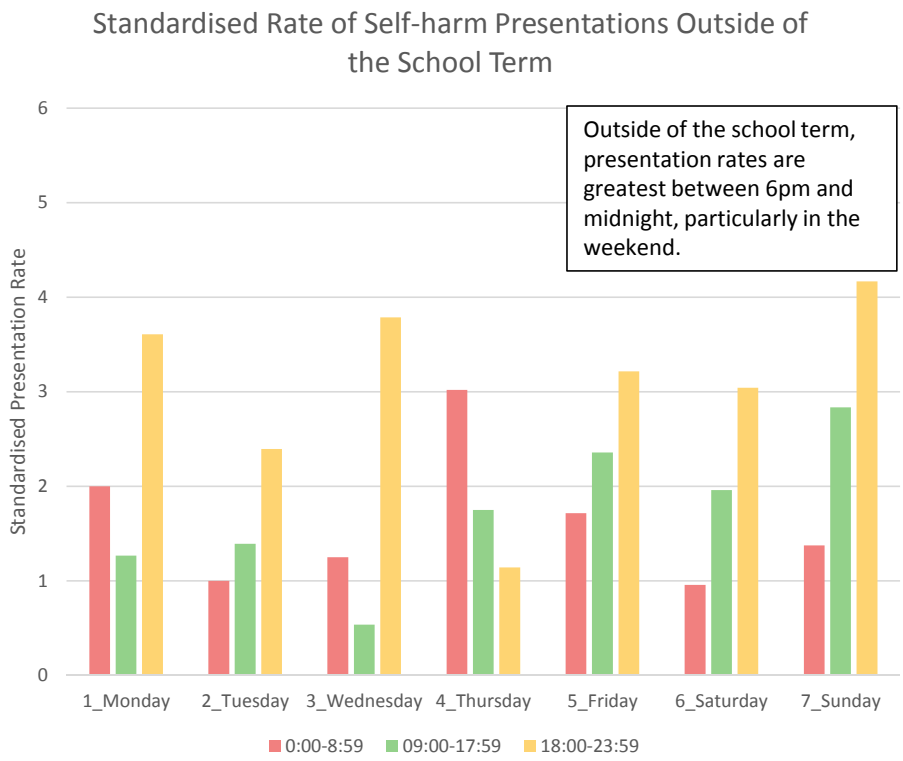
Environmental Factors:
a key stress factor for those in the 0-19 year age group is school.

- The school term accounts for a large portion of the year while holiday periods can be as short as two weeks.
- Furthermore, terms in 2020 were impacted by the COVID-19 lockdown and had different lengths compared to previous years.
- To adjust for these factors, presentations were standardised to an average presentation rate per week in order to be comparable.
- Even with standardised rates, we can see a steady increase in presentations as the school year progresses.



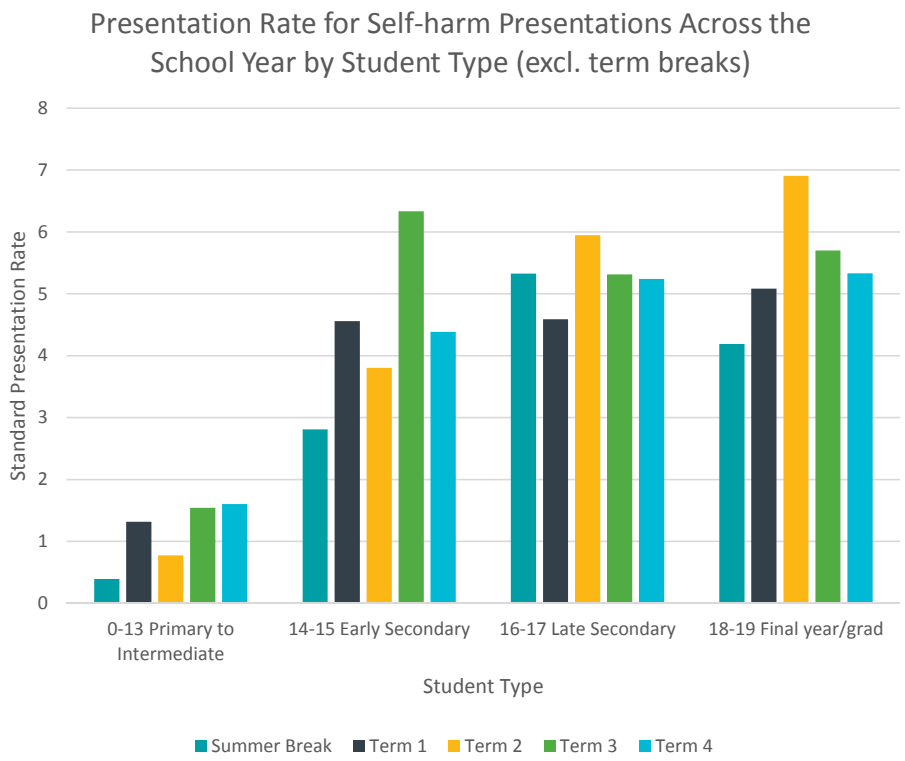
79% of self-harm related presentations occur during school terms



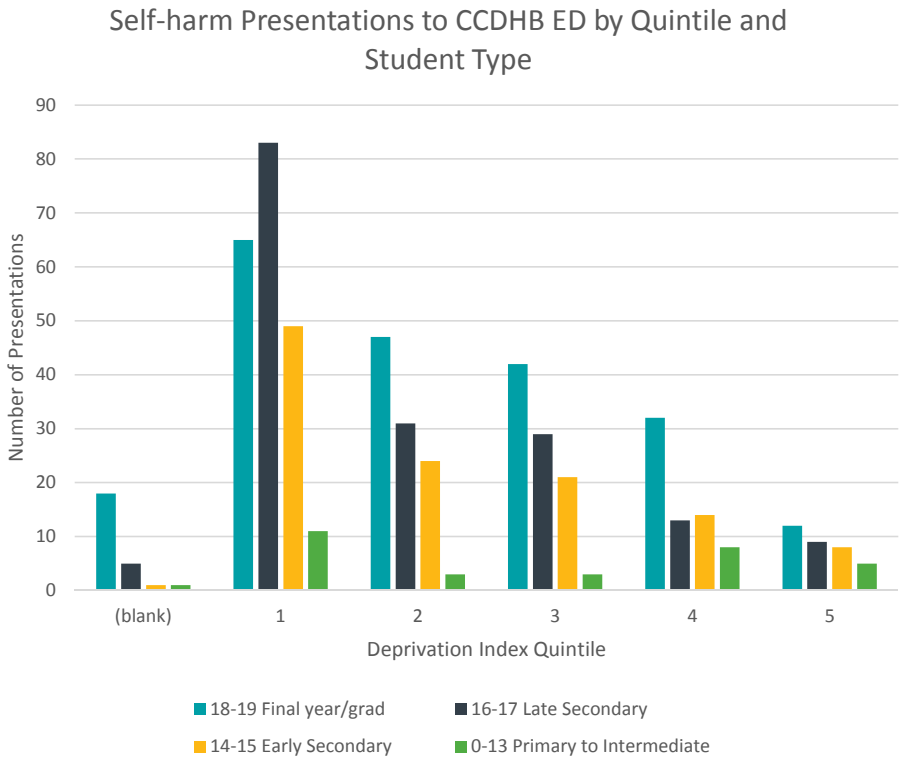


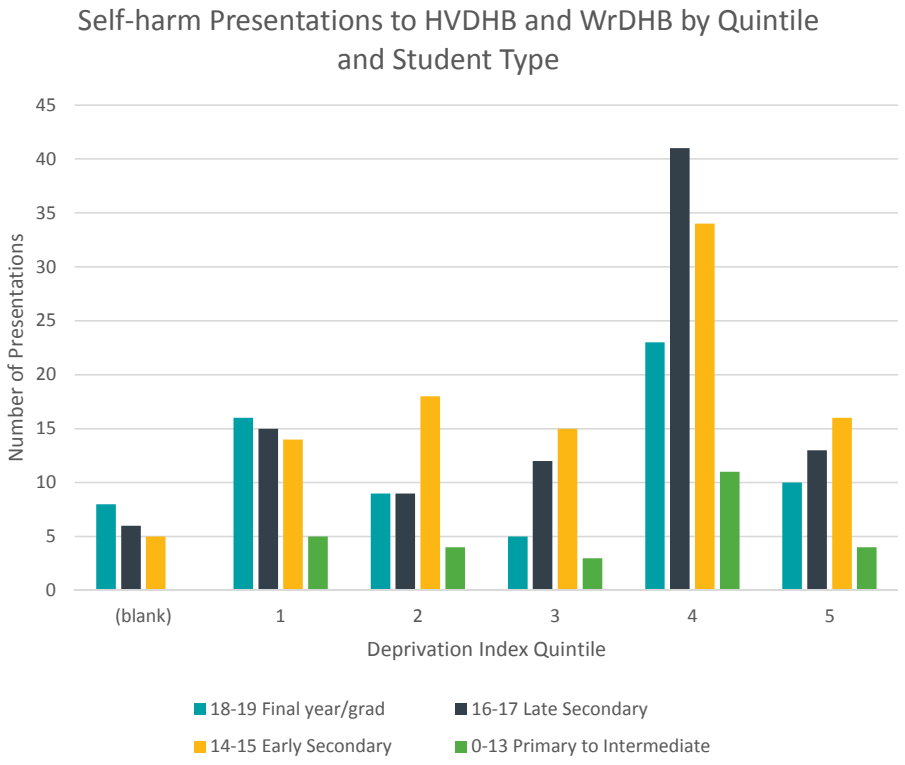
Students Experience Different Periods of Increased Distress

- **The time period with the highest presentation rate for Primary, Intermediate and early Secondary students is in term 3 which coincides with their exam period.**
- **Older Secondary students have higher presentation rates throughout the year as NCEA levels have assessments throughout the year.**
- **However, key periods of stress for this group would be mock exams in term two/three and exams in term four.**
- **Higher presentation rates during the summer break may be related to the release of NCEA results or other environmental factors.**



CCDHB EDs are primarily seeing older youth from more affluent areas (Q1) while HVDHB and WrDHB EDs are seeing a younger population from more deprived areas (Q4 & Q5)





The 3DHB Suicide Prevention and Postvention Action Plan responds to suicide and self-harm in the sub-region

The 3DHB Action Plan covers four areas :

1. Promotion	• Promoting wellbeing
2. Prevention	• Responding to suicidal distress
3. Intervention	• Responding to suicidal behaviour
4. Postvention	• Supporting after a suicide

By focussing on promotion & prevention, we hope to decrease the amount of intervention and postvention required in the future

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Well-being promotion

- Support promotional activities and programmes linked to reducing suicide risk
- Work within the education sector to identify and implement targeted wellbeing solutions for tamariki and rangatahi
- Work with intersectoral agencies to develop in house wellness promotion / suicide prevention programmes
- Work with Māori to develop and deliver ‘for Māori by Māori’ wellbeing initiatives
- Identify and implement targeted wellbeing initiatives for priority groups

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Prevention

- Deliver suicide prevention training
- Develop suicide prevention guidelines and support for workplaces
- Implement kaupapa Māori suicide prevention initiatives
- Work with people and service providers to guide the development of trauma-informed and inclusive suicide prevention practices
- Work with intervention programmes which target associated suicide risk factors such as family violence and alcohol and drug abuse programmes

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Intervention

- Develop a comprehensive 3DHB database for suspected suicides
- Investigate the opportunities for peer-led support after discharge from a suicide attempt
- Support work aimed at improving crisis response services
- Work on the Mental Health and Addiction Crisis Support Capability Project (MHACs), particularly on improving the experience and outcomes of people and their whānau who present to ED in acute distress.
- Provide tailored training and support for frontline staff

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Postvention

- Implement a community-led postvention approach
- Implement specific 3DHB Māori and a 3DHB Pacific postvention processes
- Develop tangihanga resources and a bereavement register
- Support awareness of and increase access to local programmes and peer support groups for people bereaved by suicide

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Board Information – Public

3 November 2021

Hutt Valley Maternity progress update

Action Required

The HVDHB Board notes:

(a) **A** review of the women's health service was commissioned in 2018 which identified areas of risk and made 67 recommendations for improvement in a report released in mid-2019.

(b) The Women's Health Service Clinical Governance Group are accountable for monitoring and reporting on progress against the review recommendations, and report through to the Clinical Governance Board and Chief Executive.

(c) All recommendations from the 2018 women's health service review have been implemented or are in progress.

(d) A $1.9 million plus investment made by the DHB has supported enhanced leadership, safer clinical practice and a greater focus on quality.

(e) The $9.53 million maternity facility redevelopment at Hutt Hospital is on track to be completed in October 2023.

(f) Optimising birth and reducing caesarean sections is a current area of focus with analysis of a retrospective clinical audit and project information to be released in December 2021.

(g) Maternity is a highly regulated and monitored sector and based on this we can assure safe clinical practice standards.

Strategic Alignment	The Board has agreed maternity and neonatal as one of its 11 strategic priorities.
Author	Rhondda Knox, Service Group Manager, Surgical, Women's and Children's Health
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Joy Farley, Director Provider Services
Purpose	This report updates the Board on progress within the Hutt Maternity Service
Contributors	Dr Helen Tobin, Clinical Director, SWC and Chair Women's Health Governance Committee Dr Meera Sood, Clinical Head of Department, Obstetrics and Gynaecology Shelley James, Service Manager, Surgical, Women's and Children's Health
Consultation	N/A

Executive Summary

Since the November 2018 external review, improvements have been implemented to the HVDHB Maternity Service. An investment of $1.9 million was made to the base line operational expenditure. This has been key to achieving the recommendations in the report - enhancing leadership, safer clinical

practice and a greater focus on quality. This was complemented by $890K in capital expenditure supporting facility and equipment upgrades.

Additional $9.53 million redevelopment of Hutt Valley DHB's maternity services is well underway. The redesigned Maternity Assessment Unit, Maternity ward (birthing and postnatal) and the Special Care Baby Unit, will be completed by the end of 2023. Building works are complete in the Community Midwifery area. The team is now located on the ground floor of the Community Health Building in their new office and modern clinical spaces.

Robust monitoring and systems are in place at a national and local level to ensure that there are safe clinical practices and positive outcomes for women/ hapu mama and their babies/pēpi. The Women's Health Service Governance Group and Maternity Quality & Safety Programme governance group have moved beyond the 2018 review in planning service improvements focused on women, babies and their whānau.

Improvements in relation to the 2018 Women's Health review recommendations

In late 2018 a review of the women's health service was commissioned as a result of concerns raised over staff shortages, Health and Disability Commissioner (HDC) complaints, the caesarean section rate, and newborns with suspected neonatal encephalopathy (NE). The review report identified areas of risk and made 67 recommendations for improvement. There has been significant investment to address and close these since the report was released in mid-2019. Maternity service improvements and progress made against the review recommendations were shared with HVDHB staff, Board members and stakeholders at a hui on 23 July 2020.

The Women's Health Service Clinical Governance Group, tasked with overseeing monitoring of the recommendations, report that all recommendations are now implemented or being actioned. The Governance group is chaired by the Clinical Director of Surgical, Women's and Children's Health (SWC), and reports to the Clinical Governance Board and Chief Executive.

An operational budget increase of $1.9 million in 2020/21(and out years) for growing the workforce. Today we have an overall increase of 24.6 FTE on the 2019 establishment covering senior medical staff, junior medical staff, obstetric anaesthetics, associate clinical midwifery management, theatre midwives, quality and safety, midwifery education, Community midwives, health care assistants, social work, clinical midwifery coaches and midwifery support workers. Corporate and senior leadership is in place through permanent Women's and Children's senior leadership with increased FTE provided for Service Manager and Director of Midwifery positions.

A strengthened clinical governance model is in place, as is a clinical guideline framework, and systems for auditing and adverse event follow up. Review of mothers admitted to ICU, babies with suspected NE, stillbirths, HDC cases. Ongoing review and update of clinical policies and guidelines are in place. A robust maternity quality and safety improvement work programme is in place.

Education and training programmes are in place to support clinicians - weekly cardiotocography (CTG), multidisciplinary education meetings, foetal surveillance, emergency skills, topic based tutorials, a cultural safety and competence education programme was trialled and redeveloped for delivery in 2021/22.

Improvements to the physical environment have included a new staff room for privacy and refreshment breaks, a central storage room and emergency equipment bay, records storage, essential equipment stocktake with gaps filled, standardisation of restocked birthing room trolleys, painting and curtain replacements.

Through enhanced clinical leadership and a focus on improving service quality there has been a reduction in HDC cases, fewer reported Serious Adverse Events (SAC 1 and 2), no neonatal encephalopathy cases in newborns at Hutt Hospital for the last year. We have received positive feedback about the Service through external audits in 2021 (e.g. Baby Friendly Hospital Initiative, hospital surveillance).

Maternity and neonatal facilities – redesign project

In December 2020, the Minister of Health approved central funding of $9.47 million for infrastructure investment to upgrade Hutt Hospital maternity facilities. This followed submission of a successful single stage business case through the National Capital Investments Committee. The total approved budget is $9.53 million inclusive of HVDHB's contribution.

This work will improve the physical space to enable delivery of optimal maternity outpatient services, birthing and post-natal care, and special care for babies. The current Maternity Assessment Unit, Birthing Suite, Postnatal Ward and Special Care Baby Unit are no longer fit for purpose and feature inefficient layouts, cramped spaces and poor states of repair.

On track financially, the project is to be completed by October 2023 and the overall timeline remains achievable, despite a 6 week delay due to COVID-19 restrictions. Divided into four separate work streams the current status of the project is:

- A new office and consulting rooms for the Community Midwifery Team, completed on 25 May 2021.
- Expansion of the floor space in the current Maternity Assessment Unit, incorporates a separate area for early pregnancy loss, clinical flexibility through better flow and increased space. Building consent application was submitted to Hutt City Council on 4 October and open tender for the build work was posted on GETS 15 October. The expectation is that building work will start in late November.
- Modernisation of the maternity ward and birthing suites. The redevelopment of postnatal rooms 1-6 will commence prior to Christmas and has involved consultation with our staff, Lead Maternity Carers (LMCs) and Women residing in the Hutt Valley through a Maternity Action Trust forum and earlier surveys. The concept plan for the remaining Level 2 maternity area will be signed off by December.
- Creation of a new Special Care Baby Unit on Level 1 of the Heretaunga Bock. Detailed design work is in progress and the concept plan has been signed off.

Progress updates are shared with the public http://www.huttmaternity.org.nz/hutt-maternity-redevelopment/.

Optimising Birth and reducing Caesarean Sections

In the past two decades there has been a progressive increase in caesarean section (CS) births internationally. Significant debate has arisen globally on the potential maternal and perinatal risks associated with this increase, inequity of access, and associated costs. The World Health Organisation (WHO) in 2015 proposed the use of the Robson 10 classification (also known as the 10-group classification) as a global standard for assessing, monitoring and comparing CS rates both within healthcare facilities, and between them.

The Robson system classifies all women into one of ten categories that are mutually exclusive and, as a set, are totally comprehensive. Categories are based on five basic characteristics that are routinely collected in all maternity units (parity, number of fetuses, previous CS, onset of labour, gestational age, and fetal presentation).

Our region

The percentage of babies born by caesarean section at Hutt Hospital and Wellington Regional Hospital 2016-2021 is as follows:

	HVDHB	CCDHB
2021	38%	40 %
2020	40%	40%
2019	52%	39%
2018	35%	37%
2017	33%	35%
2016	33%	33%

While the percentage of babies born by caesarean section at Hutt Hospital has declined in the last two years we are an outlier in comparison with a number of DHBs. For example, in 2020 the national average caesarean section rate was 31.9% and the caesarean section rate at Hutt Hospital was 40% with 26 % of this emergency surgery.

Optimising birth project

We recognise that while many women across HVDHB experience good health outcomes, current models and services could be improved to better meet the needs of women and their whānau.

The maternity service optimising birth project involves a programme of work that endeavours to optimise the birth experience for women and reduce the volume of caesarean sections at Hutt Hospital.

A first step is to undertake a retrospective audit on caesarean sections over a 3 month period. The purpose of this is to apply the Robson 10 clinical classification system to determine the key areas of clinical improvement focus. HVDHB is using the Robson 10 classification to target quality improvement in a structured and measureable way to enable woman and baby focused initiatives that are collaboratively generated, and supported by all health care providers in the sector.

We are working with MidCentral DHB who applied this approach and significantly reduced the caesarean rate for women in Palmerston North. Further information on analysis of the audit findings and the optimising birth project will be available in December 2021, and will be reported in the New Year.

In addition we will provide further detail in the presentation at the Board meeting.

Continuous Improvement – next areas of focus

There is a national and local formal framework, regular monitoring and leadership in place to ensure that high standards of care are delivered for women, parents, pēpi, and whānau across our region.

The Midwifery Council of New Zealand, as the regulatory body for the protection of health and safety of women and babies during the childbirth process, provides mechanisms to ensure that midwives are competent and fit to practice midwifery. Structures at both DHBs ensure midwifery leadership is in place and supported.

There is robust data collection and analysis through the Maternity Quality Safety Programme (MQSP), to inform decision making and address current workforce issues. The DHBs are committed to the Midwifery Accord to address safe staffing and workload in a joint project with Midwifery Employee Representation and Advisory Service and New Zealand Nurses Organisation.

There is also national monitoring in place through Perinatal and Maternal Mortality Review Committee, Health Quality Safety Commission and National Maternity Monitoring Group quality programmes —the DHBs are engaged and working responsively.

Strategies are in place at a local level across both DHBs. This includes additional midwifery leadership roles at ward level (ACMMs working 24/7), the appointment of experienced senior midwives to clinical coach roles, collaboration with Victoria University and Otago Polytechnic to support the future midwifery pipeline, engagement with the Midwifery Council on return to practice midwives, robust graduate midwifery programmes with continuous recruitment throughout the calendar year and support to Registered Nurses transitioning to be Midwives.

Midwifery workforce shortages are well canvassed nationally. To support local recruitment Capital & Coast and Hutt Valley DHBs, have recently launched a comprehensive international recruitment campaign which aims to encourage international candidates to join our talented workforce. The intent for this international campaign is to ensure that there isn't any added pressure placed on the domestic workforce pool.

As part of this campaign, a microsite has been developed to showcase our region, the important mahi that midwives do, and to provide relevant information for those looking to move into our region.

We are now in a position to drive forward our usual business and improvement work. This includes our strategy for women's and children's health that ensures seamless care across the wider Wellington region.

2DHB Maternal and Neonatal System Strategy

Wider joint maternal health system planning has commenced. Hutt Valley and Capital & Coast DHBs are currently developing a 2DHB Maternal and Neonatal System Strategy. The purpose of this work is to create a pathway for change for maternity and neonatal care that works towards equitable outcomes and improved experiences for mothers, babies, families and whānau living in Lower and Upper Hutt, Wellington, Porirua and Kāpiti. There is an equity focus on change to improve outcomes for Māori and Pacific whānau and families, and disabled women and babies with impairments.

This work extends beyond maternity services, to improve the broader maternal health system across the continuum of care in the first 1000 days. The Strategy articulates design principles and priorities for action built on existing insights and refined with sector and community stakeholders, and will be presented to the Board for approval at the 1 December 2021 Board meeting.

APPENDIX ONE

Operational baseline budget increases to establishment inclusive of Care Capacity Demand (CCDM).

Financial Year	FTE	$(000)
2018-19	-	-
2019-20	4.6	273
2020-21	20.0	1,900

APPENDIX TWO

Capex expenditure for items above $500.

Year	Capex Amount	Items
17/18	$167,872	PCAs x2
		CTGs x2
		Breast pumps x 2
		Scales x2
		Baby warmers x2
		Trolleys
		Drug fridges
		Sonic Aids
18/19	$47,567	Cots x4
		PCEAs x2
		Resuscitaire x1
		Couch/Cushions/beds for relatives
		Chairs for staff
19/20	$278,397	CTG x1
		Monitors x 4
		Resuscitaire x2
		Dopplers x 9
		Beds for partners x3
		Trolleys
		Entonox x 7
		Ventouse x1
		Chairs for staff x9
		Carts x2
		Wardrobes x2
		Breast feeding chairs x15
		Carts x7
		Birthing couches x1
		Stools for surgeon x1
		Trauma trolley x1
		Ultrasound x1
20/21	$63,448	Replacement of defs and trolleys x2
		Plinths x7 (MAU) - Trust
		Transducers for ultrasound x1
21/22	$83,173	Epidural cart x1
		Foetal monitors
		Vital sign monitors x2 (MAU)
		CTG (MAU) x1
		PCEA x5
Total	**$640,457**	

APPENDIX THREE

Facility related expenditure excluding standard maintenance and the maternity redevelopment upgrade funding.

This project included refurbishment work of the Assessment Room, Equipment Bay, Staff Kitchenette, Storage Room, Post Natal Rooms 12 & 13 and the adjoining Ensuite.

Financial Year	Labour Costs	Invoice Costs	Total Costs
2017-2018	$2,480.00		**$2,480.00**
2018-2019		$5,009.00	**$5,009.00**
2019-2020	$73,914.74	$132,024.68	**$205,939.42**
2020-2021	$11,459.54	$25,111.44	**$36,570.98**
Total	**$87,854.28**	**$162,145.12**	**$249,999.40**

APPENDIX FOUR

Maternity redevelopment upgrade funding through to October 2023.

Funding Party	Original Funding	Total Approved Funding	Spend to date
HVDHB	$61,000	$61,000	Nil
Ministry of Health	$9,470,000	$9,470,000	$328,312
Total	**$9,531,000**	**$9,531,000**	**$328,312**

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 3 November 2021

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	OIA, section 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. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage negotiations.
Chief Executive In Confidence	As above	As above
2DHB Quality & Safety Report	As above	As above
2DHB Health and Safety Report – September 2021	As above	As above
CCDHB Financial and Operational Performance Report – September 2021	As above	As above

HVDHB Financial and Operational Performance Report – September 2021	As above	As above
2DHB Strategic Priorities update	As above	As above
FRAC items for Board Approval from meeting dated 27/10/21	As above	As above
COVID planning	As above	As above
MCPAC update from meeting dated 27/10/21	As above	As above
Chair's Report and Correspondence	As above	As above
Chief Executive's Report	As above	As above
General Business	As above	As above

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.