PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 30 March 2022 Time: 9:00am Location: Zoom Zoom Meeting ID: 835 0269 8434

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Pg
1.	**PROCEDURAL BUSINESS**			
1.1.	Karakia		All members	2
1.2.	Apologies	**NOTE**	Chair	
1.3.	Public Participation – Nil	**NOTE**	Chair	
1.4.	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair	3 7
1.5.	Minutes of Previous Concurrent Meeting – 16 February 2022	**APPROVE**	Chair	9
1.6.	Matters Arising	**NOTE**	Chair	18
1.7.	Chair's Report and Correspondence	**NOTE**	Chair	
1.8.	Chief Executive's Report	**NOTE**	Chief Executive	19
1.9.	Board Work Plan 2022	**NOTE**	Chair	34
2.	**STRATEGIC PRIORITIES**			
2.1.	2DHB Strategic Priorities Update	**NOTE**	Chief Executive	35
3.	**DHB PERFORMANCE AND ACCOUNTABILITY**			
3.1.	HVDHB Financial and Operational Performance Report – February 2022 3.1.1. Report	**NOTE**	Director Provider Services Acting Chief Financial Officer Acting Director Strategy, Planning and Performance	43 47
3.2.	CCDHB Financial and Operational Performance Report – February 2022 3.2.1. Report	**NOTE**	Director Provider Services Acting Chief Financial Officer Acting Director Strategy, Planning and Performance	94 98
4.	**DECISION**			
4.1.	HSC update and items for approval from meeting dated 16/03/22	**APPROVE**	Chair of HSC	146
5.	**UPDATES**			
5.1.	2DHB COVID Update	***NOTE**	Chief Executive	
5.2.	3DHB Sustainability Strategy Update	**NOTE**	Acting Chief Financial Officer	150
5.3.	DSAC update from meeting dated 16/03/22	**NOTE**	Chair of DSAC	158
6.	**OTHER**			
6.1.	General Business	**NOTE**	Chair	
6.2.	Resolution to Exclude the Public	**APROVE**	Chair	161

Next concurrent Board meeting:
Date: **Friday** 13 May 2022, **Location:** Zoom, **Time:** 9am

No paper – presentation on the day only

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

30/03/2022

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, Greater Wellington Rail Ltd • Councillor, Greater Wellington Regional Council • Chair, Transport Committee, Greater Wellington Regional Council • Associate Portfolio Leader, Sustainable Development • 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 and nephew are medical doctors,all 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 • Chair, Eastern bay of plenty primary health alliance • Chair, Māori Communities COVID-19 Fund • 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	• Associate Professor, University of Otago • Review Panel Member, PHARMAC Review (2021) • Board Member, Health Quality & Safety Commission • 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, Community Steering Group Establishment Unit of the Ministry for Disabled People • 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 • Son is employed by Regional Public Health
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 • Trustee Te Awakairangi (Taka) Trust • Member Saints Softball Club
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group • Lay Member, NZ Law Society Wellington Standards Committee
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

30 MARCH 2022

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
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

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 and employed by investment firm with interest in Boulcott Hospital
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*	• A Partner at PWC • Partner's father works in the printing team at CCDHB
Peter Guthrie *Acting Director Strategy, Planning and Performance*	• Nil

PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ÜPOKO KI TE URU HAUORA	**MINUTES** Held on Wednesday 16 February 2022 Location: Zoom Time: 9:00am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

Due to Covid 19 protection framework (Red light) all members were on zoom and limited staff attended in person

PRESENT

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

APOLOGIES

* These members gave apologies for lateness, leaving early or leaving for a period for other commitments

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Mat Parr	Acting Chief Financial Officer
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Services
Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
Joy Farley	Director Provider Services
John Tait	Chief Medical Officer
Peter Guthrie	Acting Director Strategy Planning and Performance
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
Anne Pedersen	2DHB Group Manager Clinical Excellence

PUBLIC

1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

1.4 INTEREST REGISTER

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** the updates to the interest register.

- Vanessa Simpson – Lay Member, NZ Law Society Wellington Standards Committee.
- Ken Laban – Son is employed by Regional Public Health

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 December 2021.

	Moved	**Seconded**	
HVDHB	John Ryall	Wayne Guppy	**CARRIED**
CCDHB	Roger Blakeley	Chris Kalderimis	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

There were no updates or comments.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair **noted** the following correspondence has been received

- Minister's Letter of Expectation dated 17 December 2021.
- Letter from Sub-Regional Disability Advisory Group received on 14 February 2022.
- Letter from Muscular Dystrophy Association (Central Region) dated 14 February 2022

The Chair advised that the DHBs are attending the Health Select Committee on 2 March 2022.

1.8 CHIEF EXECUTIVE'S REPORT

*The paper was taken as **read** and there were no questions.*

1.9 BOARD WORK PLAN 2022

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

Procedural note:

PUBLIC

The Chair reordered the agenda order as follows to accommodate availability of presenters and to allow the issues raised with the Boards regarding Homecare support in the correspondence above to be discussed at the start of the agenda:

- Item 4.1 – Covid Update
- Item 3.1 – Strategic Priorities
- Item 2 – DHB Performance and Accountability
- Items 4.2-4.5 – Updates

4.0 UPDATES

4.1 2DHB COVID UPDATE

The Boards:

(a) Noted progress with preparing for and managing the omicron variant in our community

(b) Noted the letters dated 14 February 2022 (from the Sub-Regional Disability Advisory Group and the Muscular Dystrophy Association) regarding the communications led by the Ministry of Health and the distress that the communications have caused.

(c) Agreed that the 2DHBs advocate to the Ministry of Health and DSS that it take a business continuity approach to planning for homecare support for the disability community and that the 2DHB Disability team expresses the concern of our 2DHBs to the Ministry regarding the approach that has been communicated (reflecting the discussion at the 16 February 2022 Board meeting)

Procedural note: underlined text reflected discussion at the meeting and the Board request that the steps to be taken by 2DHB staff were recorded in the resolutions.

	Moved	**Seconded**	
HVDHB	Ken Laban	Ria Earp	**CARRIED**
CCDHB	Chris Kalderimis	Vanessa Simpson	**CARRIED**

Notes:

Covid

- The SRO for Covid spoke to the paper and the overall co-ordination of the Covid response, in light of the significant change when the response shifted from Delta to Omricon.
- Noted that this week that Government has announced that we are moving to stage 2 of the Covid framework and the changes to how Covid cases will be tested and managed in the community.
- The focus is now on the care in the community part of the response.
- The booster and 5-11 year old vaccination program is key – and we are making good progress on booster rates (63 % across both DHBs for the booster)
- Discussed the strategies for raising child vaccine rates and it is a different approach to the Festival approach from last year. Recent communications have been focused on preparedness (for care at home) and this is changing to supporting families to get children vaccinated. Working in partnership with schools.
- Testing capacity is being monitored and pressure on lab processing and the public messaging to only get tested if have symptoms

PUBLIC

- Noted the intended shift to rapid antigen tests (RAT) and distribution. Comfortable that have sufficient supply to meet short to medium term demand.
- Modelling is being reviewed against information on tracking of the virus and no updates from what is in the Board paper.
- The CMO outlined the priorities in Clinical governance – noting that the 2 main risks are workforce (community and Provider) and the interaction between the Community and the Hospital. Discussed the pathway for patients with Covid and patients in hospital because of Covid.
- From next week will have a RAT test process in place for staff and also will RAT test all acute patient cases. Also revising the use of N95 masks.
- Discussed plans to address workforce pressures – in terms of hierarchy of services that can be reduced and the contingency planning.
- Discussed the issues arising from the current protest at parliament and noted impact on ED given that patients that present may not disclose vaccination status and may not comply with testing and mask use requirements. Also monitoring the public health risks.
- Discussed the care in the community model and specific isolation requirements now in phase 2 of Omicron. Noted that a total of 266 cases (116 active and 148 recovered cases). Most people are able to self-monitor and care for themselves at home. The central coordinating hub is delivering through Spokes and working closely with social sector agencies.
- Noted the facility upgrade work within our Hospitals and the 4 projects approved by MOH prior to Christmas. All a progressing and the most visible is the portico outside ED to assist with screening.
- Discussed equity of outcomes and approaches to Maori, Pacific and Disability –the key is working with providers to increase the vaccination rates for children. Working with schools.
- Outcome data be recorded and reported and be used for responding to the insights
- Discussed the interagency and all of government response- coordinated through the Regional Leadership Group and co-location of staff in the regional hub.

Homecare support

- The co-Chair of SRDAG was invited to address the meeting and outline the concerns in their letter sent to the Board, and referred to the correspondence that clients of Disability Providers have received – and that this is based on communications that were issued by the MOH, the 20DHBs and ACC. The communications have come across as stating that in the event of an Omicron outbreak, disability (and aged care) clients would need to plan ahead and provide their own backup support through friends and family and other networks.
- It was noted that the caring needs of those impacted are for essential and basic human rights and as such it is not tenable to say to people 'you are on your own and have to look after yourself'.
- The communication was not consistent with SRDAG's experience working with Regional Public Health, and the staff from the DHBs' Disability Team – and that there has been a breakdown in communication with the MOH (and in particular the DSS).
- MOH have not engaged with disabled people and planning for workforce support the already stretched workforce in the Homecare Support sector.
- It was acknowledged that the 2DHB responsibility relates to homecare support for +65s and long term care – and that the issues were being raised with the Ministry/ DSS
- The Acting Director Strategy, Planning and Performance, responded and noted that as 2DHBs we share many of the concerns raised. The communications and approach need to be tailored and respectful and the communications led by the Ministry, through the DSS system, have not met our expectations and is not what we would expect.

PUBLIC

- Our Covid response team includes representation from our Disability team and there has been considerable effort to make sure the Covid response meets the needs of our disability population. When it comes to workforce issues that are anticipated with an Omicron outbreak, this is a business continuity issue, in the context of a sector that is already managing workforce constraints and which has been impacted by the mandates. This is mitigated by some of the exemptions for Health Care workers (in terms of isolation periods and return to work protocols).
- However there will be constraints during the peak of the outbreak, where our modelling shows that the sector may have up to 30% vacancy. For these scenarios, there are layers of support services that will be impacted in a staged way, and that the planning is that personal care will not be impacted in the way that the MOH communication indicates might be likely.
- Our nationally recognised Disability leadership team will engage with the MOH and the DSS regarding how we correspond with and work with the Disability community and encourage the MOH to change their approach and revisit their communications.

3.0 STRATEGIC PRIORITIES

3.1 STRATEGIC PRIORITIES UPDATE

The Boards noted:

(a) progress implementing the strategic priorities to be delivered in 2021/22 as we transition to the new health and disability system

(b) the proposed next steps and updates the Boards will receive for the remainder of the 2021/22 year.

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Ria Earp	**CARRIED**
CCDHB	Vanessa Simpson	Chris Kalderimis	**CARRIED**

Notes:

- Commissioning and community – noted the prototype approach with the population focus of Porirua and the need to make progress on the other locality areas. Noted that the localities programme of work will be considered at the HSC meeting on 16 March 2022.
- Presentation on the Mental Health and Addictions Commissioning Change Programme (see attached).
- Maternity and neonatal – questions raised and whether the issue of birthing supplies has been actioned as requested and Board members were updated on the steps in place.

Strategic Priorities Board Update 16022

Mental Health, Addiction and Intell

Procedural note:

PUBLIC

The public meeting was adjourned at 11:45am to enable the public excluded meeting to commence at the time arranged with the Rheumatology Service. It was agreed that the public meeting would reconvene after the lunch break - at 1:45pm.

In order to facilitate this, the resolution to exclude the public was moved and seconded as follows:

5.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**	
HVDHB	Prue Lamason	John Ryall	**CARRIED**
CCDHB	Sue Kedgley	Kathryn Adams	**CARRIED**

The public meeting was reconvened at 1.45pm

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB FINANCIAL AND OPERATIONAL PERFORMANCE REPORT – DECEMBER 2021

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

The HVDHB Board noted:

(a) the DHB had a ($3.1m) deficit for the month of December2021, being ($0.6m) unfavourable to budget;
(b) the Funder result for December was $0.5m favourable, Governance $0.1m favourable and Provider ($1.2m) unfavourable to budget;
(c) total Case Weighted Discharge (CWD) Activity was 4% ahead of plan year to date;
(d) the DHB year to date deficit, excluding COVID-19 costs, was ($7.4m). This is against the budgeted position of ($9.2M), which is $1.8M favourable to the underlying budget.

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Prue Lamason	**CARRIED**

2.2 CCDHB FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS – DECEMBER 2021

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

The CCDHB Board noted:

(a) The DHB had a ($6.2m) deficit for the month of December 2021, being ($3.2m) unfavourable to budget before excluding COVID-19;
(b) In the one month we incurred ($3.7m) additional net expenditure for COVID-19;
(c) The DHB has an overall YTD deficit of ($14.8m) from normal operations (excluding COVID-19) which is $3.2m favourable to the underlying budget.

	Moved	**Seconded**	
CCDHB	Brendan Boyle	Roger Blakeley	**CARRIED**

PUBLIC

Notes:

- Planned care is a significant challenge – locally and nationally. Recovering waitlists through the private sector, however the private sector is affected by the same challenges.
- Noted the favourable variances and maintaining tight financial controls until year end.

4.0 UPDATES (CONTINUED)

4.2 3DHB DATA AND DIGITAL UPDATE – Q2 REPORT

The paper was taken as read and the 3DHB Chief Digital Officer was available for questions.

The Boards noted:

(a) The content of the attached Data and Digital update report for Quarter 2 2021/22.

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

(c) Co-ordination of ICT-related COVID requests for the 2DHBs.

(d) The core clinical work programmes – Single Clinical Portal and transition to the Regional Radiology Information System are progressing on track.

(e) A significant increase in the number of clinical equipment lifecycle projects that require ICT involvement due to clinical technology evolution.

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

(g) Central Region DHBs with (Mid-Central DHB as the lead DHB) have issued an RFP for eReferrals.

	Moved	**Seconded**	
HVDHB	Naomi Shaw	Prue Lamason	**CARRIED**
CCDHB	Kathryn Adams	Brendan Boyle	**CARRIED**

4.3 MĀORI HEALTH UPDATE – QUARTER 2

The paper was taken as read and the 2DHB Director Māori Health was available for questions.

The Boards note:

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

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

(c) Whare ki te Whare Kaiarahi – Navigation service.

	Moved	**Seconded**	
HVDHB	Yvette Grace	John Ryall	**CARRIED**
CCDHB	Vanessa Simpson	Kathryn Adams	**CARRIED**

Notes:

- Noted significant vaccination progress and focus on 5-11 year olds and as yet unvaccinated Maori population

PUBLIC

- Discussed the Rheumatology issues raised in the Spotlight Service and request that insight of any data held is reported in the quarter 3 reports.

4.4 2DHB PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN FOR THE GREATER WELLINGTON REGION 2020 - 2025: PROGRESS & PERFORMANCE REPORT NOVEMBER 2021 – FEBRUARY 2022

The paper was taken as read and the Director Pacific People's Health was available for questions.

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 November 2021 – February 2022 on activities across the system to support equitable Pacific health outcomes for the six priority areas.

(b) There are a number of initiatives that have occurred during the period of the report to meet the actions of the Strategic Plan.

(c) The Covid-19 response for Pacific.

(d) The Pacific Directorates' planned approach to support the DHBs to achieve the 2DHB Strategic Priorities and a proposed Analytics Roadmap, charting the course of actions which will support this

	Moved	**Seconded**	
HVDHB	Ken Laban	Prue Lamason	**CARRIED**
CCDHB	Chris Kalderimis	Sue Kedgley	**CARRIED**

Notes:

- Staff to meet with Rheumatology department to see what support can be provided for Pacific patients.

4.5 2DHB QUALITY & SAFETY – CLINICAL GOVERNANCE AND THE CENTRE OF CLINICAL EXCELLENCE

The Boards **note:**

(a) the overview of Clinical Governance and the Centre of Clinical Excellence.

(b) the priorities for the first six months of 2022 (as noted in Appendix 3)

	Moved	**Seconded**	
HVDHB	Josh Briggs	Ken Laban	**CARRIED**
CCDHB	Chris Kalderimis	Sue Kedgley	**CARRIED**

Notes:

- Moved from Quality Assurance model to Quality and safety model.
- The foundations are in place to move to a centre of clinical excellence.

5.0 OTHER

5.1 GENERAL BUSINESS

Nil.

PUBLIC

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

DATED this day of 2022

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 30 MARCH 2022

Action Number	Date of meeting	Assigned	Status	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status
2022-2	16-Feb-22	Chief Executive	In progress	Public	2.1	Covid Update - Homecare Support	The Board agreed that the 2DHBs advocate to the Ministry of Health and DSS that it take a business continuity approach to planning for homecare support for the disability community and that the 2DHB Disability team expresses the concern of our 2DHBs to the Ministry regarding the approach that has been communicated (reflecting the discussion at the 16 February 2022 Board meeting).	An update of steps taken will be provided at the Board meeting on 30 March 2022 as part of the COVID-19 Update (item 5.1 of the public agenda).

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 28 January 2022 to 16 March 2022.

2 Communications and Engagement

2.1 External engagement with partners and stakeholders

Given the current Omicron outbreak, the main focus has been on ongoing engagement with iwi, Māori providers, Pacific providers, primary health, community partners, councils, Regional Leadership Group partners, the new Regional COVID Coordination Centre, and government agencies as we roll out public health messaging, the COVID-19 Care in the Community programme, and the ongoing vaccination campaign.

2.2 External communications and engagement – news and media

DHB	Subject	Outlet / Channel
2DHB	Marked the closure of the Bay Plaza MIQ facility.	Websites
2DHB	Te Wao Nui update.	Websites
2DHB	Advised people to seek COVID-19 tests in the community rather than ED.	Websites
CCDHB	Notified that a member of WRH staff has tested positive for COVID-19.	Websites
2DHB	Celebrated one of our registered nurses becoming the region's first Pacific nurse practitioner.	Websites
2DHB	Information about COVID-19 measures, patient volumes and wait times.	Websites
2DHB	Marked World Hearing Day.	Websites

2DHB	Visitor policy update.	Websites
2DHB	Update on testing locations and data availability and highlighted aggressive behaviour by people at testing centres.	PR / websites
2DHB	Explanation of the 'Care in the Community' framework.	Websites
2DHB	Highlighted new Wellington ED and Hut Hospital renal infrastructure initiatives to bolster hospital resilience.	PR / websites

Commissioning and Community

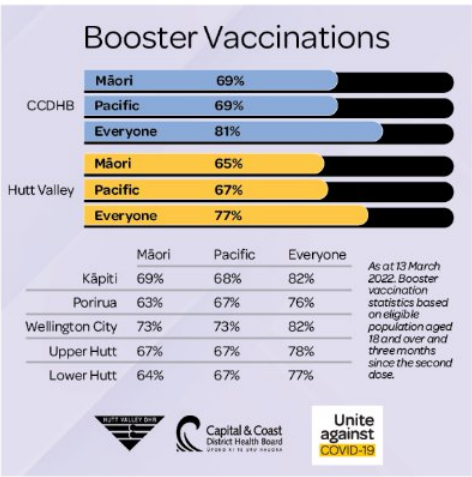
Our People

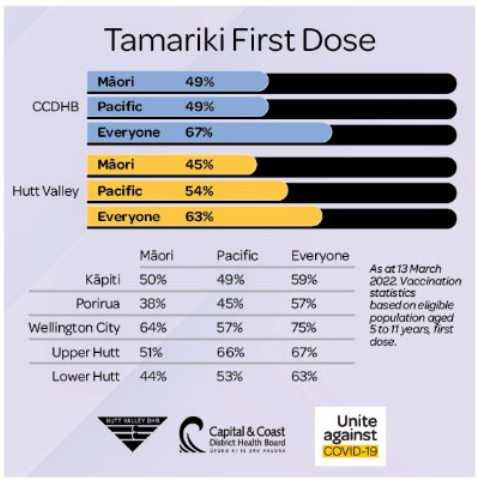
3.3 Health promotion campaigns

Vaccination programme highlights

In mid-February, we reached our goal of 90 per cent of eligible Māori in the Hutt Valley DHB who have had their second dose. This is a fantastic achievement and testament to the great mahi and collaboration between Māori providers, PHOs, the local pharmacy network and the DHB.

At 13 March, we reached over 80 per cent for boosters and 67 per cent of tamariki first dose across the Capital and Coast DHB region and 77 per cent for boosters and 63 per cent for tamariki first dose in the Hutt Valley. Information on vaccination by locality at 13 March is shown below.

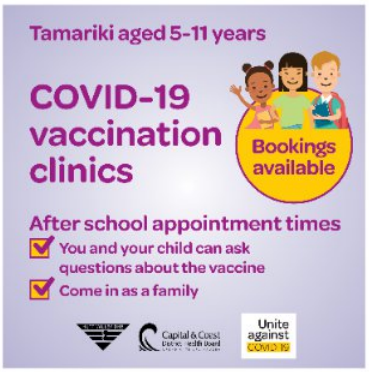




There are over 60 clinics operating in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites. Mobile outreach clinics continue to focus on areas with lower vaccination rates such as Naenae in Lower Hutt.

The Pacific Health team working alongside Pacific providers and PHOs are focusing on reaching families for boosters and 5-11 year old vaccinations including new community-based evening clinics. Our 2DHB Disability Team is working with schools with a disability focus, or disability units to see what will work best for them.

We continue to work with schools, however the high percentage of children sick or away from school means we are reviewing the viability of in school pop up clinics and considering other options including drive-through community clinics.



We have focused on communicating key messages (through social, website and provider channels) about tamariki vaccinations and clinics that offer convenient after school or weekend appointment times.

In February, we ran pop-up clinics at schools in Porirua and Lower Hutt. We also created information packs (digital and hard copy) for schools to share with parents including 'How to Prepare your Tamariki', FAQ and additional clinic options in their local area. These packs have been well received and we continue to provide information to school principals as needed.

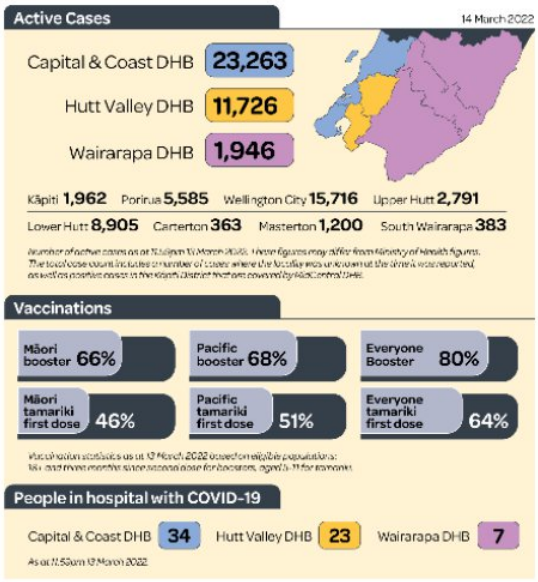
Care in the Community

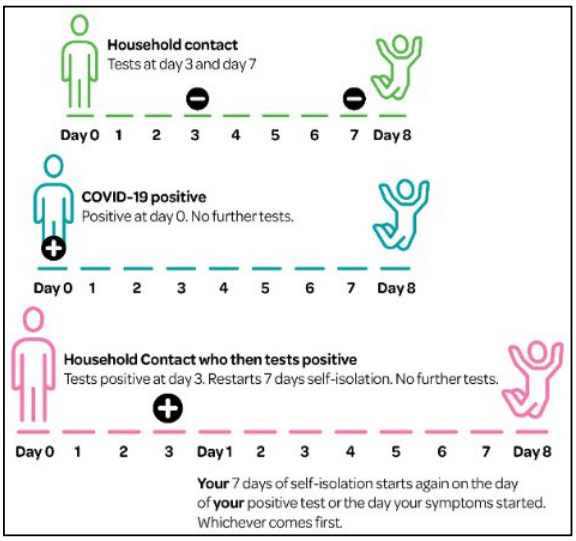
As the number of positive cases and people isolating increases in the Greater Wellington region, there have been a number of changes to the rules and requirements, as well as a huge increase in the health and manaaki needs within our communities.

The new 3DHB COVID-19 social media hub continues to quickly build a local following, with more than 8,700 highly engaged followers by the end of February. The daily comments and questions are showing that many people are trying to follow the rules but are finding some of the information and changing situation confusing. This has given us an opportunity to be responsive and tailor our information towards what people are asking about the most.

The new 3DHB website has also launched and is being constantly updated to provide information in simple, clear terms while providing links to the most useful and accurate tools and resources. This has replaced the Vaccinate Greater Wellington website and covers all aspects of the COVID-19 Care in the Community programme.

The main focus has been on providing reassurance to the community as many people have been scared and stressed about the rising numbers of cases in the community. To ensure consistent and accurate communication on key metrics such as active cases at the local level, a new public reporting process was instituted whereby active cases, vaccination uptake and hospitalisation numbers are released twice a week via Facebook and the website.





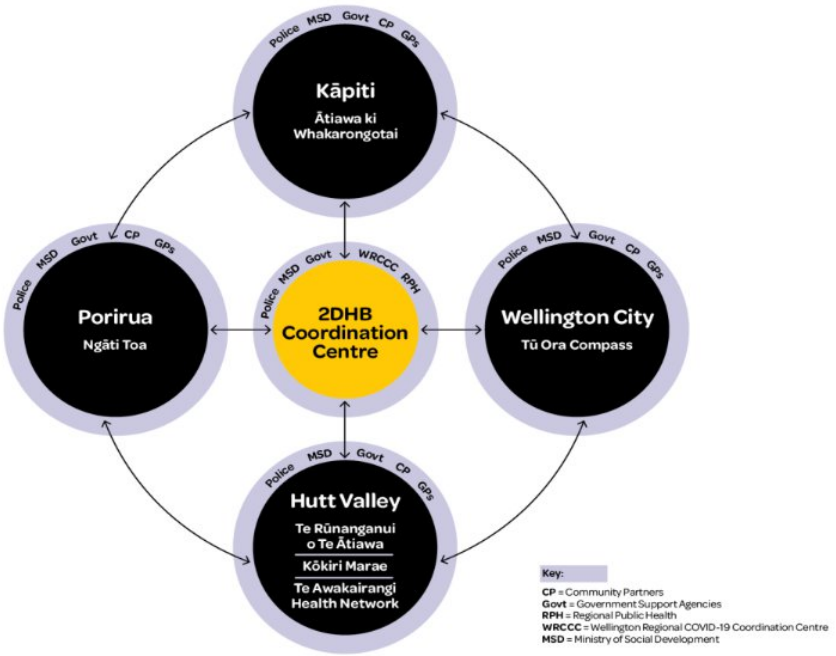
Recent key messaging has been focused on making the isolation and testing timeline as simple as possible by using graphics and collateral (as per the visual shown), as well as reinforcing the need to continue to get vaccinated and how to access rapid antigen tests.

We have also looked to involve our followers in peer-to-peer communication by providing their own tips for people who are isolating.

Care in the Community programme

We continue to work closely with the different organisations involved in the COVID-19 response at local, regional and national levels including councils, WREMO and the Regional Leadership Group, to plan and implement our communications and public information strategy.

This involves our ‘hub’ and ‘spoke’ network as shown below, and includes sharing information to ensure that information for both public and stakeholder audiences is easy to access, and putting in place shared communications, channels, and resources for the public.


Police MSD Govt CP GPs
Kāpiti
Ātiawa ki Whakarongotai
Police MSD Govt CP GPs
Porirua
Ngāti Toa
Police MSD Govt WRCCC RPH
2DHB Coordination Centre
Police MSD Govt CP GPs
Wellington City
Tū Ora Compass
Police MSD Govt CP GPs
Hutt Valley
Te Rūnanganui o Te Ātiawa
Kōkiri Marae
Te Awakairangi Health Network
Key:
CP = Community Partners
Govt = Government Support Agencies
RPH = Regional Public Health
WRCCC = Wellington Regional COVID-19 Coordination Centre
MSD = Ministry of Social Development

2.4 External stories and releases

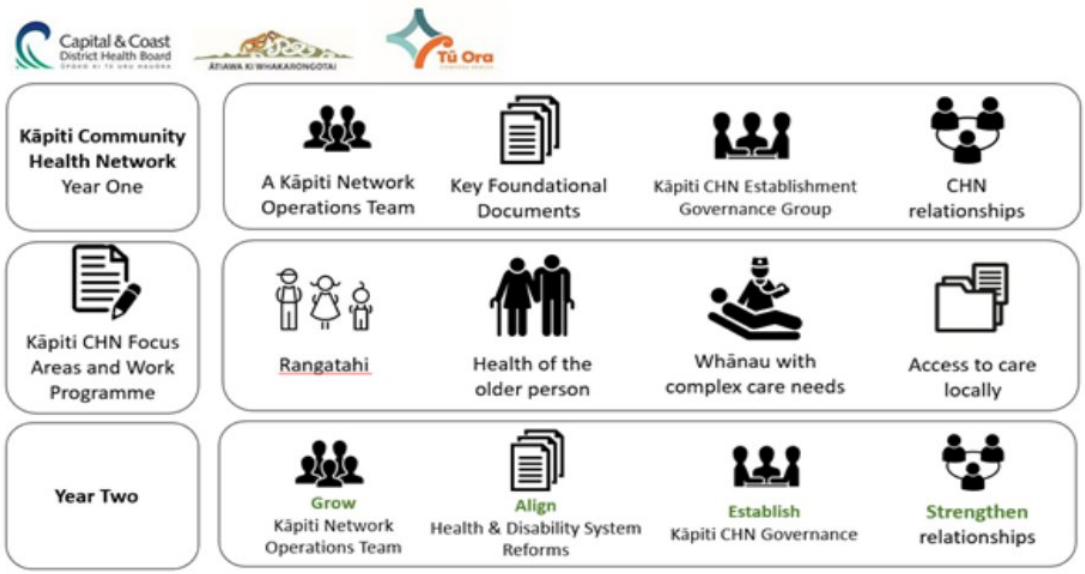
Kāpiti Community Health Network

Since its official launch in November 2020 the Kāpiti Community Health Network has gathered strength and momentum. Health care is being delivered to people more efficiently and effectively through a central organising point of health providers. The network means people can be treated and supported more in the community, and connected to specialist services when they need it.

Kāpiti Community Health Network is a team of local leaders and providers dedicated to re-aligning and strengthening local health service provision for the benefit of Kāpiti people and Whānau. The Network is being developed in partnership with Te Ātiawa ki Whakarongotai, Tū Ora Compass Health and CCDHB, and has four focus areas – health of older people, rangatahi, whanau with complex needs, and access to care closer to home.

Some of the key initiatives completed or underway include:

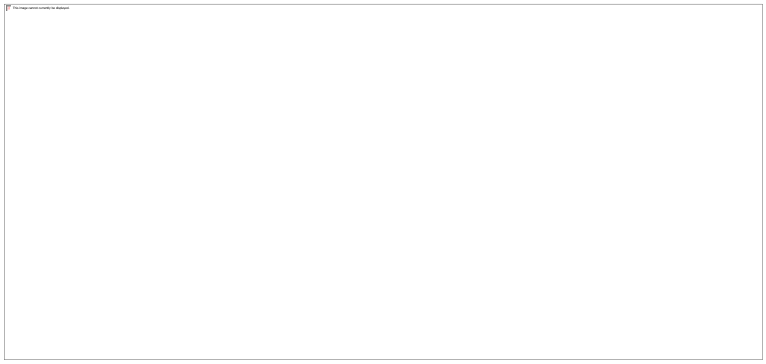
- Establishing coordinated care and an outreach clinic for residents with complex care needs
- The Kāpiti Ambulance Diversion expanding to include direct referrals to Community ORA
- Coordinating a networked community pharmacy initiative for patients with complex needs including: community pharmacy, clinical pharmacist in primary care, general practice and hospital pharmacy.
- Wānanga day at Whakarongotai marae attended by over 50 clinicians



CSIQ response team – heroes at work

Our People

There are many heroes at work in health. Two people in 2DHB who are distinguishing themselves right now are Alister Thorby and Tracey Albertsson working in the COVID-19 Response team. Alister and Tracey have worked non-stop providing support for those who have contracted COVID-19 in the region as well as those who are close contacts that require isolation.



Each day there has been a new scenario with all cases being less than straightforward. Their goal is to quickly build a trust relationship with those they are meeting and supporting with the aim of gaining compliance while staying in isolation.

It has at times been difficult work as they often have to work through complex problems of non-compliance, domestic violence, mental health, fear, confusion. They have many, many stories from the work so far, but often, once the clinical considerations have been ascertained, it can come down to something as simple as getting hot food to a family about to arrive home late at night to a house without food.

They have bought clothes, made connections with GPs and landlords, and helped in transporting people in order to create coherency from the word go in their COVID-19 journey.

Says Tracey: “Most importantly the people in isolation know they have friends on the outside. There have been many days where we are still at work into the early hours.”

While they continue their work, as case numbers rise Tracey and Alister are mentoring and supporting the Spoke Lead organisations based on their learning curve of the past few months.

40 years in Health culminates in true success – “coolect grandmother”

Our People

Hutt Valley based Kokiri Marae Keriana Olsen Trust is one of Care in the Community Covid Response Spokes. At the same time as handling massive numbers of referals for covid-related support, Kokiri became a target for protestors dispersing after eviction from Parliament.

Teresea Olsen was at the front line as the Wainuiomata community gathered to fend off the abusive attacks at the entrance of the marae Covid vaccination clinic. With police on site and the police helicopter circling above, Teresea and her team held their ground. However, it was the sudden 8000 likes on TikTok where Teresea was seen making a stand that caught the attention of Teresea’s seven-year-old grand daughter.

Teresea says: "Suddenly I was the coolest grandmother on earth. So, after 40 years of working to raise awareness in health I have suddenly made it in the eyes of someone I love very dearly. What could be better."

Shout out to our MIQ team

Our People

Not all visitors come by air. The crew on the container ship Timaru Star welcomed our MIQ swabbing team aboard so they could get tested before being allowed on shore leave. The team performed RATs so the crew got their results quicker and were able to enjoy Wellington's balmy weather of the past few days.

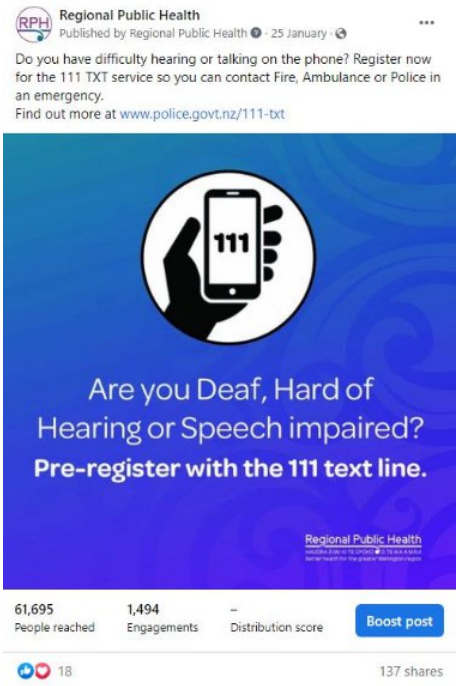
Left: Vanessa Pickens, Katie Wheeler and Marie Habowska dressed for the occasion

2.5 Social media views and stories

2.5.1 Top social media posts

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 1,201,086 Twitter: 13,536 LinkedIn: 48,223	Facebook: 305,267 Hutt Maternity Facebook: 6,383 Twitter: 4,596 LinkedIn: 17,813	Facebook: 124,871

2.5.2 Regional Public Health social media focus



Left: Popular RPH post that was picked up and widely shared by Fire and Emergency branches across New Zealand. Right: One of a series of simple messaging tiles around staying home if unwell.

In late January – there was public need to explain the difference between Exposure Events and Locations of Interest.

2.6 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
223,905 page views	61,336 page views	72,529 page views	15,841 page views

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

- Exemption for face coverings
- COVID-19 Community based assessment centres
- Connect Me and Webmail
- Careers with CCDHB
- COVID-19: changes to our services

Top five webpages HVDHB

- COVID-19 Community based assessment centres
- COVID-19: Information for visitors
- Contact us
- Hutt Hospital campus map
- Careers with HVDHB

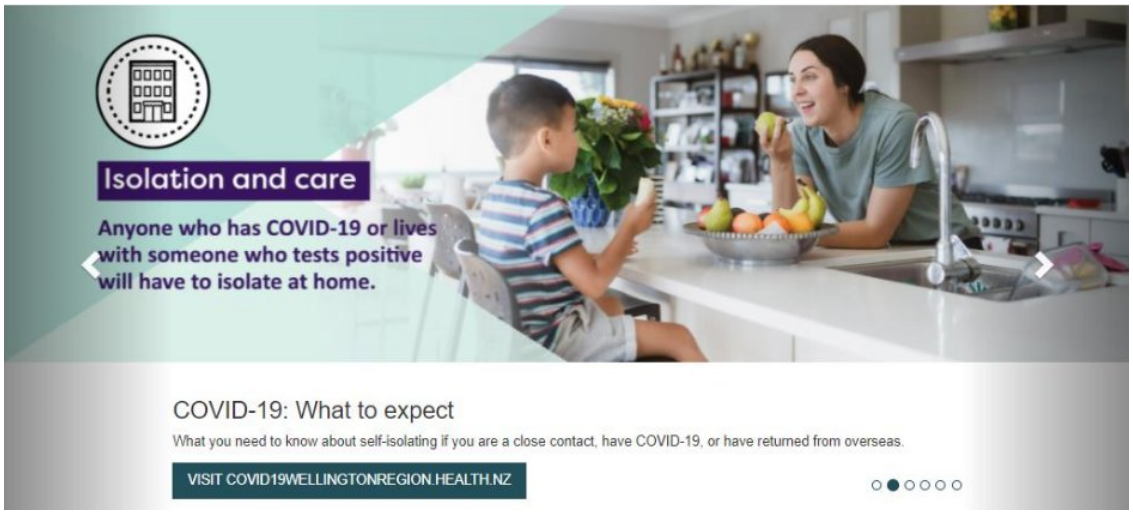
Top five webpages RPH

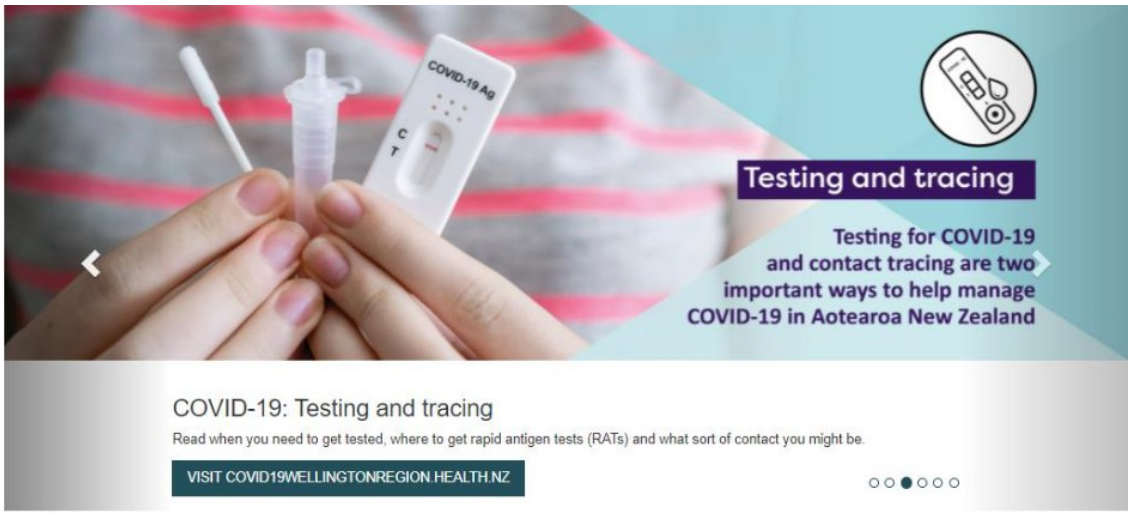
- Vaccination Centres
- Getting Vaccinated
- COVID-19 FAQ's
- Get vaccinated in Wellington, Porirua the Hutt Valley and Kapiti
- RPH Home page

Top five webpages MHAIDS

- Index page https://www.mhaids.health.nz/
- Child and Adolescent Mental Health Services
- Do you, or does someone you know, need help now?
- Community Mental Health Teams
- How to contact us
- Central Region Eating Disorder Services

New website banners





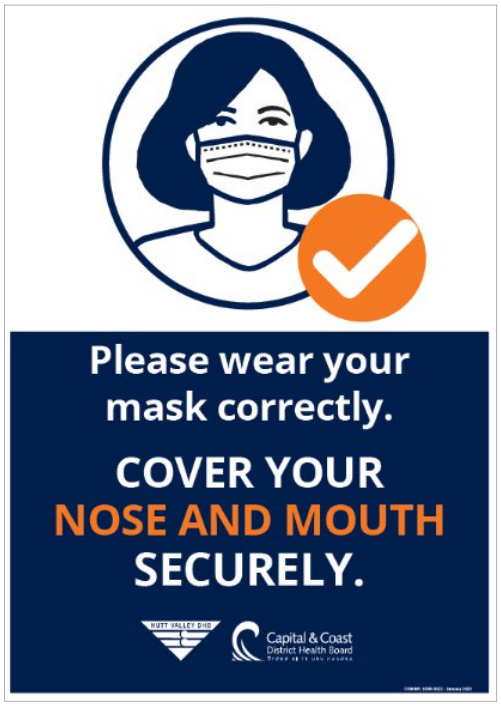
2.7 Internal Communication and Engagement

2.7.1 Intranet page views and stories

CCDHB	HVDHB
104,205 page views	183,597 page views

2.7.2 Staff posters

We have focused heavily on correct mask use to avoid COVID-19 transmission.



2.7.3 Top intranet stories

Catherine Soana Latailakepa Tu'akalau – Leading the way for Pacific nurses

History has been made with Hutt Valley and Capital & Coast DHBs celebrating the first Pacific nurse practitioner in the Wellington region!

Despite the challenges experienced across our region related to COVID-19, we have many milestones and developments to celebrate.

Catherine Soana Latailakepa Tu'akalau, of both Samoan and Tongan descent, has achieved what no other Pacific nurse in Wellington has done and progressed from a registered nurse position to a qualified nurse practitioner.

Mātanga tapuhi nurse practitioners combine advanced nursing knowledge and skills with diagnostic reasoning to manage patient centred care—their advanced education and training sees them taking a key role as a lead healthcare provider in partnership with health consumers and their whānau.

See the full story here.

Degu Geddebo – Riding for lives

Degu Geddebo has turned cycling to work up a few gears!

Scott Stoll, a man who travelled around the world on his bicycle once said, "A bicycle ride around the world begins with a single pedal stroke".

Well, this bicycle ride may not be close to around the world, but there is no denying the mammoth feat Wellington Hospital Paediatric SHO Degu Geddebo has almost completed, cycling from his home in Wainuiomata to Wellington Hospital and back for 28 days.

Degu, originally from Ethiopia, has been undertaking the long bike ride to work as part of the Aotearoa Bike Challenge, but also to remember the innocent lives lost during the ongoing war in Ethiopia.

His goal is to ride 400km in the month of February as well as raise funds to rebuild hospitals destroyed back in his homeland.

He is hoping to raise one dollar for every kilometre cycled.

With just one more week to go, Degu is calling for more cyclists to join him in the challenge, whatever route you may want to take, and also help him raise funds for such an amazing cause.

“Riding from Wainuiomata to Wellington has been very hard, especially the Wainuiomata Hill which is quite tough. I would like to involve more people to join me for the rest of the challenge. The other thing I would like to achieve is raise some money which can be used to rebuild the hospitals in Ethiopia.”

If you would like to contribute to this great cause here is the link to Degu’s Givealittle page: https://givealittle.co.nz/cause/bike-challenge-to-help-rebuild-hospitals-destroyed.

“I would like to thank everyone who is participating in this challenge and I hope we have more time to go and we can achieve more together.”

World Hearing Day 2022: Listening right

March 3 marks World Hearing Day and this ‘ear’, the theme is ‘To hear for life, listen with care’.

Each year, the World Health Organisation (WHO) focuses on a theme to raise awareness on how to prevent deafness and hearing loss and promote ear and hearing care across the ‘lobe’. The 2022 theme is, ‘To hear for life, listen with care’.

And the safe listening message could not have come at a better time according to Hutt Valley DHB Audiology Professional Leader Kylie Bolland, who said with sound/audio technology ramping up intensely over the years, so has the potential further risk to our hearing safety, particularly in younger generations.

“Historically it has been older males in particular working in very noisy environments that induces hearing loss. But what the concern now is that we are seeing younger people having noise damage from recreational activities, such as listening to music loudly.”

Bolland said on average it takes seven years for people to realise from the first time they feel they have got a hearing problem to when they actually get a hearing test’ and do something about it. So now, it was all about getting people aware that regular loud noise can cause significant hearing damage in the long run. See the full story here.

2DHB BOARD WORK PLAN 2022 – 30 March 2022 - *All meetings on zoom until further notice*

	Fri 13 May 2022	Wed 22 Jun 2022
Service Spotlight	**Community Dental Service**	**TBC**
2DHB and MHAIDS Quality and Safety	2DHB Quality and Safety Report	2DHB Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting		
Financial and Operational Performance HVDHB	Report for March 2022	Report for May 2022
Financial and Operational Performance CCDHB	Report for March 2022	Report for May 2022
Scheduled reporting		
People and Culture Report	People and Culture Report	
3DHB Digital Report	Q3 Report	
Māori Strategy (Te Pae Amorangi and Taurite Ora)	Q3 Report	
Pacific Health and Wellbeing Strategic Plan	Q3 Report and selected focus area	
Strategic Priorities		
Strategic Priorities Overview	Strategic priorities update	Strategic priorities update
Our Hospitals	TBC	Our Hospitals and the 2DHB Hospital Network Update
Commissioning and Community		
Mental Health and Addiction Services		
Maternity & Women's Health		
Committees		
FRAC items for Board Approval	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 27/04/2022	MCPAC update from meeting dated 27/04/2022
HSC update and items for Board Approval		
DSAC update and items for Board Approval		
Engagement		
Te Upoko o te Ika Māori Council (TUI MC)	Boards meet with TUI MC (**TBC**)	
Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group
Annual Planning and Reporting		
Budgets for 2022/23	**Advice to each DHB**: The 22/23 budget process will be run by interim Health New Zealand and the budgets for each entity amalgamating into HNZ will be agreed by the HNZ Board. These budgets do not get agreed by the outgoing DHB Boards.	
Annual Report	N/A	
Other items		
Environmental Sustainability Strategy		
Procedural and Board process issues		
Action log items and other		
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)		
Site Visit		

Board Information – Public

30 March 2022

2DHB Strategic Priorities Update

Action Required

The Boards note:

(a) Progress in relation to the implementation of the strategic priorities to be delivered in 2021/22 as we transition to the new health and disability system

(b) we are continuing to progress the Strategic Priorities Work Programme with risk being actively managed in our constrained COVID-impacted environment.

Strategic Alignment	We will focus on moving as far as possible towards achieving equity, clinical excellence, and financial sustainability to ensure the needs of our populations are met during a period of change. Our priorities align to the Government's planning priorities for health and the Minister's Letters of Expectations. Our work on the priorities is consistent with the transition to the new health and disability system.
Presented by	Fionnagh Dougan, Chief Executive, CCDHB and HVDHB
Purpose	This paper updates the Boards on progress towards implementing the agreed strategic priorities in 2021/22 as we transition to the new health and disability system.
Consultation	N/A

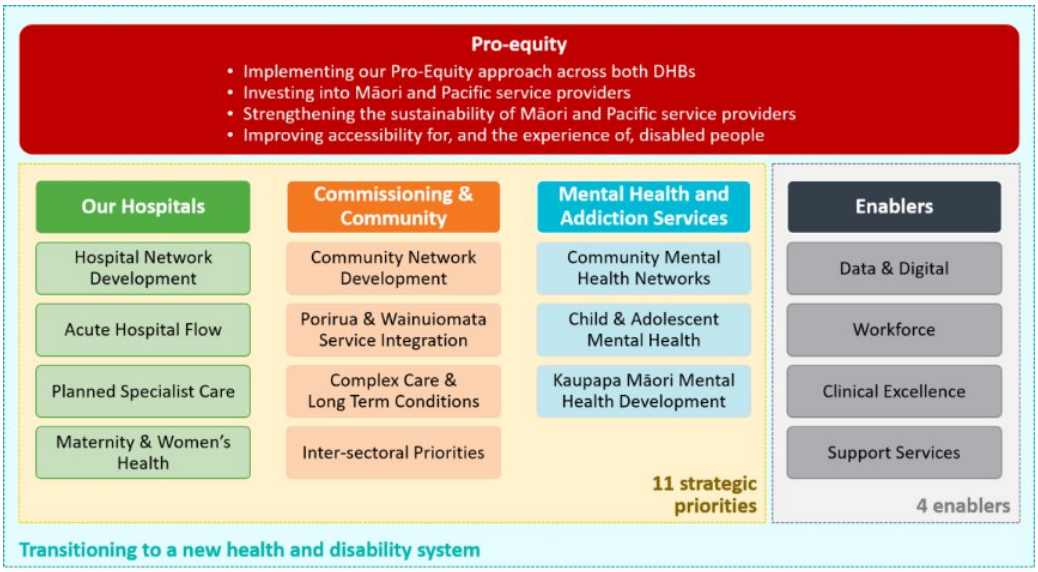
Executive Summary

Our DHBs are well positioned to support the planned changes to New Zealand's health and disability system. We have embarked on a transformation journey aligned with the direction and future of the wider health and disability system. Our focus remains on delivering equitable health outcomes and intensifying support for Māori, Pacific people and those living with disability, mental illness and addiction. We will:

- *accelerate work in focus areas that will support the plans of Health NZ and the Māori Health Authority.*
- *continue COVID-19 testing, vaccination efforts, RAT supplies and up-to-date public messaging*
- *continue to commission, fund, and deliver health outcomes for our local and regional population*
- *stop/pause some work that may duplicate efforts by other DHBs or national health organisations.*

This paper focusses on the first bullet point.

The Boards have agreed on the following strategic priorities and enablers to be delivered in 2021/22 as we transition to the new health and disability system:



The Maternity and Neonatal Health Strategy spans both the 'Our Hospitals' and the 'Commissioning & Community' workstreams.

Strategic Considerations

Service	Implementing our strategic priorities will improve service delivery across hospital, primary and community services and help maintain a strong focus on looking after the health needs of our populations during a time of change.
People	The Pro-Equity priority is woven through all work programmes and will contribute to our goal of achieving health equity and optimal health for Māori, Pacific peoples, and disabled people by 2030.
Financial	The investment process is focussed on implementation of the strategic priorities, and the enablers needed to support them. We continue to ensure we have resources (including executive time) targeted to this work.
Governance	A governance structure to support implementation of the strategic priorities is established.

Engagement/Consultation

Patient/Family	A specific communications and engagement approach underpins this work to support engagement and understanding.
Clinician/Staff	
Community	

Identified Risks

Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
There is a risk of diluting our focus and resources across areas of work that are not critical to the needs of our populations during this time of change and transition to the new system.	Fionnagh Dougan	Communicating an agreed set of strategic priorities and enablers ensures that we are focussed on meeting the needs of our populations during this period of transition. The Director Transformation role is designed to ensure there is executive level focus and alignment across the programme. We are ensuring that we progress key asset replacements to maintain the current standard of care and mitigate a further increase of patient risk.	Low Risk	Low Risk
The recent outbreak of the omicron variant of COVID-19 will disrupt the focus on our strategic priorities work programme. Although we are well prepared for this outbreak, the expected disruption will have an impact our community and hospital networks.	Fionnagh Dougan	We are actively monitoring our work programmes and resourcing to ensure that we manage both current COVID pressures and start planning for post-peak activity. We are working with partners so up-to-date messaging is shared with those most at risk. Our public messaging prioritises information about getting tested, managing symptoms, safe isolation, and accessing support. RAT supplies have been distributed to all staff and we have a robust restocking process for staff that have used and recorded initial tests.	Medium Risk	Medium Risk
There is a risk that the transition to the new system will take longer than expected. The localities work is a new way of working, as we are shifting the balance of power to communities. It requires careful planning and engagement, and we are waiting for clearer direction in some respects from Health NZ and the Māori Health Authority.	Peter Guthrie	We are working across the system to share understanding, build community capability, and support local service development and delivery. We need to support the voice of communities and Iwi in the development and delivery of services to meet local needs.	Low Risk	Low Risk

Implementing our Strategic Priorities

Governance

To support the role of the Executive Leadership Team (ELT), there are three ELT-led Forums overseeing the Strategic Priorities work programme.

Programme and Project Development – Key Deliverables

We have identified the work programmes and key projects that sit under each of four work streams required to deliver on the strategic priorities.

Rolling Programme of Reporting

There is a rolling programme of 'deep dive' reports and commissioning decisions to the concurrent Board and committees for each work stream. A paper and presentation on the 2DHB Hospital Network is on this Board agenda.

The Health System Committee meeting dated 16 March 2022 received reports and presentations on:

- 2DHB Maternal and Neonatal System Implementation Plan
- Commissioning & Communities: Progress Update on Localities and a paper on Health Care Home, Localities and Networks Funding.

The papers and presentations are available on Diligent and the Chair will report the noting and decisions recommendations to the Board at this meeting.

Work Stream Updates

Mental Health and Addiction

This work stream has four main projects that are underway and progressing well in spite of the challenges related to Covid-19. The community mental health and addiction services projects aim to improve local service integration and achieve equity, particularly improving Māori mental health and addiction outcomes. A Māori Expert Advisory Group has been established to provide guidance on the direction for mental health and addiction services to improve the outcomes for Māori and whānau.

Concept design working groups were held late last year to test the piloting of community mental health and addiction hubs. Workshops have also been held this year with a range of stakeholders including lived experience, primary care, Māori, Pacific and NGOs. Data analytics have highlighted areas for investment focusing on Kaupapa Māori. Recommendations will be made to the Mental Health Commissioning Forum in April 2022 about how services and providers could work in more integrated ways to meet people's needs.

These recommendations will feed into work to implement the Porirua locality prototype project, which is part of the Community & Commissioning work stream. The Mental Health & Addiction Services (MHAS) Team in the Strategy, Planning, and Performance directorate (SPP) is progressing our commissioning approach in the Porirua Locality prototype project, by identifying priority investment in Kaupapa Māori and Pacific services in partnership with the Mental Health, Addiction and Intellectual Disability Service (MHAIDS) Directors.

A presentation on the broader commissioning activity for the transformation programme was jointly provided to the Community Commissioning forum on 10 March. SPP is coordinating the MHAS community COVID-19 response and therefore disrupted progress on the community work stream is likely to continue throughout April.

The Child and Adolescent Mental Health project will focus on improving access and waiting times by strengthening the application of the Choice and Partnership Approach (CAPA).[1] Working groups have been established to progress this work. There will a concurrent project that is designed to improve integration between child and youth providers through the development of a stakeholder network.

Planning for the new acute mental health unit, Te Whare Ahuru, at Hutt Hospital is ready to commence, subject to the development of the Project Control Group by the Health Infrastructure Unit at the interim Health New Zealand. Work on the model of care to support the detailed design for the new unit with occur concurrently.

By June 2022

By the end of June 2022, we anticipate:

- a newly refined intake and assessment approach will be established to enable the timely and efficient management of referrals to MHAIDS
- a strengthened model of service delivery (CAPA) for the community Child and Adolescent Mental Health Service will be implemented
- an agreed model of service delivery and plan for investment for Kaupapa Māori Mental Health and Addiction services
- a model of service delivery will be confirmed for Integrated Community Mental Health and Addiction Services, together with an implementation plan.

Community & Commissioning

The Community & Commissioning work stream is focused on implementing the 2DHB strategic objectives in a way that is closely aligned to the health reforms. This includes undertaking work to ensure that the 2DHB area is ready to transition into providing integrated locality-based networks of primary and community care. The locality approach is intended to drive a focus on equity and priority populations, taking a place-based approach using population-health analytics and community engagement to plan and deliver services with communities in a way that enables local needs and preferences to be met.

The voices of communities are essential to realise the potential of a localities model and our current work programme seeks to work closely with mana whenua and other community leaders to ensure the aspirations of our communities are realised. DHBs, Health NZ and the Māori Health Authority are expected to be 'servant leaders' – where the role of a leader is to serve, with a primary focus on the growth and well-being of people and their communities.

In partnership with Ngāti Toa, we have submitted a proposal to the Transition Unit for Porirua to be a prototype locality. The Transition Unit allocated additional funding ($20,000) to support the development of the prototype proposal. The final submission was signed off by the chief executives of Ngāti Toa, CCDHB and Tu Ora Compass and presented jointly to the Transition Unit on 22nd February. The feedback at this presentation was positive and we expect to hear from the Transition Unit before the end of March. Regardless of the outcome of the prototype process, the partners involved in the development of the submission are committed to taking this approach in Porirua. Funding has been identified (from released Health Care Home investment) to support the development of the locality model and discussions are underway with Ngāti Toa in relation to how this funding can be best used to support this work.

[1] CAPA introduces ways of working that increase the efficiency and quality of services by implementing systems to utilise resources effectively while keeping the service user at the heart of the process. This includes making sure that children, young people and their family/whānau are met in a timely fashion, listened to and respected, offered all options available, given opportunity to voice their views and are supported with their decisions.

With the knowledge of mana whenua a small group of health system experts from the DHB, PHO and local providers has been formed to work on the foundational information necessary to support the implementation of a locality approach in Wainuiomata. They have undertaken initial stakeholder analysis and collected data to support a community asset mapping exercise. The initial analysis is being actively engaged with by mana whenua (who are focused on the COVID response currently) and other community partners for consideration of next steps. Mana whenua are keen to engage on the information through the Marae network once the current wave of COVID has passed. Mana whenua is also keen to extend the analysis to Naenae, Taita, Stokes Valley and parts of Upper Hutt. The DHB has seconded a project lead from SPP to Te Atiawa. This is strengthening our partnership relationship and is increasing the ability of the Iwi to leverage the foundation work and lead future action towards a full localities model. The analysis work will also be presented to the Healthy Families Hutt Valley Senior Leadership Group in April. The working group has reviewed the Collective Impact framework used to underpin the development of a number of Whānau Ora models nationally and we are working with the Healthy Families team to develop training workshops for partners on this approach. A detailed plan setting out the resources available is being developed to ensure that locality and network development are prioritised across the Hutt Valley area in 2022/23.

In partnership with Te Ātiawa Ki Whakarongotai and Tū Ora Compass Health, the Kāpiti Community Health Network has continued to develop and strengthen relationships. The Kāpiti Network has a well-developed work programme and this is progressing to plan. A key development in the last six months has been the work undertaken to develop a local outcomes framework for Kāpiti recognising the importance of using shared outcomes to inform priorities and to monitor progress.

Plans for community network and locality development in Wellington are in the early stages. The Design and Implementation Team (Strategy, Planning and Performance) has gaps in the team due to a combination of staff turnover and secondments to support Covid 19 response and interim Health NZ. However, recent successful recruitment and the progress made in Porirua and Kāpiti mean that time can be allocated between April and June to the first stages of stakeholder engagement and developing robust plans for taking this forward in 2022/23.

Synergia Consulting has been commissioned to provide advice on priorities for investment and implementation in relation to the care continuum for after hours and urgent care services as well as Community Radiology. Synergia has finalised its first phase report, which was a desktop exercise building on previous work. Phase 2 is underway and involves more comprehensive analysis and stakeholder engagement to develop proposals to inform business cases for investment. Due to Omicron, many key stakeholders are currently not available for participating in design workshops, therefore Synergia is currently focusing on analysis and further key informant interviews. We are using this time to develop an appropriate design process to ensure all components of the work are tied together effectively and engagement is robust. This will ensure we continue to make progress despite the impacts of Omicron on the sector.

By June 2022

By the end of June 2022, we anticipate:

- confirmation of our localities, which are likely to be Kāpiti, Wellington, Upper Hutt, Lower Hutt, and Porirua (this will require working with communities to ensure this reflects their aspirations and the agreement of the Iwi Māori Partnership Board).
- for Porirua - the locality function will be established in Porirua along with a detailed locality-level outcomes assessment, health system mapping and stakeholder analysis completed
- for Wainuiomata - the advisory group will have consolidated and collected information to gain a better understanding of current local health and wellbeing needs and analysis of local service provision

- for Hutt Valley - we will have worked with our partners in the Hutt Valley to agree the way forward for locality development there
- for Wellington - we will have undertaken detailed locality analysis and have engaged with our partners in planning work for 2022/23
- we will have an implementation plan to re-commission and improve the model of accident and medical care, and community radiology services
- we will have started the 'World of Difference' organisation-wide staff education programme to enhance understanding of disabilities
- we will have begun to implement better support for health professionals and people with lived experience of family violence.

2DHB Maternity and Neonatal Health

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

A detailed Implementation Paper was presented to the Health System Committee on 16 March. A summary is provided as part of the Committee Chair's update to the Board.

By June 2022

By the end of June 2022, we anticipate:

- development of a new community model of care and prototype for community midwifery teams (the goal is to implement the new model and prototype in 2022/23)
- expansion of our Pēpē Ora website to provide education to DHB maternity workforce and support culturally safe and enabling care.

2DHB Hospital Network

We are developing our hospital network so that in the future our Hutt, Kenepuru, and Wellington hospitals will promote safe working environments for teams; deliver contemporary models of care that provide high quality and safe patient-centred care; make the most effective use of resources for clinical and financial sustainability; and achieve equitable population health outcomes.

Our Hospitals Forum oversees the management of the two programmes - Hospital Network Development and Planned Care - to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes. Within these programmes are 10 projects. All projects progressing with risk being actively managed in our constrained COVID-impacted environment. Overall planned care at both DHBs is behind schedule and recovery trajectories are complicated by access to workforce and private capacity. The Front of Whare project and business case have an ambitious timeline and resources are being fully prioritised to these projects to ensure delivery. The impact is pauses on Master Site Planning and Bed & Theatre capacity projects until other resources are secured.

By June 2022

By the end of June 2022, we anticipate that the work on the Master Site Plan will be well progressed and an update will be provided to the Board at the meeting on 22 June 2022.

Enablers

Enablers support the Strategic Priorities Work Programme through:

- **Clinical Excellence** to transform quality of care and lead purposeful innovation
- **Data & Digital** systems that support our patients and workforce, and inform service design and strategic decision-making, to improve health outcomes and achieve equity
- **Finance, Facilities, and Business Support** to maximize the use and distribution of resources to achieve equitable outcomes
- **Workforce and Organisational Culture** that supports our workforce to achieve equity outcomes.

By June 2022

By the end of June 2022, we anticipate:

- our 2DHB clinical board and 2DHB clinical governance sub-committees will be well established
- processes will be standardised across 2DHBs in improvement, innovation and adverse events
- the consumer advisory group at HVDHB will be well established, with strong ties to the group at CCDHB, and consumers will increasingly have an integral role in many projects and committees across both DHBs
- our Data & Digital work programme will continue to support the implementation of all workstreams projects and we will continue to improve the accuracy and use of equity data, including ethnicity workforce and disability data
- through Workforce and Organisational Culture initiatives, we will be continue to grow our Māori, Pacific and Disability workforces, with a focus on attraction, retention and development of staff (our goal is to improve equity across our workforce data from our current baseline data)
- cultural safety training for all staff will continue to be implemented, and our wellbeing strategy and actions will continue to be focus beyond June 2022
- we will have delivered Te Wao Nui, the new children's hospital for clinical fit out
- completed our business case for a larger, redesigned Emergency Department that will enable contemporary models of care and reduce patient wait times.

Next Steps

We will provide a high-level progress update on the 2DHB Strategic Priorities workstreams at the 2DHB Board meeting on 13 May 2022 and will update the Board on priorities before June 2022 and outline our focus for beyond mid-2022.

Board Information – Public Excluded

30 March 2022

HVDHB Financial and Operational Performance Report – February 2022

Action Required

The HVDHB Board notes:

(a) the DHB had a ($0.5m) deficit for the month of February 2022, being ($1.5m) unfavourable to budget;

(b) the Funder result for February was ($2.1m) unfavourable, Governance $0.03m favourable and Provider $0.6m favourable to budget;

(c) total Case Weighted Discharge (CWD) Activity was 2% ahead of plan year to date;

(d) at the end of February 2022, the DHB had a year to date deficit of ($8.8m), $0.14m favourable to the agreed budget of a ($9.0m) deficit;

(e) excluding the unfunded COVID-19 costs year to date deficit is ($5.3m) which is $3.7m favourable to the agreed budget.

Strategic Alignment	Financial Sustainability
Presented by	2DHB Chief Financial Officer (acting), Mathew Parr 2DHB Director of Provider Services, Joy Farley 2DHB Director Strategy Planning and Performance (acting), Peter Guthrie
Endorsed by	2DHB Chief Executive - Fionnagh Dougan
Purpose	To update the Board in relation to financial performance and delivery against target performance for the DHB
Contributors	Finance Team, Health Intelligence and Decision Support, 2DHB Hospital Services.

Executive Summary

We are incurring significant additional cost due to the COVID-19 response in the 2021/22 fiscal year. The DHB is being reimbursed for a large portion of the DHB COVID-19 response costs in 2021/22 however some unfunded costs remain.

- The Ministry has asked DHBs to separately report unfunded COVID-19 impacts for 2021/22, with these being considered outside the DHB's responsible deficit and budgets.
- For the eight months to 28 February 2022 the overall DHB year to date result, (including COVID-19) costs is $8.8m deficit, this is $0.14m favourable to the agreed budget of a $9.0m deficit.
- Excluding the unfunded COVID-19 expenses the DHB's result for the eight months to 28 February 2022 is $5.3m deficit, which is $3.7m favourable to the agreed budget. Additional unfunded COVID-19 related expenditure is $3.5m year to date.

- Key underspends in the provider include; Allied Health and Management & Admin personnel offset by reduced IDF inflow revenue.
- Key underspends for the funder are demand driven costs including; ARC, Mental health contracts, other external provider payments and IDF outflow fully offset by overspends on community pharmaceuticals of $2.3m.
- In February there was an increase in the cost of community pharmaceuticals of ($1.1m) which includes price increases for prescriptions.
- Agreed budget changes of $14m were actioned in the October results. The budget changes impacted the funder by $13m reducing community pharmaceuticals and IDF outflow. The provider arm was reduced by $1m for anticipated reduction in depreciation for the current year.
- Capital Expenditure to 28 February was $5.9m with $33.4m 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 $25.4 million which is favourable to 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 suite). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

Hospital:

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.
- In response to the increasing wait times though the ED services the Operations Centre has commenced a major project to find issues and solutions. This month we focused on the diagnosis of the root causes impacting on the SS10 performance. The top root causes proved to be triage processes, data inaccuracies, workforce, the bed request process, speciality referrals and flow out processes. These areas are the focus of our improvement.
- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nursing Officer.

Funder:
In this report we have highlighted key areas of performance focused on delivery of our core services and achieving equity.

The four main work streams are:

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

Strategic Considerations

Service	Financial performance and funding is a key to delivery of the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 80 below plan year to date.
Financial	Planned deficit for HVDHB is ($16.8) million with no COVID-19 impacts included.
Governance	This monthly report enables the Board to scrutinise the financial and operational performance of the DHB.

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	Mat Parr, Acting Chief Financial Officer	Currently on track but will be impacted by current events	Major (but no payment impacts)	Major (no operational impacts)

Attachment

3.2.1 Hutt Valley DHB Financial and Operational Performance Report – February 2022

Monthly Financial and Operational Performance Report

For period ending
28 February 2022

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 February is additional costs of $3.5m in relation to Regional Public health and Provider costs.
- Excluding the net COVID-19 costs the DHB's result for the eight months to 28 February 2022 is a ($5.3m) deficit, versus a budget deficit of ($9.0m).
  - For the eight months to 28 February 2022 the overall DHB result, including COVID-19 and Holidays Act costs is a ($8.8m) deficit compared to a budget deficit of ($9.0m).
- Key underspends in the provider include; Allied Health and Management & Admin personnel offset by reduced IDF inflow. In the funder underspends in demand driven costs including; ARC, Mental health contracts, other external provider payments and IDF outflow fully off set by overspends on community pharmaceuticals of ($2.3m).
- The February month includes an increase in community pharmaceuticals of ($1.1m) which includes price increases for prescription costs.
- Agreed budget changes of $14m were actioned in the October results. The budget changes impacted the funder by $13m reducing community pharmaceuticals and IDF outflow. The provider arm was reduced by $1m for anticipated reduction in depreciation for the current year.
- Capital Expenditure to 28 February was $5.9m with $33.4m 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 $25.4 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 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.

In response to the increasing wait times though the ED services the Operations Centre has commenced a major project to find issues and solutions . This month we focused on the diagnosis of the root causes impacting on the SS10 performance. The top root causes proved to be triage processes, data inaccuracies, workforce, the bed request process, speciality referrals and flow out processes. These areas are the focus of our improvement.

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Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.

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

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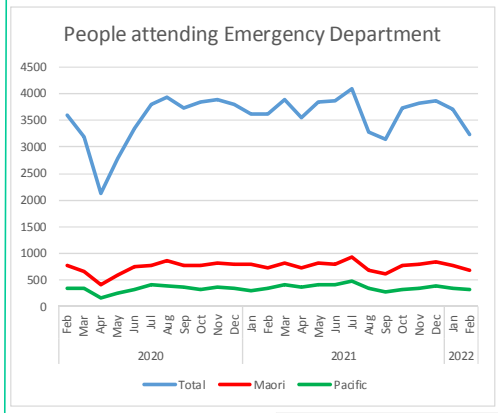
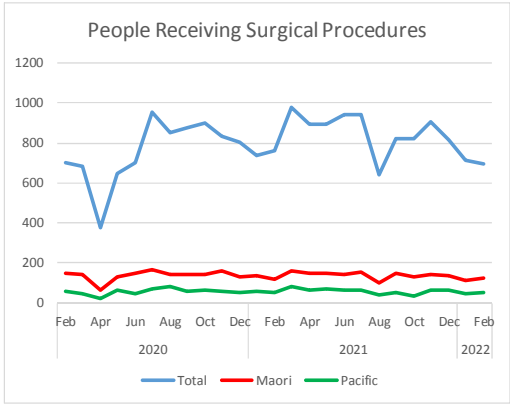
  - Strengthen Kāpiti Community Health Network. An EOI for new members has closed and is being worked through.
  - Develop Community Health Networks in Wellington and the Hutt Valley
  - Allied Health Integration
  - Community Accident and Medical redesign/ Community Radiology redesign where we are in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

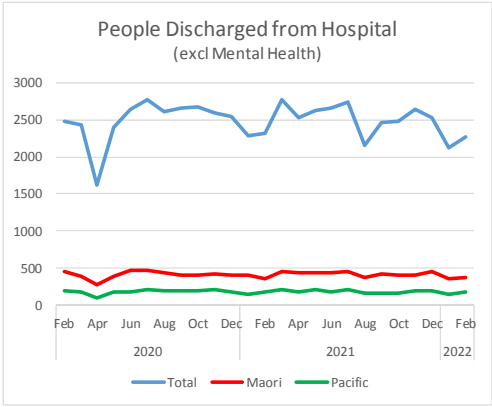
Performance Overview: Activity Context (People Served)

The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. August and September impacted by Covid lockdown, activity has now returned to normal levels. Note Mental Health now reported by CCDHB as they are the DHB of service for MHAIDS

People attending ED	**3,229**	689 Maori, 324 Pacific
People receiving Surgical Procedures	**694**	127 Maori, 55 Pacific
People discharged from Hospital (excl Mental Health)	**2,274**	365 Maori, 168 Pacific







Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

6,766

1,373 Maori, 589 Pacific

Primary Care Contacts

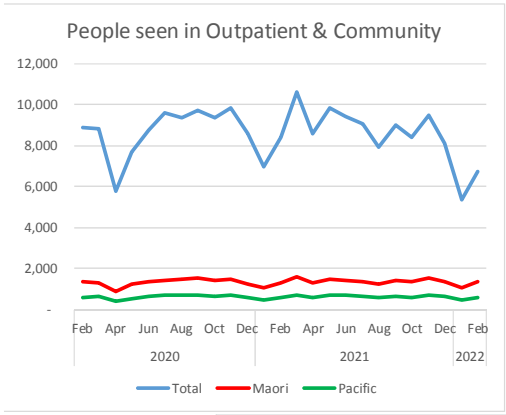
34,826

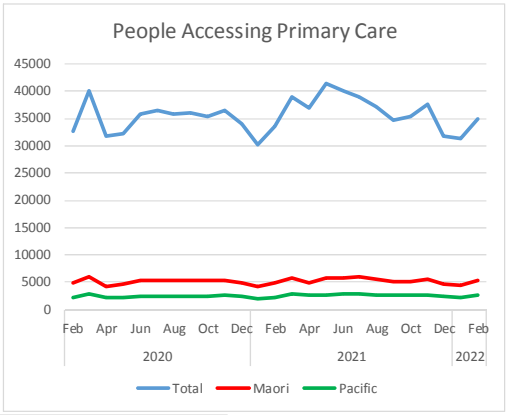
5,281 Maori, 2,722 Pacific

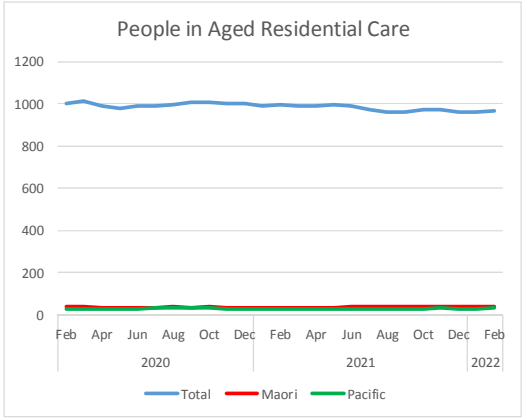
People in Aged Residential Care

967

39 Maori, 33 Pacific







Financial Overview – February 2022

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$8.8m deficit	$0.0m Deficit	$9.4m deficit	$5.9m
Against the budgeted deficit of $9.0m.	Against the budget deficit of $0.3m.	Against the budget deficit of $8.8m.	Compared to a maximum budgeted spend of $39.3m

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
2% ahead	1,846	$22.6m
380 CWDs over PVS plan at end of Feb. IDFs were 216 CWD below budget at the end of the month	YTD 80 FTE below annual budget of 1,926 FTE.	This is a decrease of $0.9m on prior period.

Hospital Performance Overview – February 2022

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
84%	1,257	1,033	89%
11% below the ED target of 95%, and similar to February 21	Against a target of zero long waits a monthly increase of 37.	Against a target of zero long waits a monthly increase of 177	We were below the 62 day target this month. The 31 day target was not achieved at 79.5%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
2% ahead	1,839	0
380 CWDs over PVS plan at end of Feb. IDFs were 216 CWD below budget at the end of the month	79 below YTD budget of 1,918 FTE. Month FTE was 85 under budget an upwards movement from December of 13 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has an unfavourable variance to budget of ($2.1m) for the month and ($0.6m) year to date.
- Community pharmaceuticals are over budget for the month by ($1,175k) which reflects the increased dispensing fees and timing of pharmacies claims being requested and processed.
- Mental Health costs are over budget for the month and under year to date reflecting timing of contracts which will be rectified with the acute care continuum investments come on stream.
- The IDF outflows are over for the month by ($337k) by under year to date $807k.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:
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Funder Financial Statement – February 2022

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of February 2022

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
39,641	39,837	(196)	37,841	1,800	Base Funding	317,126	318,692	(1,566)	302,726	14,400	475,689	478,038	(2,349)	455,083	20,607
2,693	2,411	282	2,657	35	Other MOH Revenue	29,463	19,288	10,175	22,086	7,377	42,944	28,932	14,012	34,030	8,914
23	26	(2)	4	19	Other Revenue	201	204	(3)	517	(316)	295	307	(11)	733	(437)
9,015	9,557	(542)	9,033	(18)	IDF Inflows	75,617	76,452	(836)	74,714	902	114,644	114,678	(34)	111,945	2,700
51,371	**51,830**	**(458)**	**49,535**	**1,836**	**Total Revenue**	**422,407**	**414,636**	**7,771**	**400,044**	**22,364**	**633,573**	**621,955**	**11,619**	**601,791**	**31,783**
					Expenditure										
259	349	90	328	70	DHB Governance & Administration	2,698	2,788	90	3,115	416	4,093	4,183	90	4,652	559
21,329	21,391	61	20,547	(783)	DHB Provider Arm	176,456	171,126	(5,330)	167,656	(8,800)	262,616	256,689	(5,927)	252,732	(9,884)
					External Provider Payments										
3,643	2,468	(1,175)	2,695	(948)	Pharmaceuticals	27,955	25,630	(2,325)	27,626	(329)	41,543	38,057	(3,487)	37,162	(4,381)
4,359	4,413	55	4,267	(91)	Laboratory	35,472	35,446	(25)	35,129	(342)	53,195	53,169	(25)	52,577	(618)
2,681	2,684	4	2,587	(94)	Capitation	21,442	21,476	34	20,865	(577)	32,180	32,214	34	31,021	(1,159)
1,092	1,129	38	984	(108)	ARC-Rest Home Level	10,006	9,890	(115)	9,259	(747)	14,974	14,858	(115)	13,871	(1,103)
1,667	1,792	125	1,642	(25)	ARC-Hospital Level	15,072	15,708	636	14,386	(686)	23,044	23,599	556	21,724	(1,319)
2,825	2,803	(22)	2,501	(324)	Other HoP	22,549	22,423	(126)	20,512	(2,037)	34,501	33,635	(866)	30,333	(4,168)
1,097	1,022	(75)	898	(199)	Mental Health	7,897	8,177	280	7,417	(480)	12,352	12,265	(86)	11,898	(454)
2,253	1,821	(431)	2,110	(142)	Other External Provider Payments	17,135	14,833	(2,302)	17,423	288	27,755	23,403	(4,353)	25,067	(2,688)
12,328	11,991	(337)	8,641	(3,687)	IDF Outflows	95,122	95,930	807	73,524	(21,599)	141,901	143,894	1,993	108,813	(33,088)
53,532	**51,864**	**(1,668)**	**47,201**	**(6,331)**	**Total Expenditure**	**431,804**	**423,429**	**(8,376)**	**396,912**	**(34,892)**	**648,154**	**635,967**	**(12,187)**	**589,851**	**(58,302)**
(2,161)	**(34)**	**(2,126)**	**2,334**	**(4,494)**	**Net Result**	**(9,397)**	**(8,792)**	**(605)**	**3,131**	**(12,528)**	**(14,580)**	**(14,012)**	**(568)**	**11,939**	**(26,520)**

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 ($196k) to budget for the month.
- Other MoH revenue is favourable $282k for February.
- IDF inflows ($542k) unfavourable based on information available.

Other MOH Revenue Variance	MTH $000's	YTD $000's
Capitation Funding	19	202
COVID-19 Funding	104	3,370
COVID-19 Comm. Pharmacy from balance sheet	-	740
2020/21 Planned Care	-	(111)
2021/22 Planned Care	(0)	205
Additional Immunisation funding	-	31
Nurses' MECA Funding	260	5,941
IBT - rest breaks	9	9
Pay equity LCI Adjustment	-	-
Crown funding agreements		
B4 School Check Funding	0	(31)
Additional Immunisation funding	-	31
More Heart and diabetes checks	(5)	(44)
Additional School Based MH Services	(10)	(78)
Maternity Quality and Safety Programme	0	100
Rheumatic Fever / Healthy Homes	(45)	(371)
Midwifery Clinical Coaches and Return to Practice Pro	8	67
Pilot Alert Programme	(7)	(59)
B4SC Active Families	-	(37)
VIP Programme Coordination in DHB's	2	15
Tobacco Control	36	(65)
Well Child/Tamariki Ora Services	(97)	45
Other CFA contracts	(7)	(10)
Year to date Variance $000's	**282**	**10,175**

Expenditure:

Governance and Administration favourable to budget $90k for the month. Provider Arm payments variance includes IDF Inflows passed through to the Provider and the additional funding for the Nurses MECA Settlement.

External Provider Payments:

Pharmaceutical costs are unfavourable ($1,175k) for February.

Capitation expenses are $4k favourable for the month.

Aged residential care costs are $162k favourable for the month.

Other Health of Older People costs are unfavourable by ($22k) for the month and ($126k) YTD.

Mental Health costs are unfavourable ($75k) for the month.

Other External Provider Payments are ($431k) unfavourable for the month including the IDF budget reduction and COVID-19 costs offset by revenue.

IDF Outflows are unfavourable ($337k) for the month based on available information.

Inter District Flows (IDF)

IDF Wash-ups and Service Changes February 2022			
IDF Outflows $000s	Variance to budget		
	Month	YTD	Forecast
Hawkes Bay - Alcohol & Drug inpatients	(1)	(4)	(6)
CAP - Mental Health	12	(42)	(88)
CAP - Measles CFA	-	(211)	(211)
Wash-ups			
2021/22 Outflows - inpatient	(369)	1,337	420
2021/22 PHO	-	(131)	(131)
2021/22 Outflows - outpatient	-	-	665
2021/22 Outflows - PCT	-	-	726
2021/22 Outflows ATR	-	-	522
21/22 FFS GP services	21	21	21
2020/21 Outflows wash-ups	-	(161)	(161)
Rounding (timing) differences	-	-	-
IDF Outflow variance	**(337)**	**807**	**1,756**

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 ($542k) unfavourable for the month.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are unfavourable for the month ($337k), favourable YTD $807k including the impact of COVID-19 lock down.

Commissioning: Families & Wellbeing

What is this measure?

Mothers

- 75% of pregnant women registered with a Lead Maternity Carer (LMC) within the 1st trimester
- 80% of infants are exclusively or fully breastfed at two weeks
- 85% of newborns enrolled in a PHO by three months

Why is this important?

- Early engagement with an LMC provides an opportunity for screening, education and referral, and begins the primary-maternity continuity of care relationship.
- 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.
- Newborn enrolment ensures access to affordable and essential health care as early as possible, such as childhood immunisation, community oral health and Well Child Tamariki Ora services.

How are we performing?

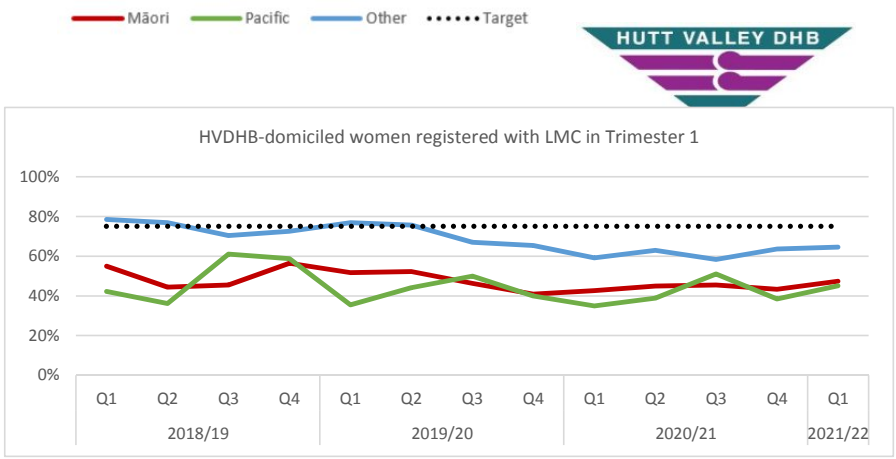
- Performance is below the 75% target for LMC registrations in Trimester 1 for Māori (47%) Pacific (45%) and non-Māori, non-Pacific (65%).
- Performance is below the 80% target for exclusive or full breastfeeding for Māori (59%), Pacific (65%) and non-Māori, non-Pacific (72%).
- Performance is below the 85% target for PHO enrolment at 3 months for Māori (83%), and above target for Pacific (92%) and non-Māori, non-Pacific (93%).

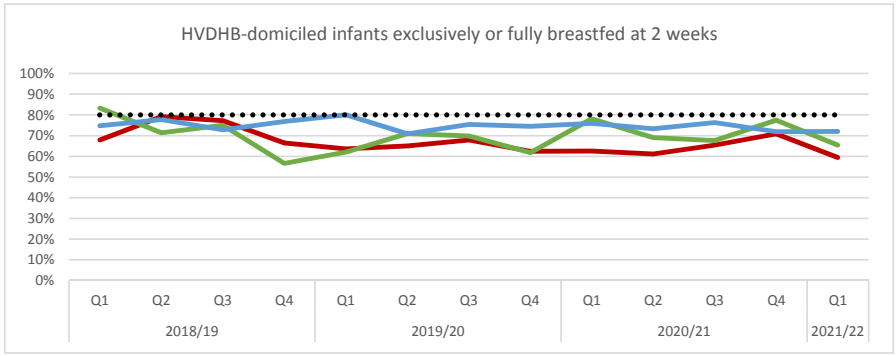
What is driving performance?

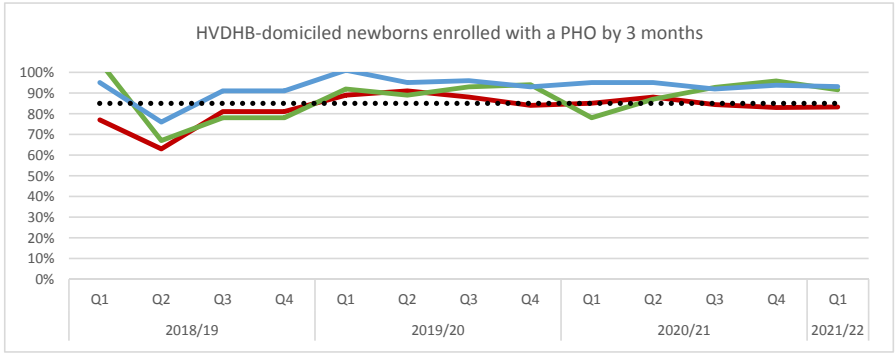
- A national shortage of midwives impacts women's ability to engage early with LMC care. In 2021, as part of the First 1000 Days commissioning plan, HVDHB commissioned new antenatal education services that sit within Te Ao Māori and Pasifika cultural frameworks. We expect this antenatal education will support additional continuity of care for these populations while impacted by LMC shortages, and provide additional support with breastfeeding knowledge.
- HVDHB has contracted a breastfeeding education specialist to build a community of support for Māori, Pacific, Indian and disabled women on their breastfeeding journey. The programme will consist of (1) Breastfeeding education/promotion; and (2) Training breastfeeding Kaiawhina.
- Work has re-started on HVDHB's electronic newborn notification system. The system will eliminate the need for faxing and other manual processes currently used for newborn enrolment.

Management comment

- Mothers and Babies is a 2DHB Board endorsed strategic priority in 2021/22. Progressing improvements across the maternal health system remains a top priority with close monitoring by our Executive team.







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. An ACP often also includes an advance directive. This documents their healthcare wishes for a time in the future when they are not able to speak for themselves. An ACP 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.

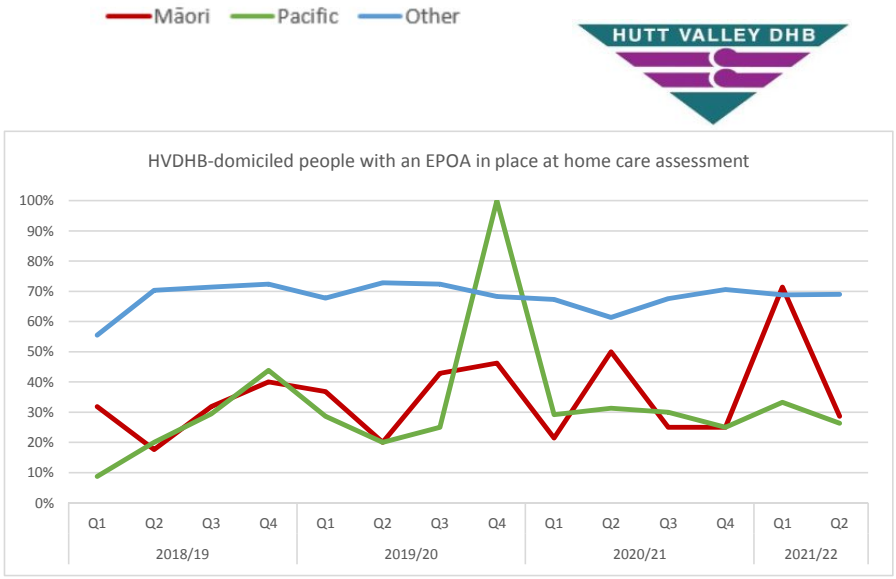
- Performance for Home Care Assessments where an EPOA was in place is 29% for Māori, 26% for Pacific, and 69% for non-Māori, non-Pacific.
- Performance for Home Care Assessments with a completed ACP is 4% for Māori and 3.3% for non-Māori, non-Pacific. The most recent result for Pacific in 2020/21 is 3%.

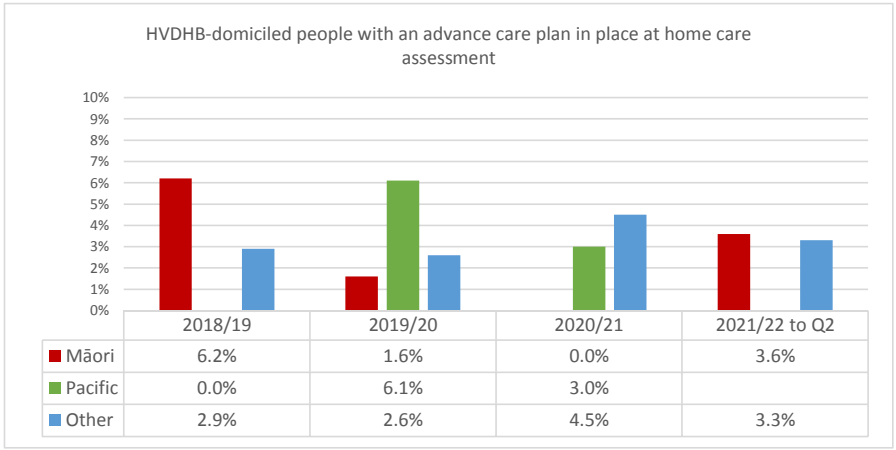
What is driving performance?

- At the end of 2020, Tū Ora Compass Health 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 ACP 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.
- ACP is a 3DHB role. Promotion, support and education are provided to health and social care providers across DHBs, primary health, ARC, NGOs, and tertiary education.





	2018/19	2019/20	2020/21	2021/22 to Q2
Māori	6.2%	1.6%	0.0%	3.6%
Pacific	0.0%	6.1%	3.0%	
Other	2.9%	2.6%	4.5%	3.3%

Commissioning: Mental Health and Addictions

What is this measure?

Addiction

- 80% of people seen within 3 weeks for non-urgent addiction services
- 95% of people discharged from community addiction services with a transition/wellness plan
- Alcohol-related presentations (ARPs) to Emergency Department per 100,000

Why are these important?

- Prompt diagnosis and early intervention in the initial stages of a mental illness and/or substance-use harm can have significant impacts on a person's wellbeing. Intervening at early stages of distress or addiction can mean a better response to treatment and increased likelihood of recovery. Ensuring that wait times are low is therefore critical for improving patient outcomes and continuity of care.
- Service transitions in the addictions sector are multiple and they are recognised as a potential risk to people and whānau. Wellness/relapse prevention and transition/discharge planning contribute to improved outcomes by ensuring that people with substance-use harm are supported, and that their broader health and social needs are met.
- Public health implement strategies to reduce alcohol-related harm in the ED and society as a whole. Raising awareness of alcohol-related harm through media and targeted programmes, along with evidence-based alcohol policies are among some of the most effective preventative approaches.

How are we performing?

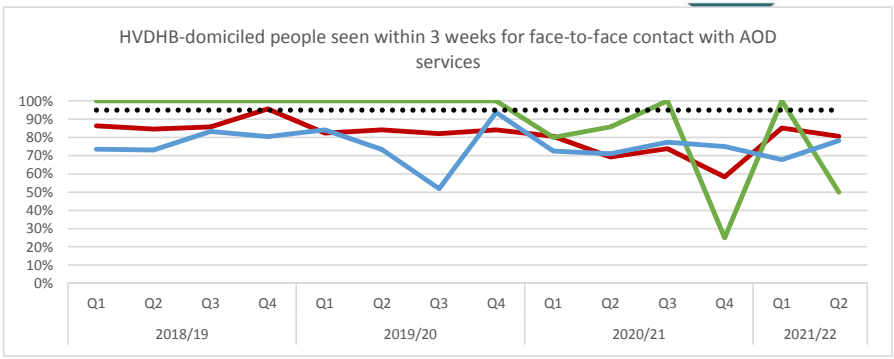
- Performance is above the 80% target for AOD mental health wait times for Māori (81%), and below target for Pacific (50%), and non-Māori, non-Pacific (78%).
- Performance for alcohol-related presentations to ED per 100,00 is for 262 for Māori, 181 for Pacific, and 160 for non-Māori, non-Pacific (75%).
- Performance is below the 95% target for AOD transition/wellness plans for Māori (88%) and non-Māori, non-Pacific (67%), and above target for Pacific (100%).

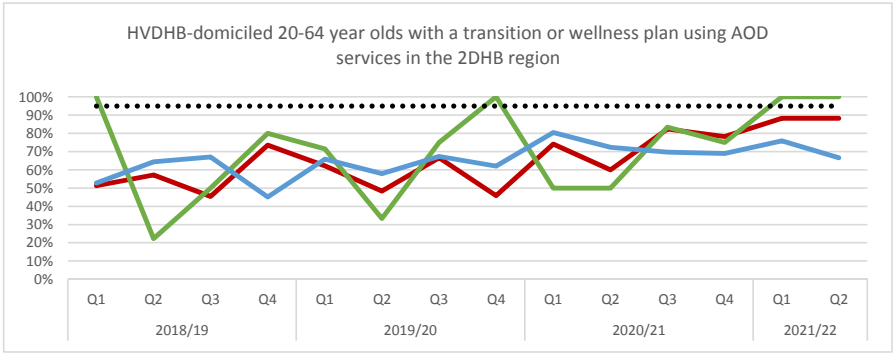
What is driving performance?

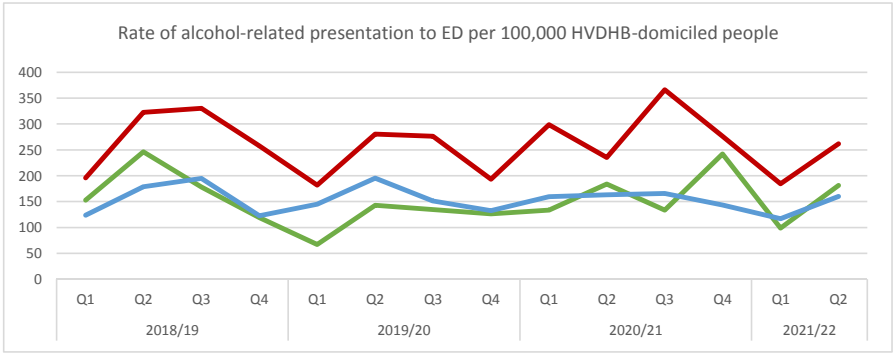
- There is no statistically significant variation for the wait-time to first contact and transition/discharge measures in the periods reported. The AOD Collaborative will share data with the addiction DHB and NGO providers to gain further insight to performance and quality improvement initiatives.
- MHAIDS addiction team data quality needs to be resolved to improve reporting accuracy

Management comment

- The role of the AOD Collaborative is to ensure that the 3DHB Model of Care is implemented effectively and promotes a strategic, integrated and effective AOD system of care across the 3DHB region
- The AOD Collaborative will develop a measurement framework to understand and track improvement in performance. Wait-time and transition plan measurements are proposed, pending endorsement from the Collaborative
- Engagement with the Emergency Department and Regional Public Health is required to determine if the ARP measure can be utilised to measure improvement for public health strategies to reduce alcohol related harm.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination programme - Boosters and Children

Why is this important?

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

How are we performing?

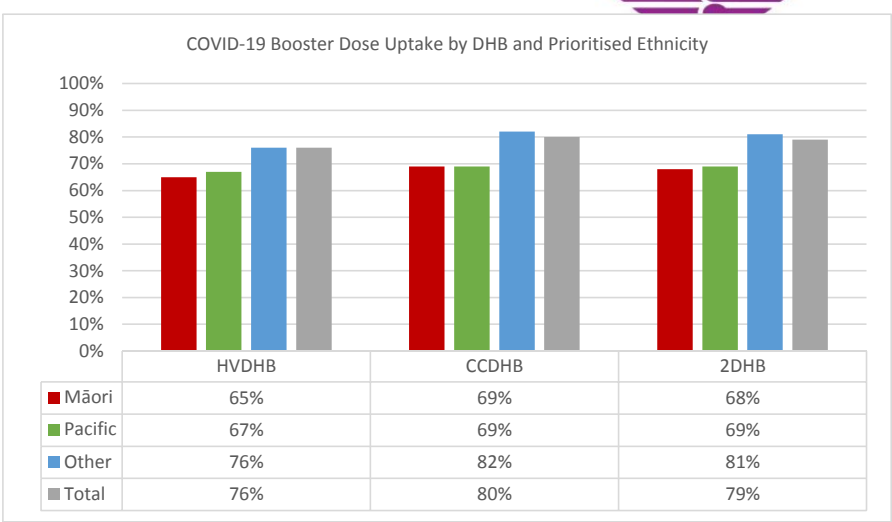
- 259,825 eligible people in the 2DHB region have received a booster dose (79% of eligible)
  - 20,421 Māori (68%), 13,927 Pacific Peoples (69%), 225,477 'Other' (81%)
- 26,613 children 5-11 years in the 2DHB region have received a 1st dose (63%)
  - 3,753 Māori (45%), 2,087 Pacific Peoples (48%), 20,773 'Other' (71%)
- 390,131 people 12+ years in the 2DHB region are fully vaccinated (97%)
  - 42,579 Māori (92%), 27,495 Pacific Peoples (95%), 320,057 'Other' (98%)

What is driving performance?

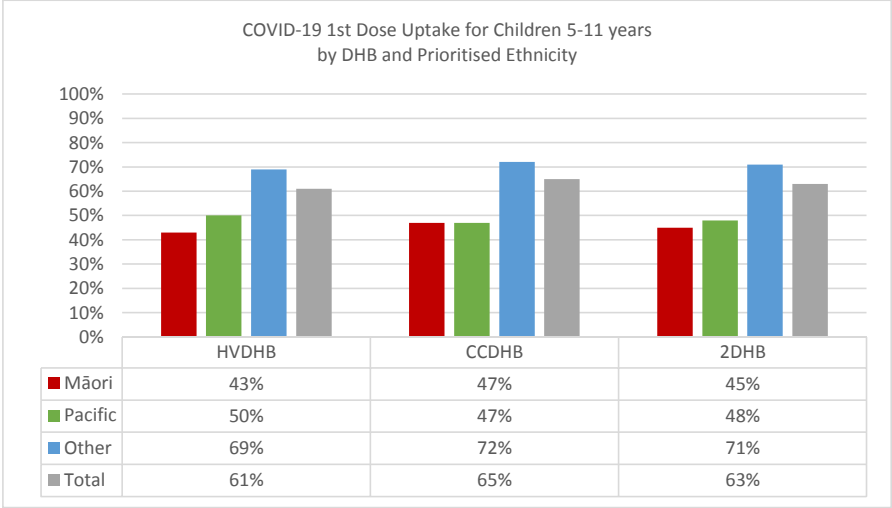
- The reduction in booster eligibility periods (from six to three months) has created a significant overhang of people eligible for booster vaccinations in early 2022.
- COVID-19 vaccination requirements and training for children were not fully available until New Year 2022 and required a material re-orientation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

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

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



	HVDHB	CCDHB	2DHB
Māori	65%	69%	68%
Pacific	67%	69%	69%
Other	76%	82%	81%
Total	76%	80%	79%



	HVDHB	CCDHB	2DHB
Māori	43%	47%	45%
Pacific	50%	47%	48%
Other	69%	72%	71%
Total	61%	65%	63%

Data Source: MOH Covid-19 Vaccine Data
Date Range: 22/02/2021 to 01/03/2022
Data current at: 03/03/2022 @1.27pm

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.
- In response to the increasing wait times through the ED services the Operations Centre has commenced a major project to find issues and solutions . This month we focused on the diagnosis of the root causes impacting on the SS10 performance. The top root causes proved to be triage processes, data inaccuracies, workforce, the bed request process, speciality referrals and flow out processes. These areas are the focus of our improvement.
- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- We remain at budget.

Hospital Throughput

Completed for period					Hutt Valley DHB Hospital Throughput YTD Feb-22	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							
980	1,050	70	1,026	46	Surgical	8,366	9,347	981	9,004	638	14,143	13,880
1,708	1,536	(172)	1,696	(12)	Medical	14,826	13,645	(1,181)	14,989	163	20,853	22,570
317	356	39	430	113	Other	3,032	2,992	(40)	3,483	451	4,464	5,221
3,005	**2,943**	**(62)**	**3,152**	**147**	**Total**	**26,224**	**25,984**	**(240)**	**27,476**	**1,252**	**39,461**	**41,671**
					CWD							
1,036	1,083	47	1,114	78	Surgical	9,393	9,803	410	9,568	175	14,879	13,880
928	849	(79)	892	(36)	Medical	8,039	7,455	(584)	7,861	(178)	11,317	22,570
295	416	121	399	103	Other	3,185	3,434	249	3,308	123	5,146	5,087
2,260	**2,349**	**89**	**2,405**	**145**	**Total**	**20,617**	**20,692**	**75**	**20,737**	**120**	**31,342**	**41,537**
					Other							
3,574	3,827	253	4,026	452	Total ED Attendances	32,316	32,608	292	33,263	947	49,261	50,206
870	822	(48)	913	43	ED Admissions	7,704	7,539	(165)	8,092	388	11,294	12,086
632	803	171	712	80	Theatre Visits	5,831	6,815	984	6,184	353	10,232	9,587
79	96	17	121	42	Non- theatre Proc	929	1,077	148	1,101	172	1,638	1,631
5,798	6,460	662	6,439	641	Bed Days	50,925	55,920	4,996	53,073	2,148	84,357	80,941
3.98	4.55	0.57	4.35	0.37	ALOS Inpatient	4.22	4.55	0.33	4.49	0.28	4.55	4.55
1.69	2.08	0.38	2.03	0.34	ALOS Total	1.92	2.08	0.16	2.06	0.14	2.08	2.08
4.42%	8.02%	3.59%	8.38%	3.95%	Acute Readmission	7.38%	8.02%	0.64%	8.04%	0.66%	7.31%	7.80%

Volumes are affected by COVID-19 Omicron outbreak in February and reduced planned care services during the national COVID lockdown during 18 Aug – 7 Sept 2021. Surgical discharges and caseweights are under budget for February and under budget year to date despite efforts to clear the backlog after the lockdown. Medical discharges were over budget for February but similar to the same time last year. Year to date, Medical caseweights are higher than budget mainly due to unusually high Medical Inpatient caseweights since November. Also Emergency (treated over 3 hours and discharged) was especially high during the RSV outbreak in July and again in October to December. Year to date, caseweights for other services are under budget mainly due to the national lockdown and low volumes in the last two months.

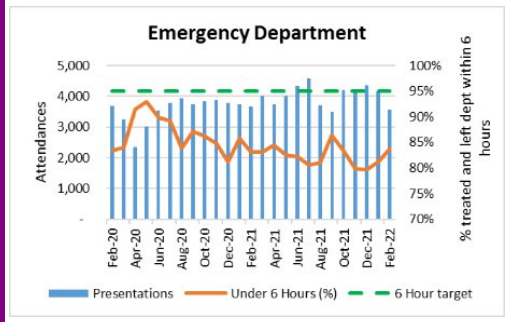
Total ED visits were under budget for the month and the same time last year. Theatre visits are 14% lower than budget year to date. Bed days are lower than budget for the month and year to date. Inpatient ALOS in February was lower than budget and the same time last year. The acute readmission rate for the month was lower than budget but similar to the same time last year

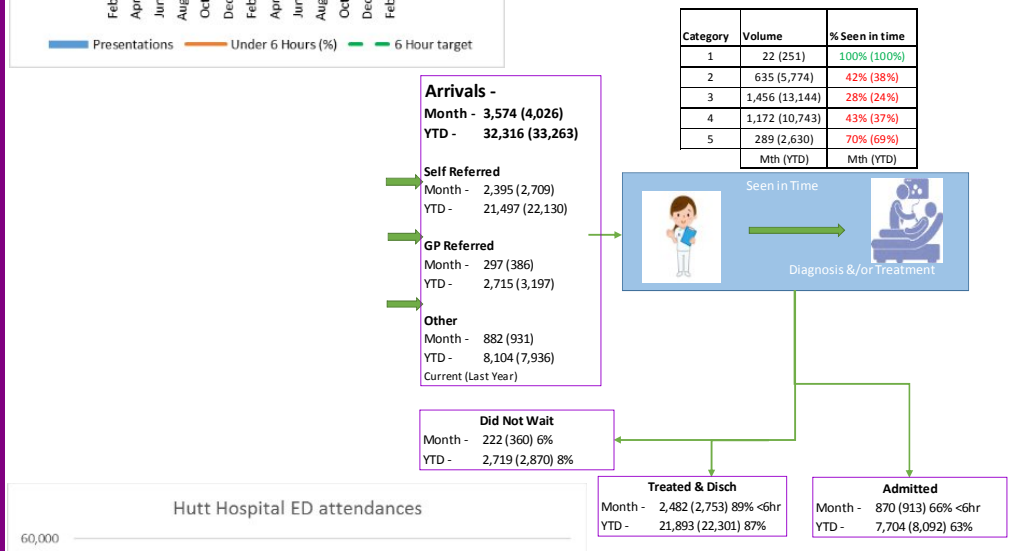
Operational Performance Scorecard – 13 mths

Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Safe	Serious Safety Events[1] confirmed	Zero	3	3	3	0	2	0	3	1	3	2	2	4	0
	SABSI Cases [2]	Zero	0	1	0	0	1	3	2	0	3	2	2	0	0
	C. difficile infected diarrhoea cases	Zero	0	1	2	1	1	2	5	1	2	3	4	1	2
	Hand Hygiene compliance (quarterly)	≥ 80%	79%		80%			79%			TBC				
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		22.4	39.8	13.6	21.0	21.4	16.9	22.4	14.7	14.1	12.3	7.9	5.5	14.3
Timely	Emergency Presentations	49,056	4,026	4,315	3,982	4,315	4,331	4,593	3,711	3,482	4,199	4,235	4,362	4,156	3,574
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	83.1%	83.1%	84.6%	82.6%	81.5%	79.0%	80.0%	86.1%	82.1%	78.6%	78.2%	79.6%	83.4%
	SSiED % within 6hrs - non admitted	≥95%	89.9%	89.5%	89.7%	89.6%	89.2%	86.5%	87.0%	91.6%	88.0%	84.1%	84.0%	84.1%	89.1%
	SSiED % within 6hrs - admitted	≥95%	62.8%	65.3%	70.3%	61.3%	56.8%	55.5%	60.2%	71.2%	65.2%	62.8%	62.4%	66.8%	66.9%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	1,328	1,238	1,177	1,020	904	930	1,021	1,118	1,135	1,140	1,169	1,220	1,257
	No. Theater surgeries cancelled (OP 1-8)		139	198	124	127	186	153	206	150	144	127	112	70	136
	Total (Elective, Acute & Arranged) Operations in MainTheatres 1-8[6]		712	898	816	843	856	867	600	743	760	812	758	658	643
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,124	1,093	1,015	808	625	624	717	812	1,003	836	830	1,073	1,033
	Outpatient Failure to Attend %	≤6.3%	5.6%	5.5%	6.2%	6.4%	6.6%	6.5%	6.5%	7.8%	6.4%	7.2%	7.6%	9.3%	7.6%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)		($2.03)	($16.06)	($19.72)	($20.40)	($25.09)	($25.43)	($3.94)	($3.94)	($3.24)	($1.85)	($4.11)	($4.06)	($4.69)	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)		($8.14)	($14.24)	($14.25)	($14.01)	($16.93)	($12.23)	($30.84)	($30.84)	($16.84)	($17.71)	($18.09)	($18.76)	($18.10)	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.2%	87.8%	88.4%	87.8%	87.3%	87.1%	86.0%	85.9%	86.2%	87.7%	83.8%	81.3%	
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.37	4.89	4.35	4.69	4.80	4.64	4.92	5.27	4.25	4.83	4.29	4.27	4.31
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	34	20	23	29	22	25	35	16	18	15	15	8	22
	Overnight Beds (General Occupancy) - Average Occupied	≤130	149	146	143	148	152	153	144	130	135	145	135	127	137
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	96.5%	94.8%	92.9%	96.2%	98.5%	94.3%	89.1%	80.2%	88.0%	94.3%	87.5%	82.3%	89.3%
	All Beds - ave. beds occupied[8]	≤250	253	253	243	257	258	262	243	222	236	247	221	213	228
	% sick Leave v standard	≤3.5%	2.5%	3.5%	3.1%	3.2%	3.8%	4.1%	4.4%	2.7%	3.0%	3.3%	3.8%	2.2%	2.6%
	% Nursing agency v employee (10)	≤1.49%	12.4%	13.0%	11.8%	0.4%	14.5%	0.0%	0.5%	0.3%	0.3%	2.0%	1.1%	1.7%	TBC
	% overtime v standard (medical) (10)	≤9.22%	9.6%	7.9%	8.3%	10.1%	8.7%	11.2%	7.4%	11.7%	6.8%	11.6%	7.1%	17.7%	TBC
	% overtime v standard (nursing)	≤5.47%	14.2%	11.2%	15.7%	13.2%	15.9%	12.5%	13.1%	12.2%	9.2%	14.9%	5.3%	26.5%	TBC

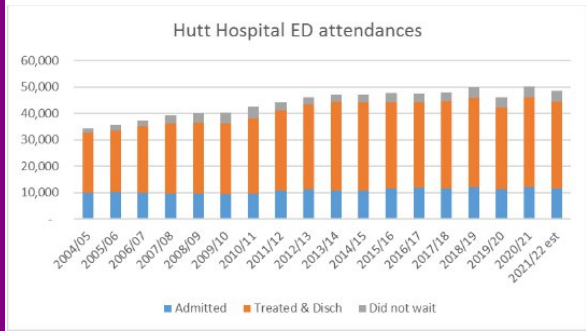
Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 20/21.

Shorter Stays in Emergency Department (ED)





Category	Volume	% Seen in time
1	22 (251)	100% (100%)
2	635 (5,774)	42% (38%)
3	1,456 (13,144)	28% (24%)
4	1,172 (10,743)	43% (37%)
5	289 (2,630)	70% (69%)
	Mth (YTD)	Mth (YTD)



- **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**
  - 83.7% YTD this is an improvement and is similar to February 2021
- **What is driving Performance**
  - The top root causes are triage processes, workforce, the bed request process, speciality referrals and flow out processes.
- **Management Comment**
  - Although ED continues to see lower presentations numbers, our admission rate remains stable.
  - High acuity and high occupancy in the hospital and covid cases have continued to put pressure on this target.
  - Operations Centre has commenced a major project to find issues and solutions. This month we focused on the diagnosis of the root causes impacting on the SS10 performance. The top root causes proved to be triage processes, data inaccuracies, workforce, the bed request process, speciality referrals and flow out processes. These areas are the focus of our improvement.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

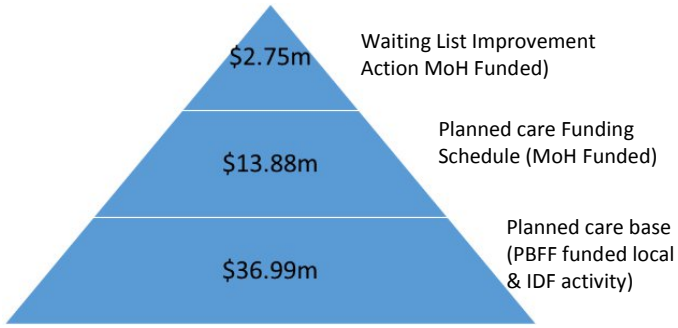
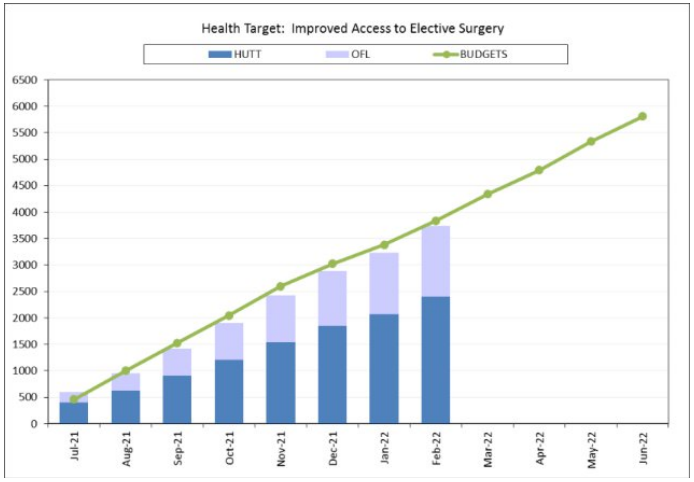
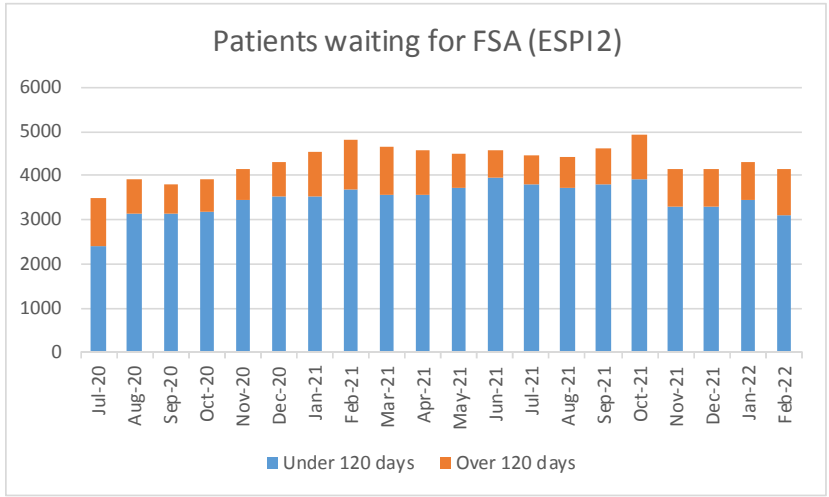


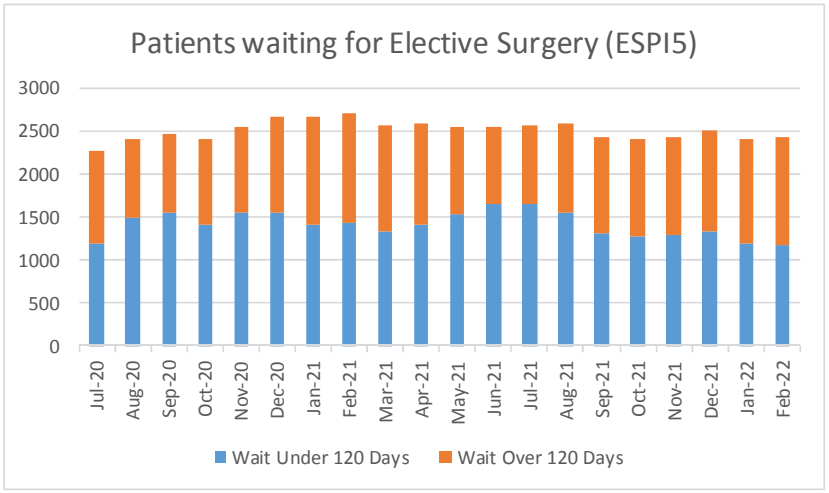
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 97%



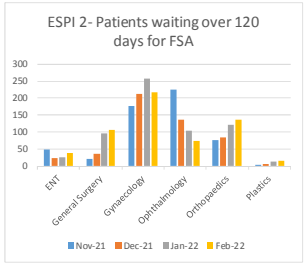
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 98 behind plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 97% as per figure 2.
  - YTD results are 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.
  - The Ministry of Health have confirmed Quarter one payments – July at volume delivered, August and September at full funding. This is positive for HVDHB as July target was met.
- **What is driving performance?**
  - 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.
  - Our 2 DHB outsourcing process has progressed with the next step Statements of Work (SOW) being developed with three private provider. It is anticipated that outsourcing against the SOW will commence in Quarter 3
  - Completed design of Optometrists in cataract First Specialist Assessment and surgical follow which will reduce the ESPI 2 waitlist by 200 patients in 2021-2022. EOI completed and contracting underway with activity to start in February
  - 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. Building work has commenced with estimated completion December 22.

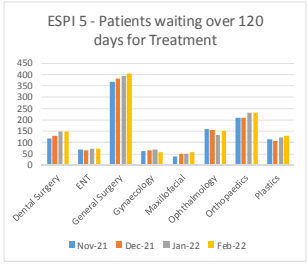
Planned Care – waiting times

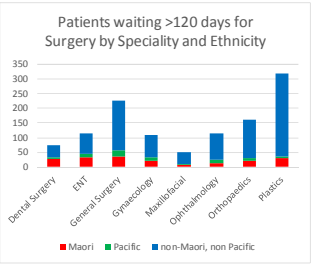




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 4% (170) this month. The number waiting over 120 days rose by 21% (177)
  - The number waiting for elective surgery rose by 8 to 2,425 and the number waiting over 120 days rose by 37 to 1,257
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

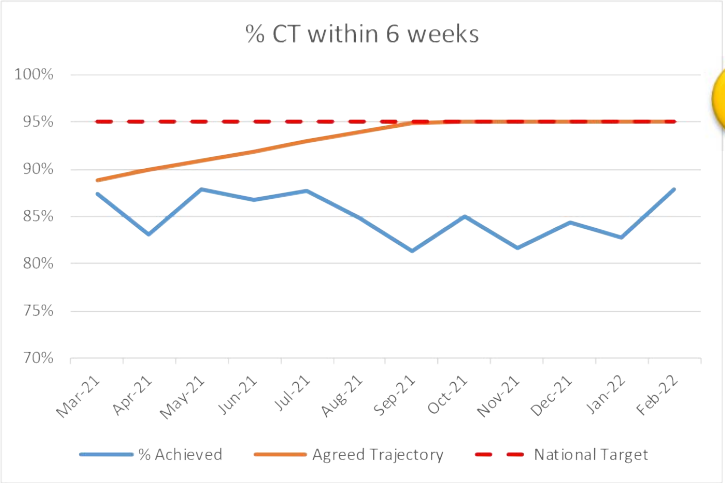


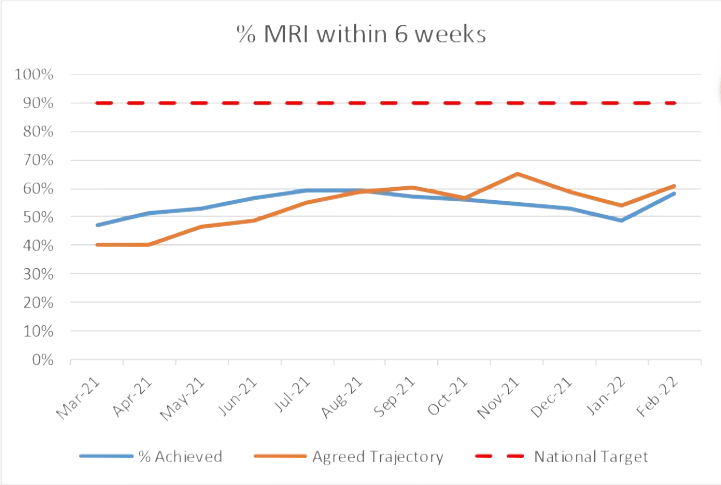




- **What is driving performance?**
  - Impact of COVID lockdown and preparations for the NZNO and MERAS strikes and staff sickness
  - Work continues on system improvements to address our waiting list management along with a strong focus to maximise clinic capacity and improve scheduling processes.
  - 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.

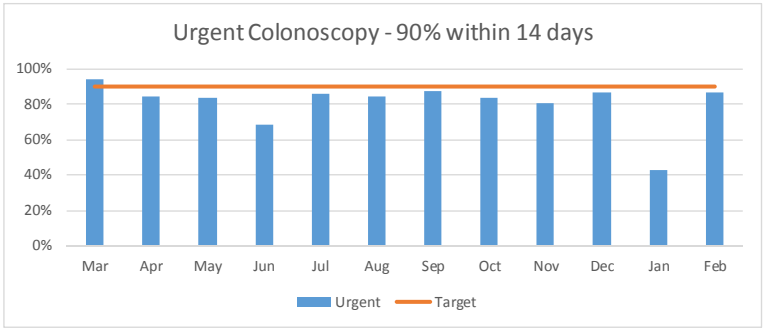
CT & MRI wait times

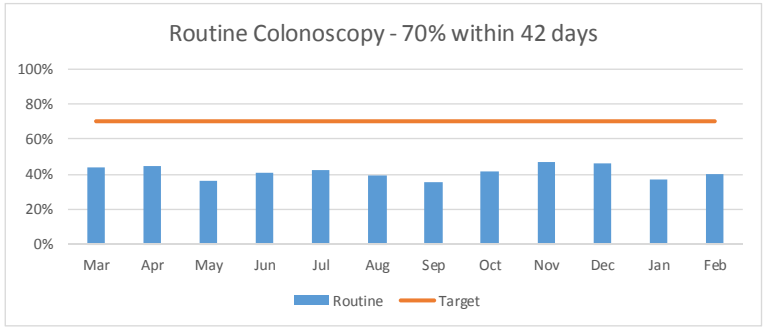


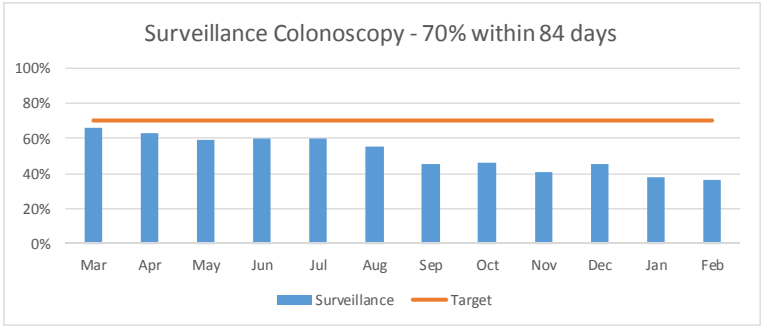


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How 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 84.2% scanned and reported within 6 weeks.
  - MRI performance is just below the newly agreed (with MOH) trajectory with 47.9% 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.
  - In January public holidays resulted in a reduced number of referrals and scanning capacity.
- **Management comment**
  - Actions currently underway:
    - CT weekends lists
    - Voluntary overtime weekend MRI day lists
    - MOH additional Planned Care trajectory funding assumption of additional revenue is being used to outsource 40 MRIs per month & the reading of 100 CT scans per month

Colonoscopy Wait Times







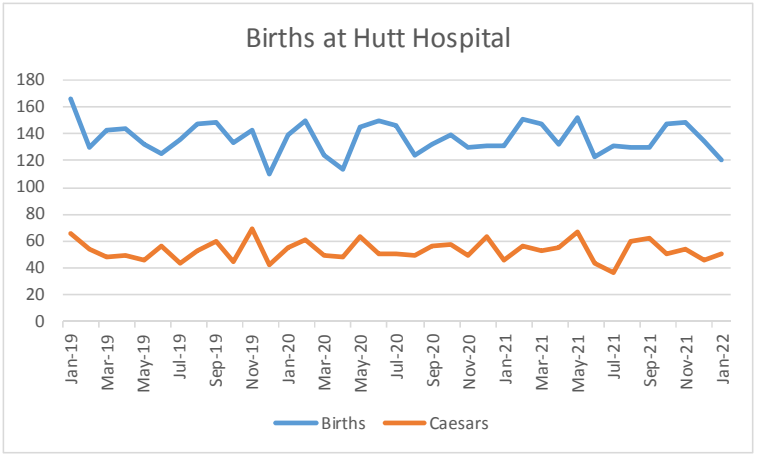
Urgent
81% YTD

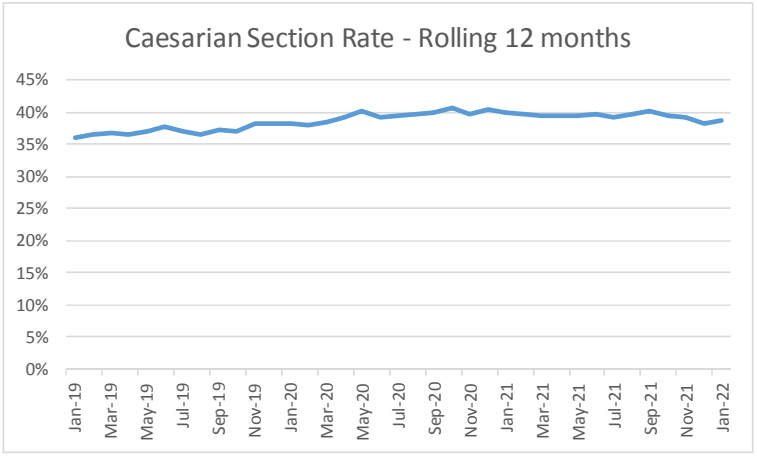
Routine
41% YTD

Surveil
47% 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?**
  - Our urgent performance target was missed due to two patients being reassigned to another clinician, however they received a colonoscopy within 30 days. The overall volume in this graph represents a total of 8 patients.
  - The service is balancing the overall improvement in performance with a trajectory to full compliance within the coming months.
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - We have adapted the way Maori and Pacifica patients are booked, prioritising contact and booked as soon as referral is received. There is a total of 9 Maori or Pacific patients who are overdue across all categories, 1 has rescheduled their appointment that was booked for end of January, whilst 5 are self-deferred.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - Revised trajectories due to the hospital alert level changes are now seeing full recovery by May 22

Maternity

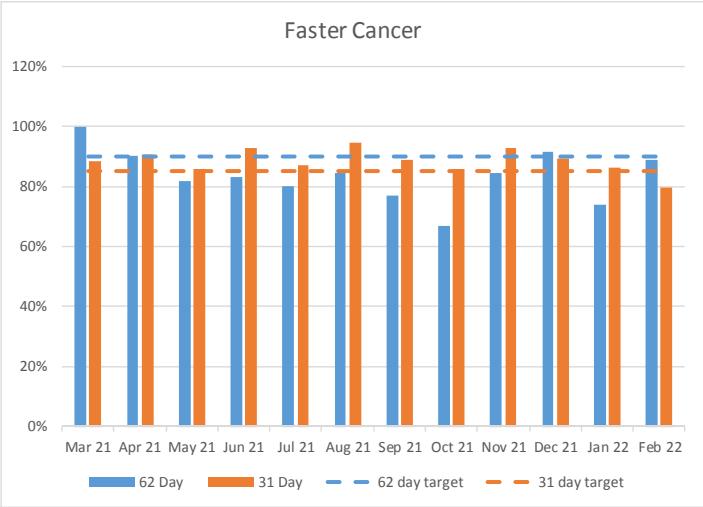


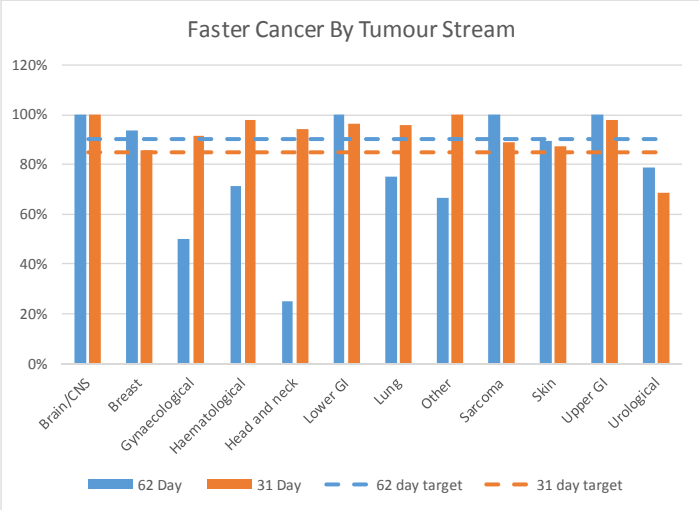


Due to Coding Lag these graphs run 1 month behind

- **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 that focuses on the Robson 10 criteria for caesarean sections and pathways for optimal birth. This is a six month audit with analysis completed for first the period from April-June 2021.
- **Management comment**
  - 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.
  - Maintaining service sustainability due to workforce vacancies remains the key focus of maternity. In January staffing across Midwifery was critical. Initiatives around retention, recruitment, model of care and supporting clinical staff are in place and continuing to be developed. In January we worked collectively on a regional sustainability and retention approach. The casual Midwifery Support Worker role is now implemented with 9 new staff employed (all are student midwives).
  - Regional business contingency planning relating to Omicron is nearing completion and this will see both DHB maternity services working in a more integrated way to deliver safe service.
  - An update to the programme discussed at Health Systems Committee was circulated - An upgrade of postnatal rooms one-six has progressed with completion of rooms one and two in the next three weeks. Planning of room eight the interim primary birthing room has been completed and work is envisaged to commence and be completed in that room during April.

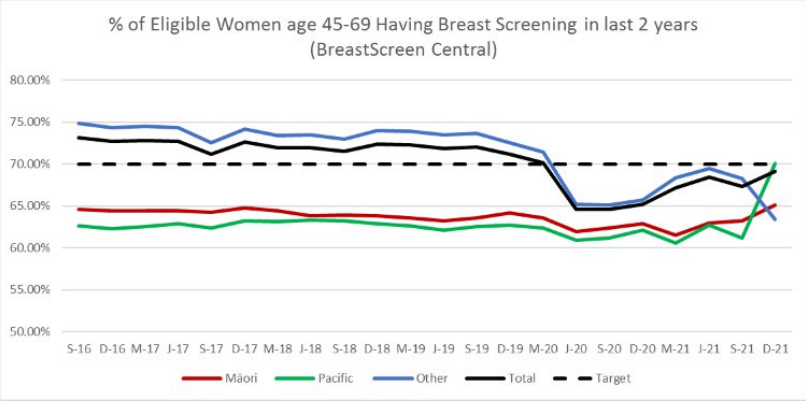
Faster Cancer Treatment

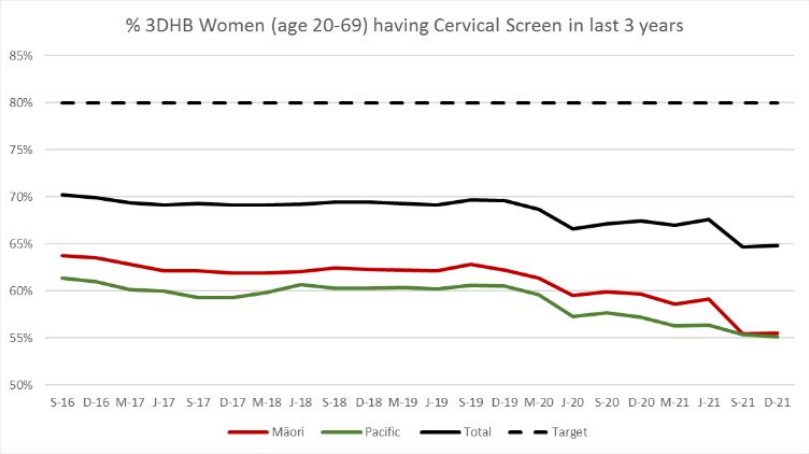




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have 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?**
  - 89% of patients met the HVDHB 62 day pathway for February - (3 out of 11 patients breached due to capacity related issues post lockdown). 79.5% for the 31 day target pathway was achieved.
  - There were no breeches of the 62 day target in February for Maori or Pacifica people.
- **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.

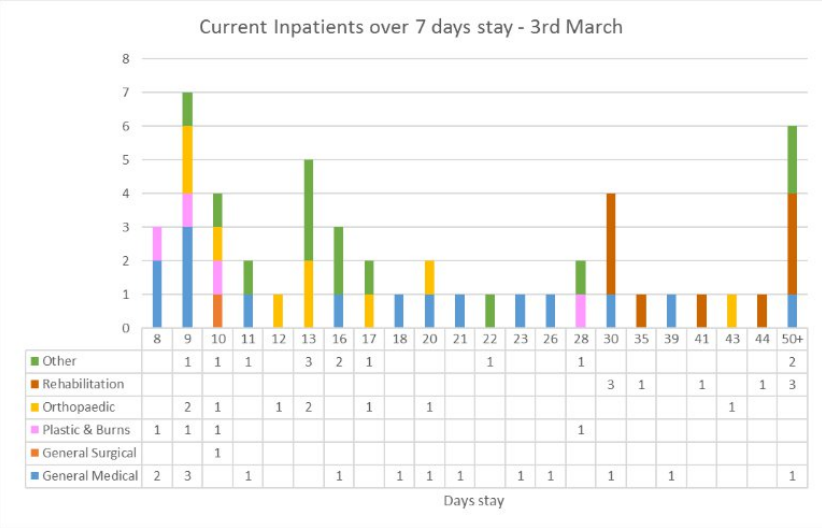
Screening



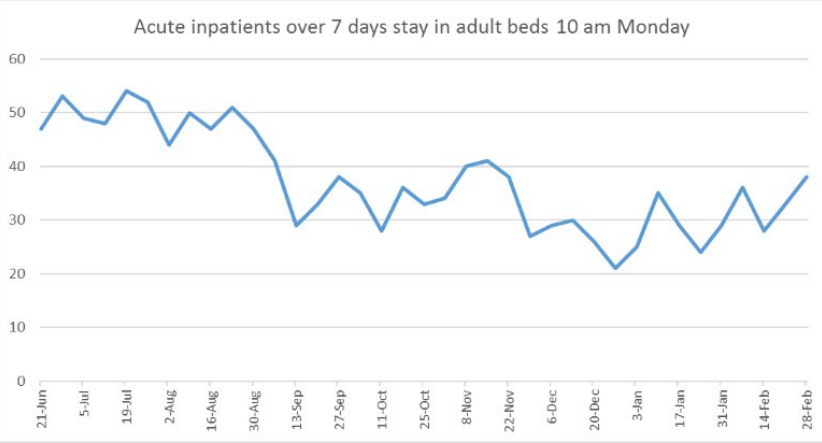


- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 45-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist 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?**
  - Cervical Screening coverage in December continued to be impacted by COVID, priority population clinics had to be deferred.
- **What is driving performance?**
  - In February 55 priority women attended their first screen (35 Maori and 20 Pacific). In addition 185 priority women attended for their subsequent screen (131 Maori and 54 Pacific).
  - Social distancing is impacting Mobile unit capacity
  - The service continues to provide Saturday and evening sessions on a (staff) volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued.
  - Symptomatic Services are running Saturday clinics for new referrals until the service can return to all day Monday clinics with the arrival of two new breast radiologists in the New Year.
- **Management Comment**
  - The service is on track to make up screening numbers that were deferred from recent hospital alert level response, 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 through to December.
  - Māori, Pacific and Asian women continue to be identified through the PHO data matching and prioritised for screening in both Cervical and Breast Screening.

Long Stay inpatients



	8	9	10	11	12	13	16	17	18	20	21	22	23	26	28	30	35	39	41	43	44	50+
Other		1	1	1		3	2	1				1			1							2
Rehabilitation																3	1		1		1	3
Orthopaedic		2	1		1	2		1		1										1		
Plastic & Burns	1	1	1												1							
General Surgical			1																			
General Medical	2	3		1			1		1	1	1		1	1		1		1				1



- **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 3rd March there were 51 current long staying patients; most were acute adults. This is stable. There was 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**
  - The Specialist Discharge Case Manager role has commenced, with orientation started.
  - Enhanced Early Supported Discharge for mild-moderate stroke patients and some medical patients went live in August. This will support earlier discharge for this group of patients and better hospital flow over all.
  - Residential care facilities are experiencing staffing issues partly due to Covid and border restrictions, this impacts on capacity

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for February 2022

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
42,333	42,249	84	40,498	1,835	Devolved MoH Revenue	346,611	337,996	8,615	324,812	21,798	518,663	506,994	11,669	489,113	29,550
2,019	1,621	397	1,055	963	Non Devolved MoH Revenue	15,694	13,288	2,406	14,565	1,130	22,869	20,179	2,690	21,680	1,189
1,174	612	562	492	682	ACC Revenue	4,768	4,823	(55)	4,568	199	6,921	6,976	(55)	7,129	(209)
445	503	(58)	451	(7)	Other Revenue	3,908	4,040	(132)	5,160	(1,252)	5,914	6,054	(140)	7,483	(1,569)
9,015	9,557	(542)	9,033	(18)	IDF Inflow	75,617	76,452	(836)	74,714	902	114,644	114,678	(34)	111,945	2,700
1,288	1,025	263	1,245	43	Inter DHB Provider Revenue	9,833	8,201	1,632	8,354	1,479	14,134	12,302	1,832	13,197	937
56,273	**55,567**	**706**	**52,775**	**3,498**	**Total Revenue**	**456,431**	**444,801**	**11,629**	**432,174**	**24,257**	**683,145**	**667,183**	**15,961**	**650,547**	**32,598**
					Expenditure										
					Employee Expenses										
5,330	5,021	(309)	4,987	(342)	Medical Employees	43,645	43,205	(439)	41,363	(2,281)	65,874	65,245	(628)	62,678	(3,196)
6,218	5,753	(464)	5,808	(410)	Nursing Employees	56,200	48,739	(7,461)	48,291	(7,909)	82,610	73,986	(8,625)	72,415	(10,195)
2,253	2,340	86	2,176	(77)	Allied Health Employees	19,446	20,166	720	18,799	(647)	29,798	30,467	669	28,663	(1,135)
840	739	(101)	714	(126)	Support Employees	6,969	6,364	(605)	6,222	(747)	10,428	9,619	(809)	9,579	(849)
1,943	2,061	118	2,021	79	Management and Admin Employees	17,043	17,981	938	17,400	357	25,778	27,053	1,275	26,733	955
16,584	**15,914**	**(670)**	**15,707**	**(877)**	**Total Employee Expenses**	**143,302**	**136,455**	**(6,847)**	**132,075**	**(11,228)**	**214,488**	**206,370**	**(8,118)**	**200,068**	**(14,420)**
					Outsourced Personnel Expenses										
197	205	8	656	460	Medical Personnel	1,841	1,639	(203)	4,764	2,922	2,661	2,458	(203)	5,973	3,312
133	15	(118)	614	481	Nursing Personnel	593	120	(473)	4,262	3,669	853	181	(673)	6,407	5,554
48	60	12	455	407	Allied Health Personnel	240	477	236	3,052	2,811	382	715	334	4,561	4,179
18	42	25	30	12	Support Personnel	436	338	(98)	327	(109)	605	507	(98)	491	(115)
713	621	(92)	443	(270)	Management and Admin Personnel	5,550	4,971	(578)	3,915	(1,634)	8,293	7,457	(835)	7,031	(1,261)
1,109	**943**	**(166)**	**2,198**	**1,089**	**Total Outsourced Personnel Expenses**	**8,661**	**7,545**	**(1,115)**	**16,319**	**7,659**	**12,793**	**11,318**	**(1,475)**	**24,463**	**11,670**
960	962	2	618	(342)	Outsourced Other Expenses	7,892	7,642	(250)	6,448	(1,444)	11,925	11,454	(471)	13,157	1,232
2,246	2,584	338	2,311	66	Treatment Related Costs	20,571	19,950	(621)	20,561	(10)	31,833	30,698	(1,135)	33,080	1,247
2,010	2,064	54	2,223	213	Non Treatment Related Costs	16,249	16,465	216	17,891	1,643	24,579	24,765	186	36,000	11,420
12,328	11,991	(337)	8,641	(3,687)	IDF Outflow	95,122	95,930	807	73,524	(21,599)	141,901	143,894	1,993	108,813	(33,088)
19,614	18,133	(1,481)	17,685	(1,929)	Other External Provider Costs	157,526	153,585	(3,941)	152,618	(4,908)	239,542	231,201	(8,341)	223,654	(15,888)
1,927	2,027	100	2,263	335	Interest, Depreciation & Capital Charge	15,946	16,213	267	16,355	408	24,030	24,321	291	23,537	(493)
56,778	**54,619**	**(2,159)**	**51,646**	**(5,131)**	**Total Expenditure**	**465,270**	**453,784**	**(11,485)**	**435,791**	**(29,478)**	**701,092**	**684,022**	**(17,070)**	**662,772**	**(38,320)**
(505)	**948**	**(1,453)**	**1,129**	**(1,633)**	**Net Result**	**(8,839)**	**(8,983)**	**144**	**(3,617)**	**(5,222)**	**(17,947)**	**(16,839)**	**(1,108)**	**(12,226)**	**(5,722)**
					Result by Output Class										
(2,161)	(34)	(2,126)	2,334	(4,494)	Funder	(9,397)	(8,792)	(605)	3,131	(12,528)	(14,580)	(14,012)	(568)	11,939	(26,520)
40	13	27	145	(105)	Governance	592	81	511	658	(66)	623	112	511	1,261	(638)
1,615	969	646	(1,351)	2,966	Provider	(34)	(272)	238	(7,407)	7,373	(3,990)	(2,939)	(1,051)	(25,425)	21,436
(505)	**948**	**(1,453)**	**1,129**	**(1,633)**	**Net Result**	**(8,839)**	**(8,983)**	**144**	**(3,617)**	**(5,222)**	**(17,947)**	**(16,839)**	**(1,108)**	**(12,226)**	**(5,722)**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $11,629k
  - Including COVID-19 funding and Nursing MECA funding.
- Personnel and outsourced Personnel unfavourable ($7,963k)
  - Medical unfavourable ($642k); Nursing unfavourable ($7,934k); Allied Health favourable $956k, Support Staff unfavourable ($703k); Management and Admin favourable $359k; Annual leave Liability cost has increased by $2,026k since February 2021
- Outsourced other expenses unfavourable ($250k)
- Treatment related Costs unfavourable ($621k)
- Non Treatment Related Costs favourable $216k
- IDF Outflow favourable $807k
- Other External Provider Costs unfavourable ($3,941k)
- Interest depreciation and capital charge favourable $267k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $706k for the month
  - Devolved MOH revenue $84k favourable, Driven by the additional funding for the Nurses MECA Settlement $260k, COVID-19 Funding $663k, and other variances.
  - Non Devolved revenue $397k favourable driven largely by Public Health COVID-19 funding $357k, and other variances.
  - ACC Revenue $562k favourable, driven by a backdated price change for Community Health.
  - Other revenue ($58k) unfavourable for the month.
  - IDF inflows unfavourable ($542k) for the month reflecting inpatient volumes.
  - Inter DHB Revenue favourable $283k.

COVID–19 Revenue and Costs

YTD Result - February 2021	Funder	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) (1)(2)	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19	3,417	94	2,239	5,749
Expenditure				
Employee Expenses				
Medical Employees		51	1,457	1,509
Nursing Employees		74	1,691	1,766
Allied Health Employees		23	896	919
Support Employees		28	0	28
Management and Admin Employees		90	442	532
Total Employee Expenses	**0**	**267**	**4,487**	**4,753**
Expenses				
Outsourced - Provider	0	0	523	523
External Providers - Funder	3,438			3,438
Clinical Expenses - Provider	0	8	5	12
Non-clinical Expenses- Provider	0	264	240	503
Total Non Employee Expenses	**3,438**	**271**	**767**	**4,476**
Total Expenditure	**3,438**	**538**	**5,254**	**9,230**
Net Impact	**(21)**	**(444)**	**(3,015)**	**(3,480)**

(1) Excludes indirect overhead charges

(2) YTD February estimates have been provided from a rebased estimate. Results reflect the use of Core Contract staff resource and funding, to undertake COVID-19 related work. Overall the Public Health unit YTD Result is favourable to budget, including all costs and overheads.

- The February year to date financial position includes $9.2m additional costs in relation to COVID-19.
- Revenue of $5.7m has been recognised to fund additional costs for community providers and Regional Public Health.
- Based on Direct funding, the net impact year to date is ($3.5m) deficit.
- COVID-19 result for RPH is ($3.0m) deficit. RPH's overall bottom line is a deficit of ($0.5m), which is $1.0m favourable to budget reflecting the use of Core contract funding and resources to undertake COVID-19 activity.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($835k) for the month
  - Medical personnel incl. outsourced unfavourable ($301k). Outsourced costs are $8k favourable. Medical Staff Internal are ($309k) unfavourable, *driven by Surgical Registrars.*
  - Nursing incl. outsourced ($583k) unfavourable. Employee costs are ($464k) unfavourable driven largely by Leave *($535k)* and MECA changes. The later is partly offset by an increase in devolved income.
  - Allied Health incl. outsourced $98k favourable, with outsourced favourable $12k and internal employees favourable $86k, driven by vacancies.
  - Support incl. outsourced unfavourable ($76k), with Outsourced $25k favourable and employee costs ($101k) unfavourable. The later driven by Orderlies ($44k), Sterile Assistants ($9k) and Kitchen Staff ($17k).
  - Management & Admin incl. outsourced favourable $27k, internal staff favourable $118k, outsourced unfavourable ($92k) including recharges from CCDHB.
  - Sick leave for February was 2.6%, which is higher than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Feb-22	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
280	290	10	279	(1)	Medical	279	289	10	280	1	289	279
769	797	28	755	(14)	Nursing	760	785	26	767	7	790	763
348	365	17	342	(6)	Allied Health	349	365	17	353	5	365	352
152	148	(4)	146	(6)	Support	152	147	(5)	146	(6)	147	147
300	336	36	318	18	Management & Administration	307	339	32	323	16	338	321
1,849	**1,935**	**86**	**1,839**	**(10)**	**Total FTE**	**1,846**	**1,926**	**80**	**1,869**	**23**	**1,930**	**1,862**
					$ per FTE							
19,041	17,338	(1,703)	17,868	(1,173)	Medical	156,458	149,399	(7,059)	147,926	(8,532)	227,911	233,613
8,081	7,219	(862)	7,691	(390)	Nursing	73,963	62,050	(11,912)	62,965	(10,998)	104,537	97,019
6,472	6,405	(67)	6,366	(106)	Allied Health	55,790	55,205	(585)	53,184	(2,606)	81,573	86,588
5,525	5,004	(522)	4,902	(624)	Support	45,933	43,253	(2,681)	42,614	(3,320)	70,777	65,337
6,481	6,135	(346)	6,362	(119)	Management & Administration	55,509	52,989	(2,520)	53,816	(1,693)	76,222	84,263
8,968	**8,222**	**(745)**	**8,539**	**(429)**	**Average Cost per FTE all Staff**	**77,624**	**70,833**	**(6,791)**	**70,652**	**(6,972)**	**111,127**	**110,832**

Medical under budget for the month by 10 FTE, driven by SMOs under budget by 17 FTE, partially offset by Registrars.

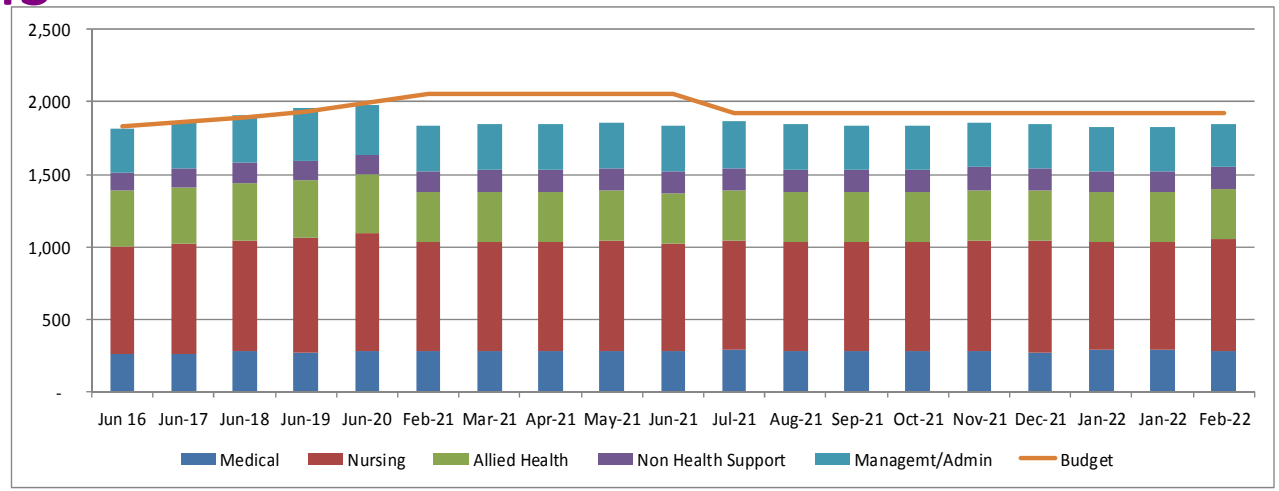
Nursing under by 28 FTE for the month the contribution to movements were; Internal Bureau Nurses, Midwives and HCA's are over budget (16) FTE mostly driven by General Surgery (1) FTE, General Medical (8) FTE, ED (4) FTE offset by other variances. This was offset by Midwives 15 FTE and Registered Nurses 12 FTE and HCA's 19 FTE . This reflects the transition to changes made under both CCDM recommendations and the Maternity Review. The $/Fte has been materially impacted by the MECA settlements including adjustment to Annual Leave provisions.

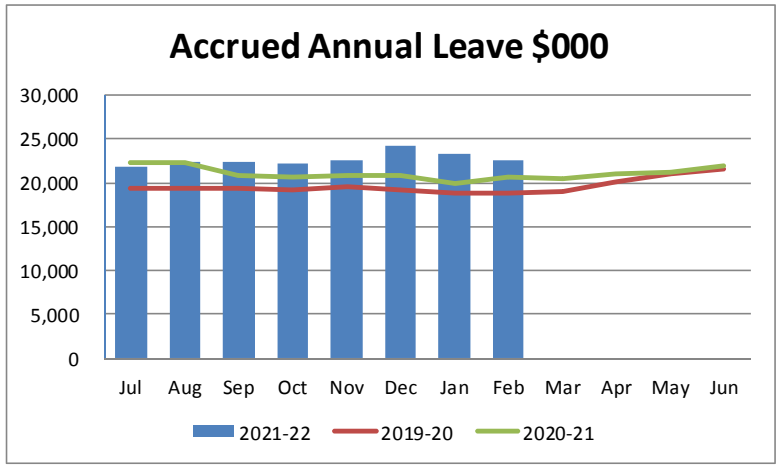
Allied FTEs are under by 17 FTEs for the month, driven by Regional Public Health 2 FTE, Community Health 9 FTE, Community Dental 4 FTE and other variances.

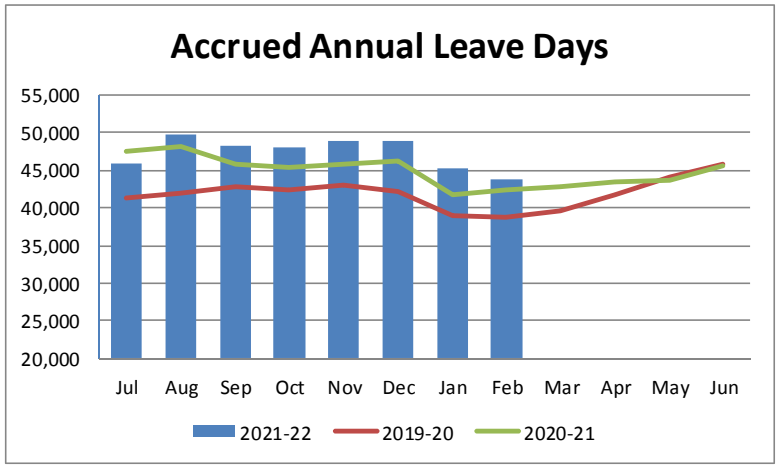
Support FTEs are over budget (4) FTE, driven by Food Services (3) FTE, and Orderlies (3) FTE.

Management & Admin are under budget by 36 FTEs driven by SPO 3 FTE, Quality 8 FTE, Communications 3 FTE, Surgical Women's & Children's 6 FTE, Regional Screening 2 FTE, Procurement 1 FTE and other variances. Noting that 2DHB corporate areas will be recruited on the CCDHB payroll and charged back to HVDHB via outsourced.

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 $2k for the month.
  - Treatment related costs $338k favourable for the month driven by Instruments and Equipment $182k, Implants and Prostheses $1115k, Treatment Disposables $141k and other minor variances.
  - Non Treatment Related costs favourable $54k driven by Compliance and Corporate Costs $154k, mostly offset by Facilities expenses. .
  - IDF Outflows ($337k) unfavourable for the month, driven by current year outflows.
  - Other External Provider costs unfavourable ($1,481k), mostly driven by Community Pharmacy ($1,175k) Aged Residential Care $163k, and COVID-19 related payment to PHO's ($328k), offset by other variances.
  - Interest, Depreciation & Capital Charge favourable $100k, driven by Depreciation $141k, reflecting delays in the Capital programme, offset by changes to the Capital Charge ($43k).

Section 5

Additional Financial Information & Updates

Financial Position as at 28 February 2022

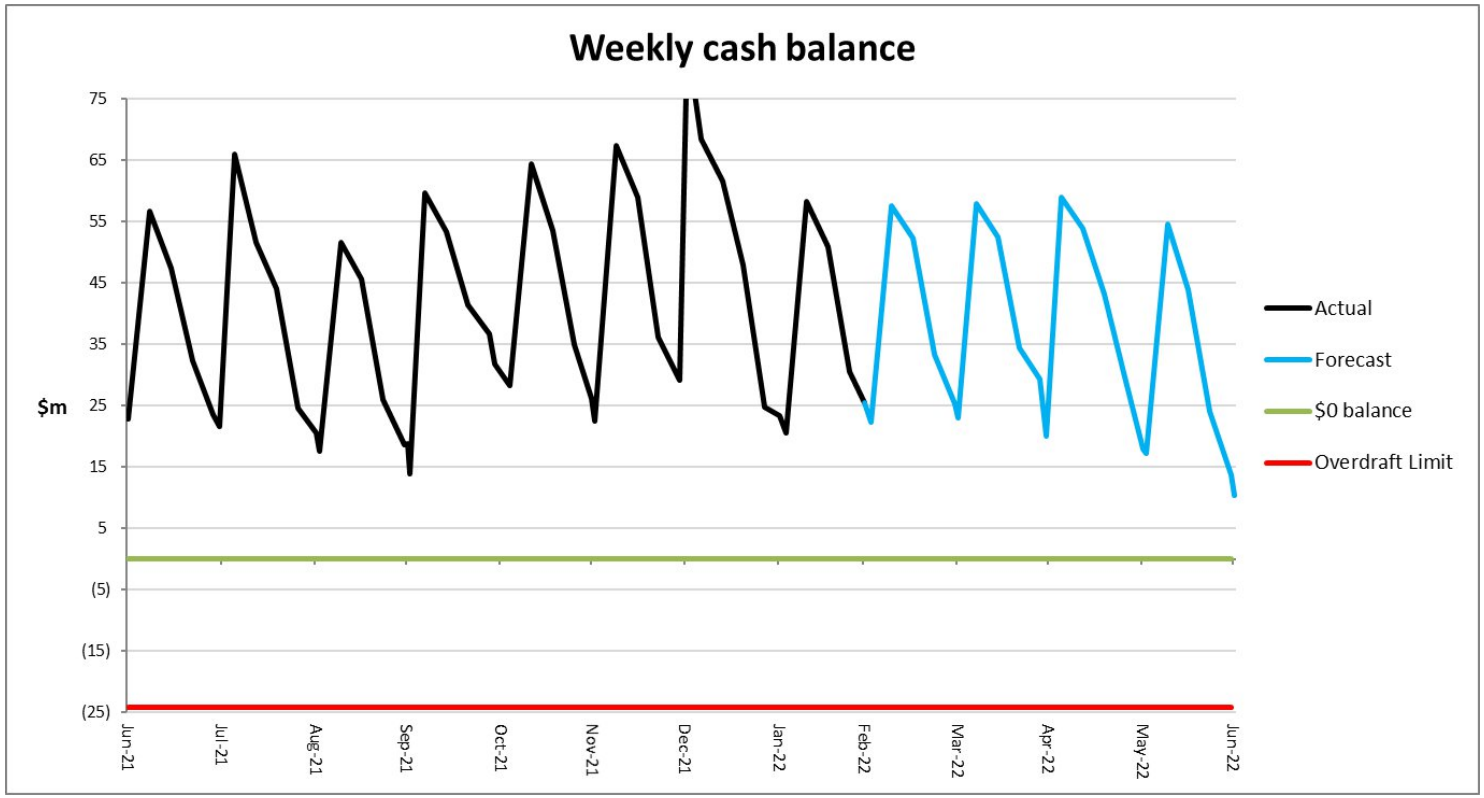
$000s	Actual	Budget	Variance	Jun 21	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	25,424	(16)	25,440	22,890	2,534	Average bank balance in Feb-22 was $44.3m
Bank - Non DHB Funds *	5,785	5,831	(46)	5,236	549	
Accounts Receivable & Accrued Revenue	33,657	25,031	8,626	33,457	200	
Stock	1,975	2,614	(638)	2,322	(347)	
Prepayments	1,740	1,161	579	1,241	499	
Total Current Assets	**68,582**	**34,621**	**33,961**	**65,146**	**3,436**	
Fixed Assets						
Fixed Assets	219,944	252,998	(33,054)	223,741	(3,797)	
Work in Progress	11,190	7,905	3,285	9,218	1,972	
Total Fixed Assets	**231,133**	**260,902**	**(29,769)**	**232,958**	**(1,825)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,317	1,266	51	1,221	96	
Total Investments	**2,467**	**2,416**	**51**	**2,371**	**96**	
Total Assets	**302,182**	**297,940**	**4,242**	**300,476**	**1,707**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	86,000	77,223	(8,778)	79,873	(6,127)	Includes Holidays Act Provision of $32.0m
Crown Loans and Other Loans	14	3	(10)	42	28	
Capital Charge Payable	1,470	4,001	2,531	0	(1,470)	
Current Employee Provisions	29,364	28,199	(1,165)	27,029	(2,335)	
Total Current Liabilities	**116,848**	**109,426**	**(7,422)**	**106,944**	**(9,904)**	
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	5,785	5,831	46	5,236	(549)	
Trust Funds	1,240	1,226	(14)	1,221	(19)	
Total Non Current Liabilities	**16,311**	**16,207**	**(104)**	**15,743**	**(568)**	
Total Liabilities	**133,159**	**125,633**	**(7,526)**	**122,686**	**(10,473)**	
Net Assets	**169,023**	**172,307**	**(3,284)**	**177,789**	**(8,766)**	
Equity						
Crown Equity	158,709	166,918	(8,210)	158,709	0	
Revaluation Reserve	146,362	146,289	73	146,289	73	
Opening Retained Earnings	(127,208)	(131,916)	4,708	(114,982)	(12,226)	
Net Surplus / (Deficit)	(8,839)	(8,983)	144	(12,226)	3,387	
Total Equity	**169,023**	**172,307**	**(3,284)**	**177,789**	**(8,766)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 28 February 2022

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	43,259	43,479	44,926	46,778	43,649	96,726	(3,945)	46,269	44,943	44,624	44,575	45,084
Receipts from Other DHBs (Including IDF)	10,208	7,504	10,523	14,609	9,547	16,266	7,610	10,013	10,994	10,778	10,778	10,778
Receipts from Other Government Sources	492	664	623	610	968	762	561	1,256	613	653	613	725
Other Revenue	4,907	(460)	(4,228)	3,218	(523)	(4,710)	3,332	1,180	113	116	113	113
Total Receipts	**58,866**	**51,187**	**51,844**	**65,215**	**53,641**	**109,045**	**7,558**	**58,718**	**56,663**	**56,171**	**56,079**	**56,700**
Payments for Personnel	(17,569)	(16,888)	(20,053)	(16,260)	(16,277)	(23,368)	(19,970)	(17,793)	(19,647)	(18,028)	(18,822)	(18,821)
Payments for Supplies (Excluding Capital Expenditure)	(9,630)	(5,793)	(2,437)	(3,561)	(7,839)	(6,430)	(1,195)	(7,793)	(5,974)	(6,049)	(6,071)	(5,532)
Capital Charge Paid	0	0	0	0	0	0	(4,410)	0	0	0	0	(4,410)
GST Movement	(848)	8	828	983	(2,263)	2,776	(1,779)	31	0	0	0	0
Payments to Other DHBs (Including IDF)	(11,963)	(11,858)	(11,945)	(11,140)	(12,003)	(11,963)	(12,299)	(12,006)	(11,195)	(11,195)	(11,195)	(11,195)
Payments to Providers	(18,979)	(16,766)	(19,201)	(21,311)	(19,652)	(19,487)	(19,293)	(18,029)	(20,502)	(20,429)	(20,699)	(20,386)
Total Payments	**(58,989)**	**(51,297)**	**(52,809)**	**(51,288)**	**(58,034)**	**(58,472)**	**(58,946)**	**(55,589)**	**(57,318)**	**(55,701)**	**(56,786)**	**(60,344)**
Net Cashflow from Operating Activities	**(123)**	**(110)**	**(966)**	**13,926**	**(4,393)**	**50,573**	**(51,388)**	**3,129**	**(655)**	**470**	**(707)**	**(3,643)**
Investing Activities												
Interest Receipts	23	23	22	31	33	43	41	35	21	21	21	21
Dividends	0	0	0	0	0	0	0	0	4	4	4	4
Sale of Fixed Assets	0	0	0	0	0	1	0	0	0	0	0	0
Total Receipts	**23**	**23**	**22**	**31**	**33**	**44**	**41**	**35**	**25**	**25**	**25**	**25**
Capital Expenditure	(1,192)	(1,007)	(783)	(823)	(1,280)	(995)	(1,082)	(1,109)	(2,256)	(2,905)	(2,256)	(2,914)
Increase in Investments and Restricted & Trust Funds Assets	(24)	7	(8)	(23)	19	5	(5)	(68)	0	0	0	0
Total Payments	**(1,216)**	**(999)**	**(791)**	**(846)**	**(1,261)**	**(989)**	**(1,088)**	**(1,177)**	**(2,256)**	**(2,905)**	**(2,256)**	**(2,914)**
Net Cashflow from Investing Activities	**(1,193)**	**(976)**	**(769)**	**(815)**	**(1,228)**	**(945)**	**(1,047)**	**(1,142)**	**(2,231)**	**(2,880)**	**(2,231)**	**(2,889)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Interest Paid on Finance Leases	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0	(2)	(2)	(2)	(2)
Total Payments	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**0**	**(2)**	**(2)**	**(2)**	**(2)**
Net Cashflow from Financing Activities	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**0**	**(2)**	**(2)**	**(2)**	**(2)**
Total Cash In	58,889	51,211	51,866	65,246	53,674	109,089	7,599	58,753	56,688	56,196	56,104	56,725
Total Cash Out	(60,204)	(52,296)	(53,600)	(52,135)	(59,295)	(59,461)	(60,034)	(56,766)	(59,576)	(58,608)	(59,044)	(63,259)
Net Cashflow												
Opening Cash	22,890	21,575	20,489	18,754	31,865	26,245	75,872	23,437	25,424	22,536	20,124	17,184
Net Cash Movements	(1,316)	(1,086)	(1,734)	13,111	(5,621)	49,628	(52,435)	1,987	(2,888)	(2,412)	(2,940)	(6,534)
Closing Cash	**21,575**	**20,489**	**18,754**	**31,865**	**26,245**	**75,872**	**23,437**	**25,424**	**22,536**	**20,124**	**17,184**	**10,650**

Weekly Cash Flow – Actual to 28 February 2022



Note

- the overdraft facility shown in red is set at $24.2 million as at February 2022
- the lowest bank balance for the month of February was $20.6m

Capital expenditure – Actual to February 2022

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	2,719	931	13,017	1,830	11,187
Clinical Equipment	629	6,043	3,824	974	2,850	9,522	2,792	6,731
Information Technology (Hardware)	1,211	1,828	862	408	454	3,493	564	2,929
Intangible Assets (Software)	56	2,853	356	185	170	3,079	46	3,032
Baseline Total	**6,282**	**18,425**	**8,691**	**4,287**	**4,405**	**29,112**	**5,232**	**23,878**
Strategic								
Buildings and Plant	1,065	-	-	-	-	1,065	-	1,065
Clinical Equipment	2,275	1,460	2,301	451	1,850	5,586	141	5,445
IT	722	2,145	1,066	359	707	3,575	369	3,206
Strategic Total	**4,063**	**3,605**	**3,367**	**809**	**2,558**	**10,226**	**510**	**9,716**
Pandemic								
Buildings and Plant	-	-	-	-	-	-	-	-
Clinical Equipment	-	-	-	-	-	-	-	-
IT	-	-	-	-	-	-	135	(135)
Pandemic Total	**-**	**-**	**-**	**-**	**-**	**-**	**135**	**(135)**
Total Capital (excluding MOH, Trust, Gym)	**10,345**	**22,030**	**12,058**	**5,096**	**6,962**	**39,338**	**5,877**	**33,459**

Summary of Leases – as at 28 February 2022

		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 (*lease status to be confirmed)		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 (131 Vehicles, including 2 Nissan Leaf EV's)			41,379	496,545		Ongoing	Ongoing	Operating
			41,379	**496,545**				
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
Zeiss Opthalmology Equipment (Plastics x1, ENT x2)	De Lage Landen (paid quartlerly in arrears)		14,332	171,988	859,938	17/12/2021	17/09/2026	Operating
		293,188	**145,745**	**1,748,962**	**7,528,150**			
Total Leases			**244,110**	**2,929,331**				

Treasury as at 28 February 2022

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$44,313	$49,746
Lowest balance for the month	$20,620	$23,426
Average interest rate	1.02%	0.97%
Net interest earned/(charged) for the month	$35	$41

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	$41,008 NZD
Largest transaction	$17,884 NZD

	No. of transactions	Equivalent NZD
AUD	2	$6,967
GBP		
CAD	1	$17,884
USD	1	$16,158
Total	**4**	$41,008

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	$6,371	$537	$228	$18	$331	$166	$181	$4,910
Ministry of Health	$3,349	$1,626	$483	$946	($188)	$160	$289	$32
Accident Compensation Corporation	$843	$498	$0	$155	($21)	($43)	$18	$236
Wairarapa District Health Board	$346	$180	$83	$0	$83	$0	$0	$0
Mental Health Solution	$208	$0	$0	$208	$0	$0	$0	$0
Ministry of Social Development	$194	$0	$148	$46	$0	$0	$0	$0
Auckland District Health Board	$164	$85	$0	$0	$0	$79	$0	$0
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
Non Resident	$52	$0	$0	$0	$0	$0	$0	$52
Wellington Southern Community Laboratories	$50	$32	$0	$18	($0)	$0	$0	$0
Total Top 10 Debtors	**$11,636**	**$3,018**	**$941**	**$1,391**	**$205**	**$362**	**$489**	**$5,230**

Board Information – Public

30 March 2022

CCDHB Financial and Operational Performance Report – February 2022	
Action Required **The CCDHB Board note:** (a) the DHB had a $1.6m surplus for the month of February 2022, being $2.1m favourable to the agreed budget; (b) In February 2022 we incurred $2.5m additional unfunded expenditure for COVID-19; (c) the total Case Weighted Discharge (CWD) Activity was 0.3% behind plan year to date; (d) at the end of February 2022, the DHB had a year to date deficit of ($29.5m), ($9.0m) unfavourable to the agreed budget; (e) excluding the unfunded COVID-19 costs the year to date of $16.9m the deficit is ($12.5m) which is $7.9m favourable to the agreed budget.	
Strategic Alignment	Financial Sustainability
Presented by	2DHB Chief Financial Officer (acting), Mathew Parr 2DHB Director of Provider Services, Joy Farley 2DHB Director Strategy Planning and Performance (acting), Peter Guthrie
Endorsed by	2DHB Chief Executive - Fionnagh Dougan
Purpose	To update the Board 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.

Executive Summary

We are incurring significant additional cost due to the COVID-19 response in the 2021/22 fiscal year. The DHB is being reimbursed for a large portion of the DHB COVID-19 response costs in 2021/22 however COVID-19 costs incurred have not been funded.

- The Ministry has asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
- For the eight months to 28 February 2022 the overall DHB year to date result, including COVID-19 costs is a $29.4m deficit, this is $9.0m unfavourable to the agreed budget of a $20.5m deficit.
- Excluding the unfunded COVID-19 expenses, the DHB's result for the eight months to 28 February 2022 is a $12.5m deficit, which is $7.9m favourable to the agreed budget. Additional unfunded net COVID-19 related expenditure is $16.9m year to date.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $56.2m year to date.
- The DHB has a positive cash Balance at month-end of $12.4 million and a positive "Special Funds" position of $14.5 million. It should be noted that there are certain financial impacts of the COVID-19 response that remain 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 $65m from the $92m signalled in the 2021/22 Annual Plan was received in January.

Hospital:

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.
- We have continued to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this is increasingly limited by COVID inpatient demands and staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- The cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list remains well outside the target waitlist size set by the Ministry programme. Factors impacting on our waitlist size is the reduction in surgery due to COVID 19 related additional cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist. A clinical team is looking at other options to support reduction in the waiting time.
- Our Hospitals programme established to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline for the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, is in place 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 Nursing Officer.
- We remain within budget.

Funder:

- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity.

The four main work streams are:

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

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 for CCDHB are 128 FTE below plan year to date
Financial	Planned surplus including the children's hospital donation for CCDHB is $7 million with no COVID-19 impacts included.
Governance	This monthly report enables the Board to scrutinise the financial and operational performance of the DHB.

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	Mat Parr, Acting 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 – February 2022

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 28 February 2022

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

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

- Excluding the COVID-19 net expenses the DHB's result for the eight month's to 28 February 2021 is $12.5m deficit, versus a budget deficit of $20.5m.

- Additional net COVID-19 related expenditure above funding, year to date is $16.9m.

- For the eight month's to 28 February 2022 the overall DHB year to date result, including COVID-19 costs is $29.5m deficit.

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

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

- The DHB has a positive cash Balance at month-end of $12.4m and a positive "Special Funds" of $14.5m, net $26.9m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Executive Summary continued

Hospital

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.
- We have continued to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this is increasingly limited by COVID inpatient demands and staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
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Funder::

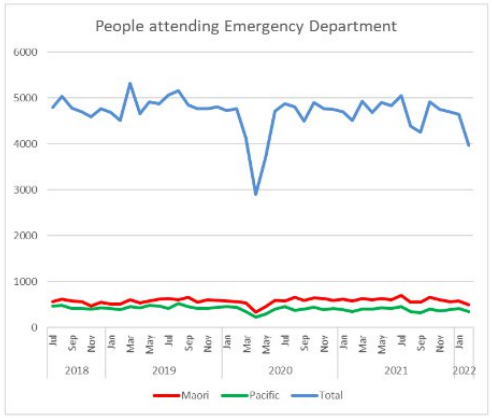
In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum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

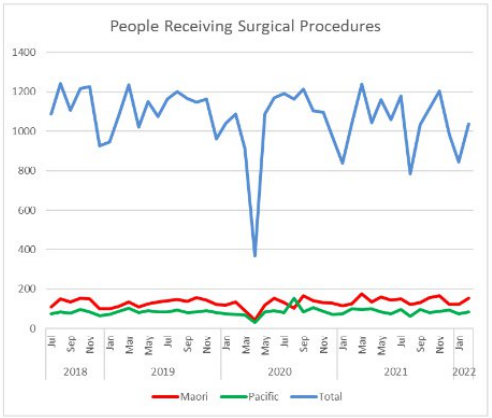
- Complex Care and Long Term Conditions
  - Improve access and reduce inequities for Maori and Pacific
- Locality Services Integration
  - We are waiting on feedback on the Porirua Prototype proposal to iHNZ and are now focusing our efforts on Lower Hutt and the Wainuiomata community.
- 2DHB Community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

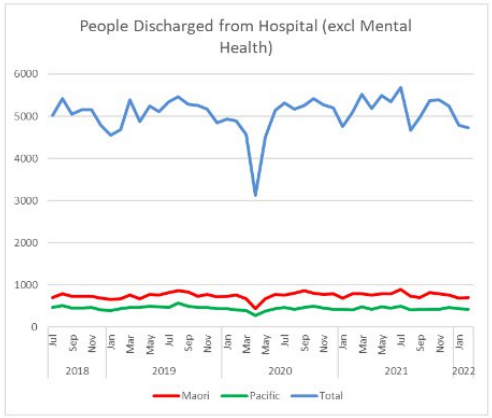
Performance Overview: Activity Context (People Served)

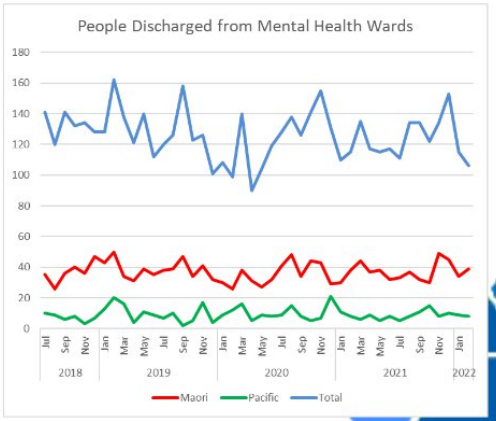
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**3,978**	501 Maori, 353 Pacific
People receiving Surgical Procedures (in main theatres)	**1,036**	155 Maori, 83 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**4,733**	704 Maori, 418 Pacific
People discharged from Mental Health Wards	**106**	39 Maori, 8 Pacific



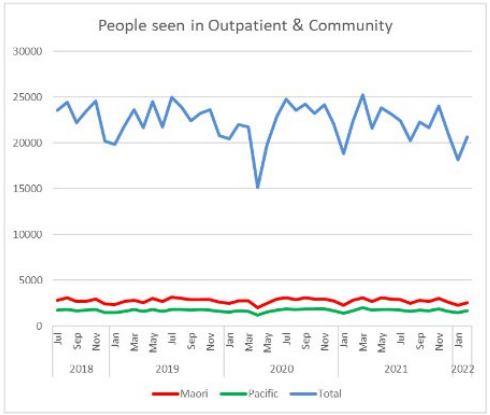


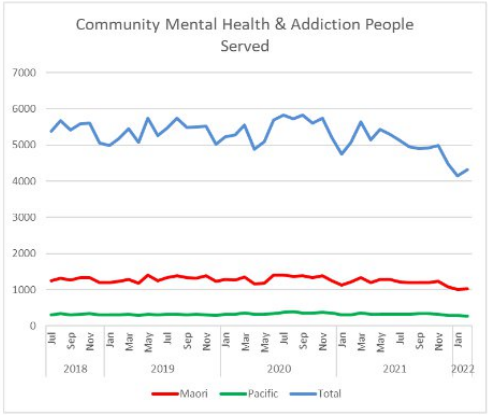


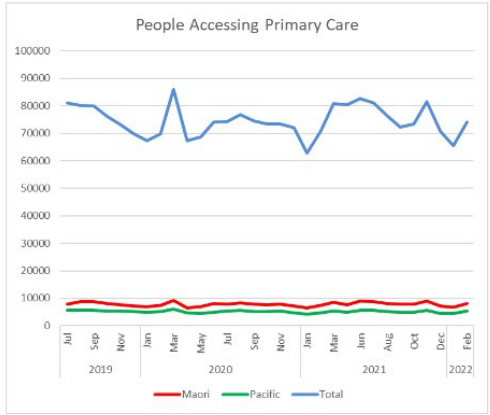


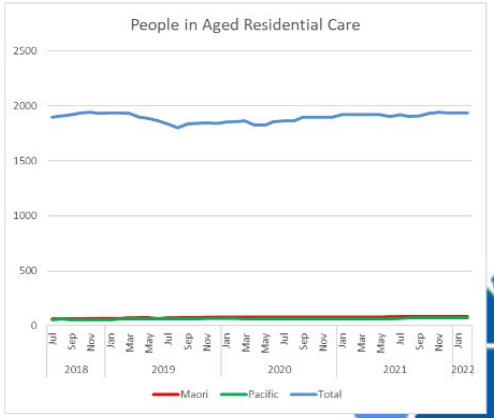
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**20,649**	2,555 Maori, 1,656 Pacific
Community Mental Health & Addiction People Served	**4,315**	1,027 Maori, 267 Pacific
People accessing primary care	**74,131**	8,147 Maori, 5,267 Pacific
People in Aged Residential Care	**1,935**	85 Maori, 71 Pacific









Financial Overview – February 2022

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$29.5m deficit Incl. $16.9m net COVID-19 costs	$24.7m deficit Incl. $16.9m net COVID-19 costs	$5.1m deficit	$56.2m spend Incl. $30.2m strategic capex
Against a budgeted YTD deficit of $20.5m. BAU Month result was $4.5m favourable. YTD $7.9m favourable BAU variance.	Against a budgeted YTD deficit of ($15.6m.) BAU Month result was $4.5m unfavourable. BAU YTD $7.7m favourable variance.	Against a budgeted YTD Deficit of $4.8m. BAU Month result was ($40k) unfavourable result. YTD ($250k) unfavourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $26.1m. Strategic incorporates funded project such as Children's Hospital & ISU

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.3% behind[1]	5,909[3]	($10.9m) annualised[4]
-1,507 CWDs behind PVS plan (-846 IDF CWDs , but -329 Hutt behind). Month result - CWDs excluding work in progress.	YTD 128 FTE below annual budget of 6,037 FTE. There is 859 FTE vacancies at end of February	Underlying YTD annual leave taken is under by 3.6 days per FTE and Lieu leave taken for public holidays is short by 3.4 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1,611 cwd outsourced (790 events) ~$9.8m 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 – February 2022

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
68%	773	1,431**	8
27% below the ED target of 95% Monthly +2.1%	Against a target of zero long waits a monthly movement of -14	Against a target of zero long waits, a monthly movement of +254 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.3% behind[1]	3,834[3]	$6,856*
-1,507 CWDs behind PVS plan (-846 IDF CWDs , but -329 Hutt behind). Month result - CWDs excluding work in progress.	YTD 5 below annual budget of 3,829 FTE. 402 FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Jan 2022

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1,611 cwd outsourced (790 events) ~$9.8m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $1.3m adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- The net unfavourable YTD variance in the Funder Arm of ($0.3m) consists of a favourable revenue variance of $86.1m offset by an unfavourable cost variance of ($86.4m) mainly due to unbudgeted COVID revenue and costs as set out below.
- COVID-19 accrued and paid revenue of $64.5m is offset by COVID-19 costs of ($64.5m). 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 Care in the Community (CitC) planning phase has been accelerated. The COVID-19 testing and vaccination programmes are still the main focus with the booster injection phase continuing to support reducing the impact of Omicron spread into the community. The programmes are managed using community sites across the CCDHB and Hutt region, some with drive through options, which can be ramped up or down at short notice. Equity priorities for Māori, Pacific and vulnerable communities are part of all the programmes to make sure vaccinations and community care is delivered promptly and that those populations are not at risk.
- The cost of funding BAU community services is ($2.2m) unfavourable to budget. Some of these costs have offsetting revenue. Additional Age Residential Care costs reflect the impact of stronger homecare support services. These are offset by lower costs in Primary Care demand driven services such as immunisations (excl COVID) and child dental services.
- The volume throughput in HHS is still below target due to COVID related lockdowns since August. The funder paid $4.8m less to the Provider Arm for services and received ($5.8m) less IDF revenue from other DHBs. The Funder Arm had to pay back planned care 2020-21 target wash-up of ($0.7m).
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant needs for improved service delivery and a pro-equity commissioning approach which is being led by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:
    - Complex Care and Long Term Conditions
        - Improve access and reduce inequities for Maori and Pacific
    - Locality Services Integration
        - We are waiting on feedback on the Porirua Prototype proposal to iHNZ and are now focusing our efforts on Lower Hutt and the Wainuiomata community.
    - 2DHB Community Health Networks
        - Strengthen Kapiti Community Health Network. An EOI for new members has closed and is being worked through.
        - Develop Community Health Networks in Wellington and the Hutt Valley
        - Allied Health Integration
        - Community Accident and Medical redesign/ Community Radiology redesign where we are in receipt of the report and are working through its implications
    - Intersectoral Priorities
        - Disability – World of Difference
        - Strengthen our response to family violence

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Feb 2022	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
76,176	76,176	72,885	(0)	3,291	- Base Funding	609,406	609,406	583,080	(0)	26,326
5,280	5,292	4,240	(12)	1,040	- Other MOH Revenue - Funder	45,347	42,337	38,007	3,010	7,340
1,200	0	0	1,200	1,200	- Other MOH Revenue - MECA	23,710	0	0	23,710	23,710
11,934	0	1,352	11,934	10,582	- COVID Revenue from MOH	64,473	0	12,768	64,473	51,705
50	46	50	4	0	- Other Revenue	435	369	1,110	66	(675)
2,855	2,892	2,908	(37)	(53)	- IDF Revenue Inflows PHOs	23,602	23,135	24,136	467	(534)
24,471	23,133	18,310	1,339	6,162	- IDF 2021-2022 wash-up provision	179,514	185,060	145,848	(5,547)	33,666
121,966	**107,539**	**99,744**	**14,428**	**22,222**	**Total Revenue**	**946,488**	**860,309**	**804,950**	**86,179**	**141,538**
					Internal Provider Payments					
839	839	824	0	(15)	- DHB Governance & Administration	6,711	6,711	6,589	0	(122)
54,849	53,888	47,982	(962)	(6,867)	- DHB Provider Arm Costs - HHS	462,419	467,588	416,212	5,169	(46,207)
11,822	11,558	7,767	(265)	(4,055)	- DHB Provider Arm Costs - MHAIDS	92,758	92,463	62,140	(295)	(30,618)
(204)	(204)	2,056	0	2,260	- DHB Provider Arm costs - Corporate	(1,523)	(1,614)	15,067	(91)	16,590
1,200	0	0	(1,200)	(1,200)	- DHB Provider Arm costs - MECA	23,710	0	0	(23,710)	(23,710)
4,356	0	0	(4,356)	(4,356)	- DHB Provider Arm costs - COVID	16,722	0	0	(16,722)	(16,722)
72,862	**66,081**	**58,629**	**(6,782)**	**(14,233)**	**Total Internal Provider**	**600,798**	**565,148**	**500,008**	**(35,650)**	**(100,790)**
					External Provider Payments:					
7,176	6,571	5,379	(605)	(1,796)	- Pharmaceuticals	53,626	52,565	53,109	(1,061)	(518)
6,676	6,550	6,702	(125)	27	- Capitation	53,488	52,403	53,604	(1,084)	117
7,018	7,454	6,649	435	(369)	- Aged Care and Health of Older Persons	59,781	59,631	57,541	(150)	(2,240)
3,442	3,184	2,740	(258)	(702)	- Mental Health	26,557	25,472	23,606	(1,085)	(2,951)
761	879	887	118	126	- Child, Youth, Families	6,814	7,034	6,471	220	(343)
285	662	557	377	272	- Demand driven Primary Services	3,673	5,294	4,502	1,621	830
3,003	3,005	1,989	2	(1,014)	- Other services	24,741	24,038	18,218	(703)	(6,524)
4,002	4,002	3,810	0	(191)	- IDF Outflows Patients to other DHBs	32,015	32,015	30,527	0	(1,488)
5,242	5,190	5,330	(52)	88	- IDF Outflows Other	41,611	41,518	42,436	(93)	825
37,604	**37,496**	**34,044**	**(108)**	**(3,561)**	**Total External Providers**	**302,305**	**299,971**	**290,014**	**(2,334)**	**(12,291)**
7,579	0	1,152	(7,579)	(6,427)	- Community COVID Testing & Vax	43,391	0	8,679	(43,391)	(34,711)
0	0	135	0	135	- Community COVID Maori & Pacific	4,360	0	1,486	(4,360)	(2,874)
0	0	0	0	0	- IDF Wash-up 2020-2021	696	0	0	(696)	(696)
118,045	**103,577**	**93,959**	**(14,468)**	**(17,794)**	**Total Expenditure**	**951,549**	**865,119**	**800,187**	**(86,430)**	**(151,362)**
3,921	**3,962**	**5,785**	**(40)**	**(1,864)**	**Net Result**	**(5,061)**	**(4,810)**	**4,763**	**(251)**	**(9,824)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	1,998	10,942
COVID-19 Community funding	7,579	47,751
COVID-19 HHS Funding	2,358	5,781
MECA - Additional Funding	1,200	23,710
PHOs volume variances offset	37	1,601
Mental Health, Aged Care, Family CFAs	365	2,158
CWD IDF 2021/22 below target	891	(5,763)
Year to Date Revenue Variances	**14,428**	**86,179**

External Revenue Variances

- COVID-19 actual funding and accrued provision of **$64.5m** in support of GP assessment testing, vaccine rollout, quarantine hotel staffing, Care in the Community & response funding for Maori and Pacific groups. The DHB will be fully funded for all COVID response and vaccination rollout costs for community activities.
- PHO additional wash-ups and volume funding variance of **$1.6m**. There are increased costs of ($1.1m) offsetting this revenue.
- New funding for Mental Health and Child & Youth services of **$2.2m** has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by **($5.8m)** due to COVID periods since Aug 2021. MECA pay equity funding of **$23.7m** passed through to Provider Arm,

Total CCDHB Funder Arm NET year to date Feb- 21 variance is unfavourable by ($0.25m).

Payments to External and Internal Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(1,998)	(10,942)
COVID-19 Community funding	(7,579)	(47,751)
COVID-19 HHS Funding	(2,358)	(5,781)
MECA - Additional Funding	(1,200)	(23,710)
HHS PVS services reduced due to COVID	(1,222)	4,818
PHOs volume variances offset revenue	(113)	(1,145)
Volume driven costs	(112)	183
Aged Care and Mental Health	113	(1,406)
2020/21 IDF and Planned Care washup	0	(696)
Year to Date Payment Variances	**(14,468)**	**(86,430)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs **($64.5m)** due to ongoing GP test assessment claims, vaccine rollout and Care in the Community in support of the COVID-19 response as directed by the Ministry. This includes Price per Dose vaccinations costs.
- PHO Capitation expenses are **($1.1m)** unfavourable. Additional costs due to volume changes are offset by additional revenue $1.6m.
- Other Community NGO contracts have a net YTD unfavourable variance of (**$1.2m)**. Increased Aged Care volumes in home support and Pharmacy claims offsets favourable volumes in demand driven services such as immunisations (excl COVID) & child dental.

Internal Provider Payments:

- Provider Arm was paid **$4.8m** less due to lower volumes achieved related to COVID lockdown periods. MECA pay equity Ministry funding of (**$23.7m)** passed through to Provider Arm,

IDF 2020-21 wash-up Payment

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

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Feb 2022 $000's
Inpatient CWD	(5,159)
Outpatient Non DRG	(236)
Uncoded & PCT	(368)
Mental Health Provider	243
PHO Volume changes	470
Other IDF Inflows	(30)
Total per Financials	**(5,080)**

Inter District Revenue Inflows

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

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($4.4m): Cardiology ($1.8m), General Surgery ($1.1m), Haematology ($798k), Vascular Surgery ($455k), Gen Med ($412k), Oncology ($412k), Spec Paediatric Surgery Neonates ($365k), Urology ($327k), Respiratory Medicine ($245k), Renal ($219k), Neurosurgery ($178k), and Offset by Neurology $612k, Otorhinolaryngology (ENT) $440k, Maternity Service $372k, Orthopaedic Surgery $277k, Gynaecology $134k, Ophthalmology $101k
  - Planned Care: ($724k); Cardiology ($666k), Cardiothoracic ($542k), Neurosurgery ($535k), General Surgery ($401k) , Vascular Surgery ($235k), Gynaecology ($103k), Paediatric Surgical Services ($41k) and offset by Orthopaedic Surgery $931k, Otorhinolaryngology (ENT) $407k, Ophthalmology $278k, Urology $191k,
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry
- Non DRG inflow relates to all IDF patient visits that do not require a overnight stay

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

Commissioning: Families & Wellbeing

What is this measure?

Mothers

- 75% of pregnant women registered with a Lead Maternity Carer (LMC) within the 1st trimester
- 80% of infants are exclusively or fully breastfed at two weeks
- 85% of newborns enrolled in a PHO by three months

Why is this important?

- Early engagement with an LMC provides an opportunity for screening, education and referral, and begins the primary-maternity continuity of care relationship.
- 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.
- Newborn enrolment ensures access to affordable and essential health care as early as possible, such as childhood immunisation, community oral health and Well Child Tamariki Ora services.

How are we performing?

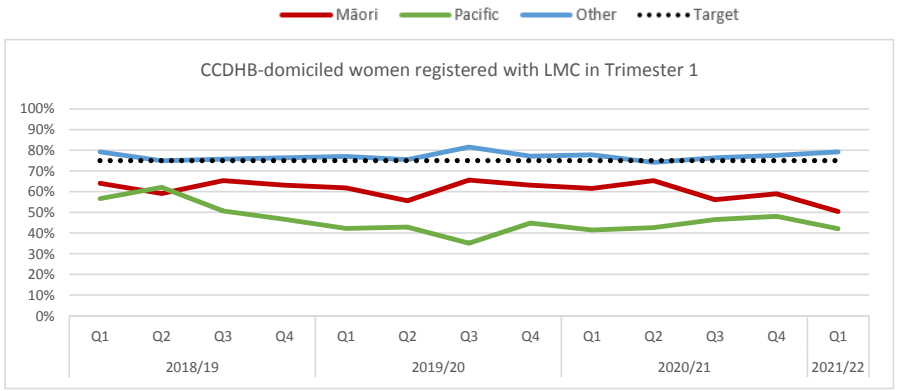
- Performance is below the 75% target for LMC registrations in Trimester 1 for Māori (50%) and Pacific (42%), and above target non-Māori, non-Pacific (79%).
- Performance is below the 80% target for exclusive or full breastfeeding for Māori (78%), Pacific (68%) and non-Māori, non-Pacific (78%).
- Performance is below the 85% target for PHO enrolment at 3 months for Māori (76%) and Pacific (80%), and above target for non-Māori, non-Pacific (97%).

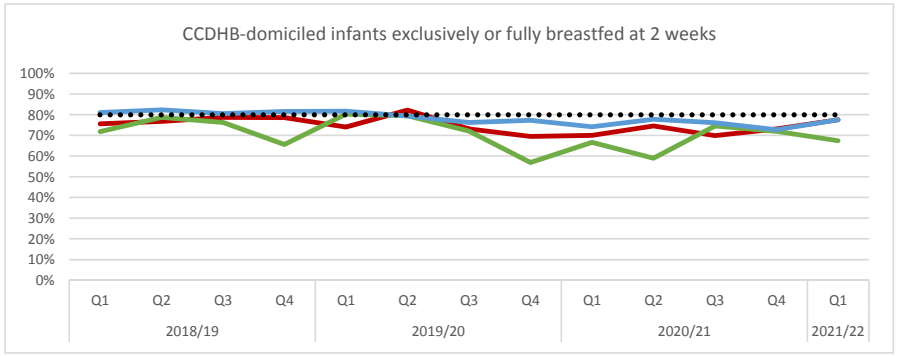
What is driving performance?

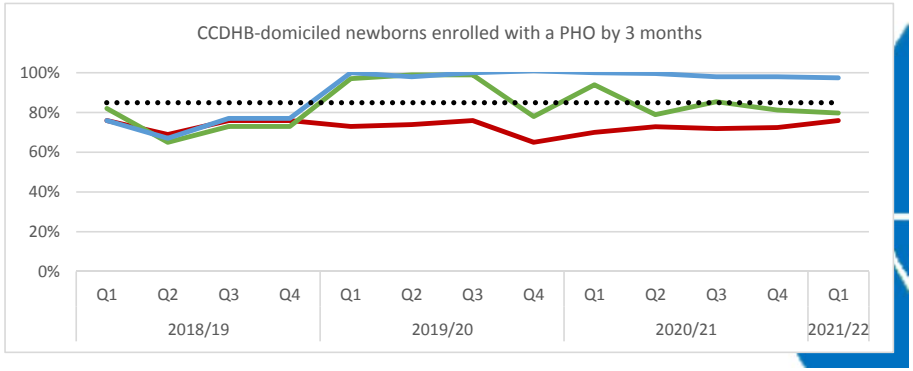
- In 2020/21, CCDHB invested in a new Māori and Pacific midwifery collective in Porirua to improve access to antenatal care in Porirua and across the DHB catchment. Investment was also made towards 3 intensive wrap-around antenatal support services; targeting Māori, Pacific and youth populations. These initiatives will support continuity of care, and support knowledge of breastfeeding for these populations while we continue to experience a national workforce shortage of LMC midwives.
- CCDHB is supporting the training of five new Māori and Pacific lactation consultants. The benefits of this investment will begin to emerge when training has been completed.
- CCDHB has initiated a community breastfeeding education programme supporting Māori and Pacific women.
- CCDHB has engaged with our PHOs to increase Māori and Pacific enrolment following a decline in performance. Our PHOs have responded and we are seeing improvements as a result of their work.

Management comment

Mothers and Babies is a 2DHB Board endorsed strategic priority in 2021/22. Progressing improvements across the maternal health system remains a top priority with close monitoring by our Executive team.







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) in place

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. An ACP often also includes an advance directive. This documents their healthcare wishes for a time in the future when they are not able to speak for themselves. An ACP may indicate who the EPOA is. The 2DHB ACP aligns with the Heath Quality and Safety Committee'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.

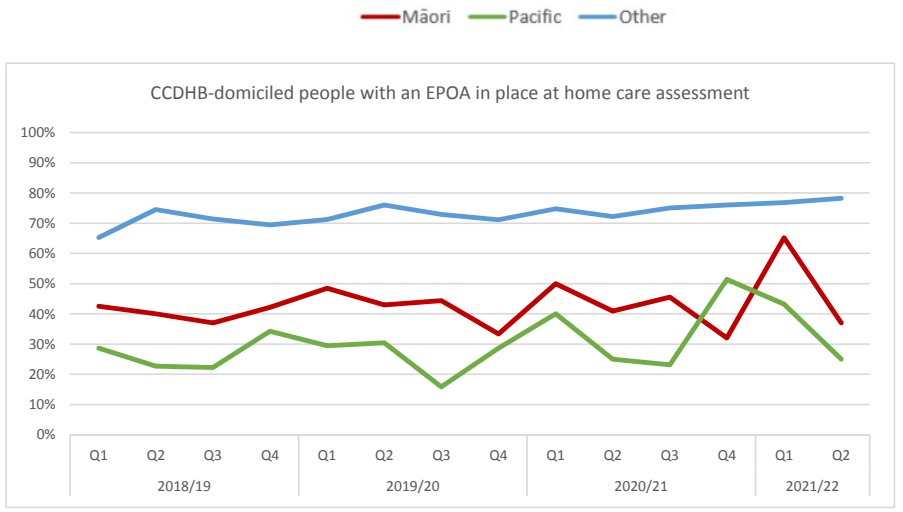
- Performance for Home Care Assessments where an EPOA was in place is 37% for Māori, 25% for Pacific, and 78% for non-Māori, non-Pacific.
- Performance for Home Care Assessments with a completed ACP is 8% for Māori, 3% for Pacific, and 5% for non-Māori, non-Pacific.

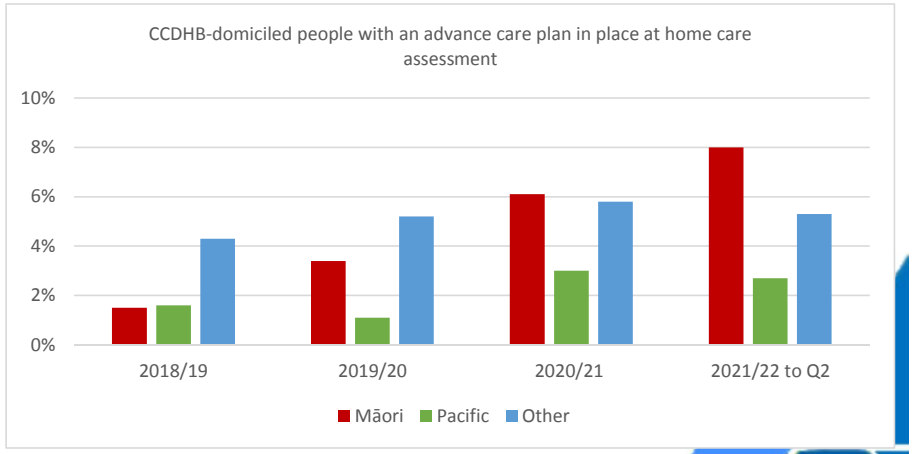
What is driving performance?

- At the end of 2020, Tū Ora Compass Health 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 ACP 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.
- ACP is a 3DHB role. Promotion, support and education are provided to health and social care providers across DHBs, primary health, ARC, NGOs, and tertiary education.





Commissioning Hospital & Speciality Services

In 2021/22 we have commissioned $474 million in hospital & specialist services for the population of Capital & Coast DHB. $450 million is delivered locally and $24 million is commissioned from other DHBs using the IDF process (IDF outflow).

IDF outflow is the mechanism used to commission care we do not provide locally and for care provided to our population elsewhere in New Zealand if they become unwell while on holiday or for other reasons.

What is this measure?
We are focusing on inpatient activity delivered by other DHBs - IDF outflow for CCDHB domiciled people. Information is shown by budget and actual, with views of speciality and DHB of service.

Why is this important?
CCDHB is a tertiary provider for most services and therefore, the nature of work we commission through IDFs is predominantly high complexity and low volume.

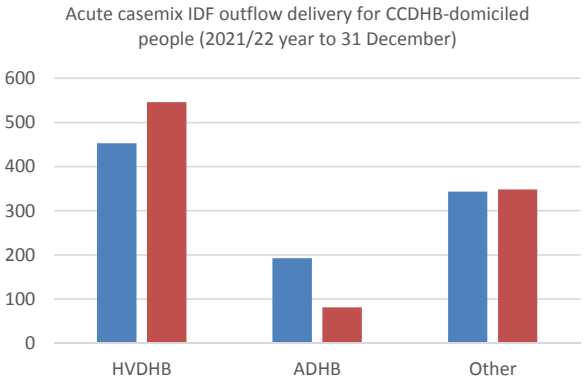
IDF outflow for inpatient activity is paid on a delivery basis, so if care is not delivered by other DHBs this results in a financial saving. However, particularly for planned events, this also represents people in our local population not receiving care.

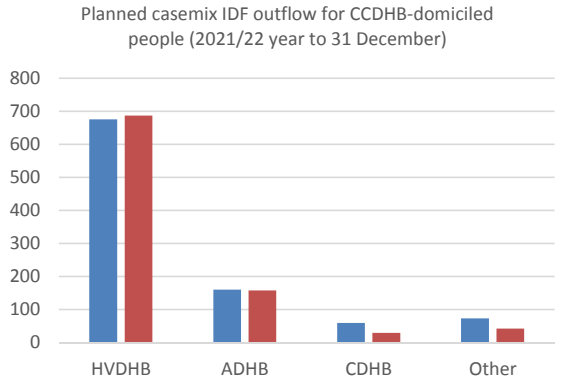
How are we performing?
IDF outflow for inpatient services (casemix) is 3.4% ($405k) behind target at the end of December. This is driven by delivery above target by Hutt DHB offsetting delivery below target at Auckland and Canterbury DHBs primarily for cardiothoracic and orthopaedic surgeries.

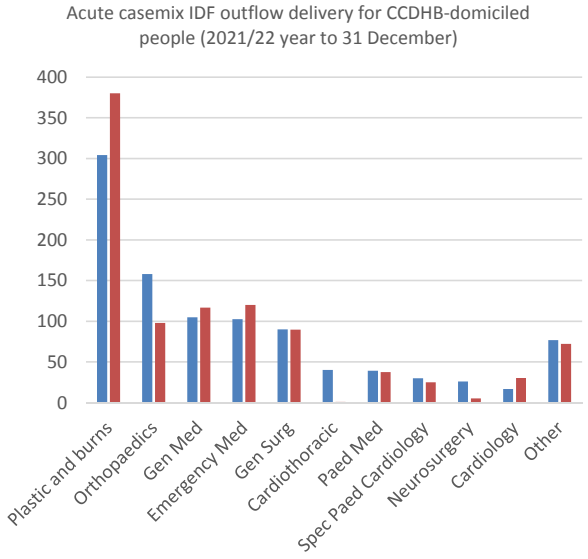
What is driving performance?
On going pressures from COVID-19 management and contingency planning in the hospital and community, especially for DHBs located in the Auckland region has caused a reduction in delivery.

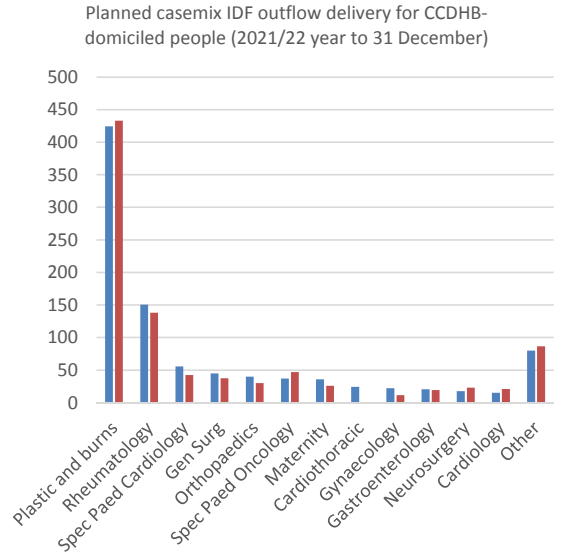
High hospital occupancy, workforce constraints and reductions in outsourcing has led to a reduction in hospitals ability to flex and provide care to patients. As these are national issues it has affected our IDF outflow.

Management comment:
The DHB maintains a close eye on IDF outflow to ensure access to high complexity services. There is a fortnightly meeting of tertiary and quaternary providers where issues with access and care delivery are discussed and problems jointly solved across DHBs and Ministry of Health.









Commissioning: Mental Health and Addictions

What is this measure?

Addiction

- 80% of people seen within 3 weeks for non-urgent addiction services
- 95% of people discharged from community addiction services with a transition/wellness plan
- Alcohol-related presentations (ARPs) to Emergency Department per 100,000

Why are these important?

- Prompt diagnosis and early intervention in the initial stages of a mental illness and/or substance-use harm can have significant impacts on a person's wellbeing. Intervening at early stages of distress or addiction can mean a better response to treatment and increased likelihood of recovery. Ensuring that wait times are low is therefore critical for improving patient outcomes and continuity of care.
- Service transitions in the addictions sector are multiple and they are recognised as a potential risk to people and whānau. Wellness/relapse prevention and transition/discharge planning contribute to improved outcomes by ensuring that people with substance-use harm are supported, and that their broader health and social needs are met.
- Public health implement strategies to reduce alcohol-related harm in the ED and society as a whole. Raising awareness of alcohol-related harm through media and targeted programmes, along with evidence-based alcohol policies are among some of the most effective preventative approaches.

How are we performing?

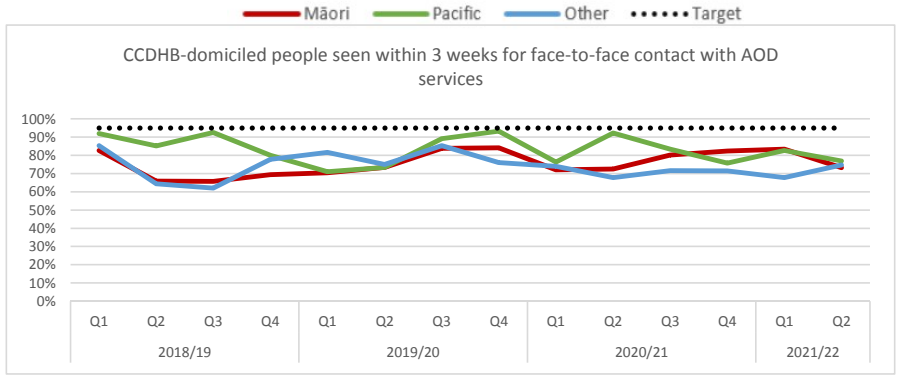
- Performance is below the 80% target for AOD mental health wait times for Māori (73%), Pacific (77%), and non-Māori, non-Pacific (75%).
- Performance is below the 95% target for AOD transition/wellness plans for Māori (56%), Pacific (40%), and non-Māori, non-Pacific (50%).
- Performance for ARPs to ED per 100,00 is for 323 for Māori, 155 for Pacific, and 169 for non-Māori, non-Pacific (75%).

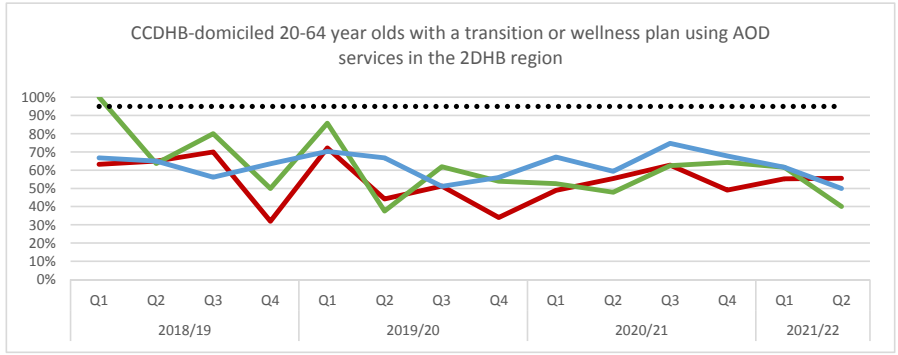
What is driving performance?

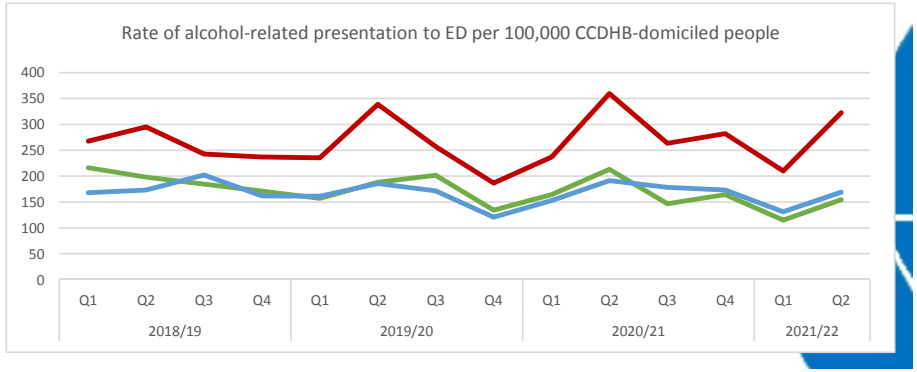
- There is no statistically significant variation for the wait-time to first contact and transition/discharge measures in the periods reported. The AOD Collaborative will share data with the addiction DHB and NGO providers to gain further insight to performance and quality improvement initiatives

Management comment

- The role of the AOD Collaborative is to ensure that the 3DHB Model of Care is implemented effectively and promotes a strategic, integrated and effective AOD system of care across the 3DHB region
- The AOD Collaborative will develop a measurement framework to understand and track improvement in performance. Wait-time and transition plan measurements are proposed, pending endorsement from the Collaborative
- Engagement with the Emergency Department and Regional Public Health is required to determine if the ARP measure can be utilised to measure improvement for public health strategies to reduce alcohol related harm.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination programme - Boosters and Children

Why is this important?

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

How are we performing?

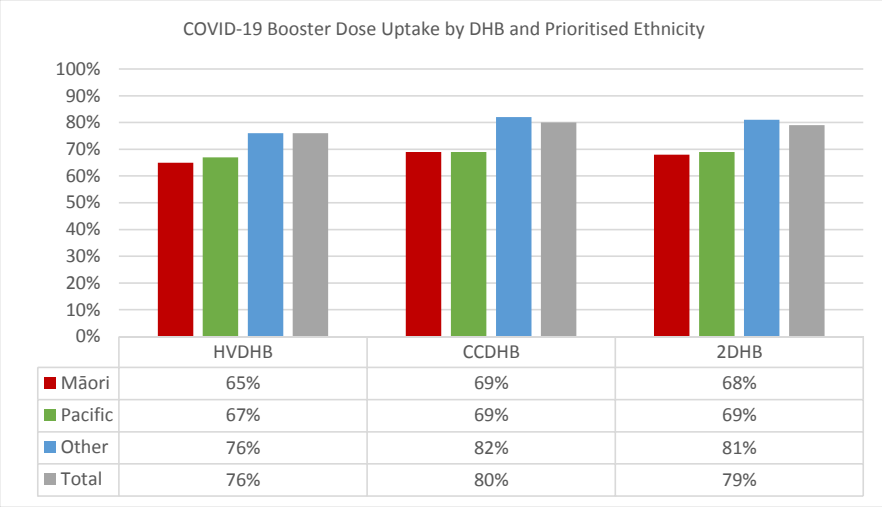
- 259,825 eligible people in the 2DHB region have received a booster dose (79% of eligible)
  - 20,421 Māori (68%), 13,927 Pacific Peoples (69%), 225,477 'Other' (81%)
- 26,613 children 5-11 years in the 2DHB region have received a 1st dose (63%)
  - 3,753 Māori (45%), 2,087 Pacific Peoples (48%), 20,773 'Other' (71%)
- 390,131 people 12+ years in the 2DHB region are fully vaccinated (97%)
  - 42,579 Māori (92%), 27,495 Pacific Peoples (95%), 320,057 'Other' (98%)

What is driving performance?

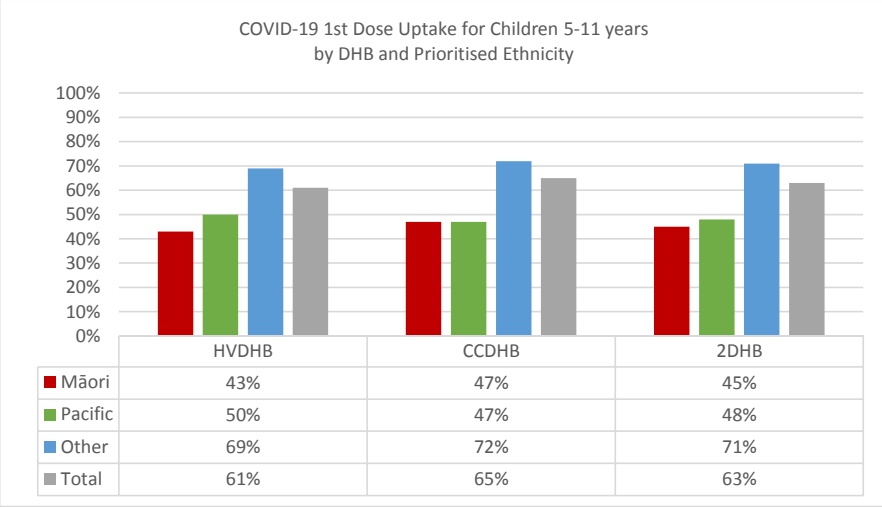
- The reduction in booster eligibility periods (from six to three months) has created a significant overhang of people eligible for booster vaccinations in early 2022.
- COVID-19 vaccination requirements and training for children were not fully available until New Year 2022 and required a material re-orientation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

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

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



	HVDHB	CCDHB	2DHB
Māori	65%	69%	68%
Pacific	67%	69%	69%
Other	76%	82%	81%
Total	76%	80%	79%



	HVDHB	CCDHB	2DHB
Māori	43%	47%	45%
Pacific	50%	47%	48%
Other	69%	72%	71%
Total	61%	65%	63%

Data Source: MOH Covid-19 Vaccine Data
Date Range: 22/02/2021 to 01/03/2022
Data current at: 03/03/2022 @1.27pm

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – as we head into March our plans for service delivery alongside our COVID reality are now in operations. As number of inpatients increase service delivery across all facets will be impacted – we intend continuing on with our hospital programme deliverables and service delivery as long as we can.
- We have continued to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this is increasingly limited by COVID inpatient demands and staff shortages. We are putting in place forecasting around service delivery and likely impact of COVID to be able to track the impact and be as responsive as we can to changing hospital response levels in our COVID framework.
- The national cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list remains well above outside the target waitlist size set by the Ministry programme. Factors impacting on our waitlist size is the reduction in surgery due to COVID 19 related additional cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in in the waiting time.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are 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.
- We remain within budget.

CCDHB Contract Activity Performance

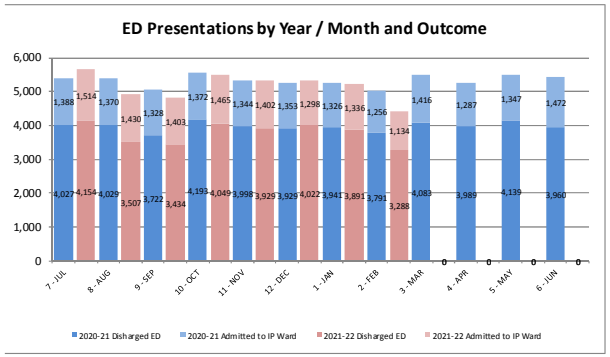
Capital and Coast DHB: February 2022

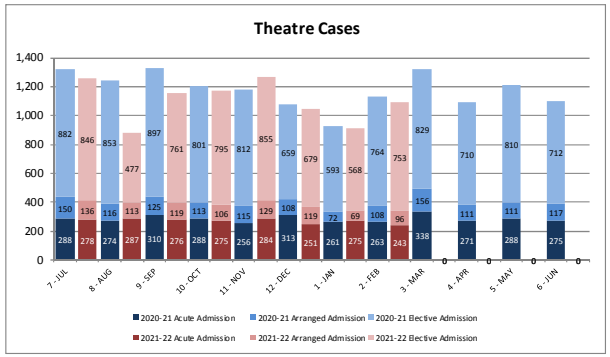
ED Presentations

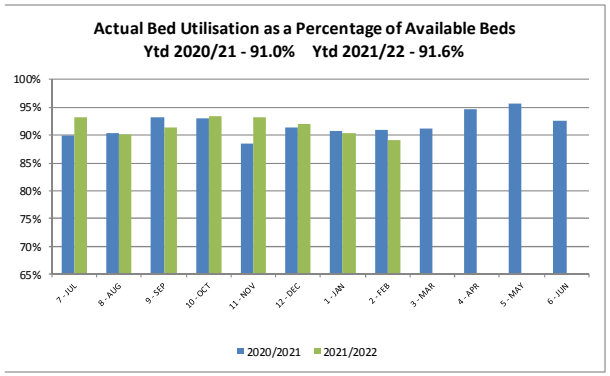
	2020/21	2021/22
YTD Totals	42,367	41,256
Change		-1,111
% Change		-3%

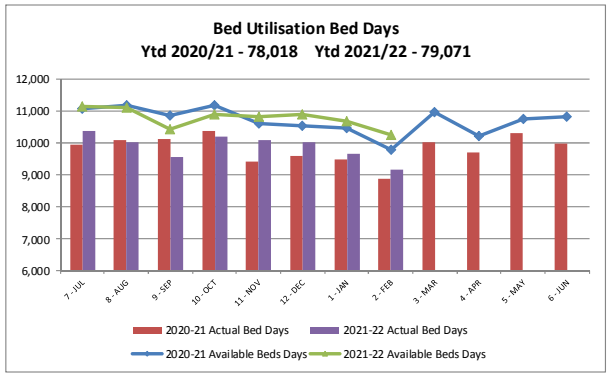
Theatre Cases

	2020/21	2021/22
YTD Totals	9,421	8,790
Change		-631
% Change		-7%









ED

- The total number of presentations to ED in February 2020 was 5,324 (this includes 502 DNWs)
- The total number of presentations to ED in February 2021 was 5,044 (this includes 554 DNWs)
- The total number of presentations to ED in February 2022 was 4,433 (this includes 354 DNWs)
- The average number of daily presentations in February 2022 was 158, this is significantly lower than the average of 180 presentations per day in February 2021.
- The number of patients with a triage level of 1-3 combined in February 2022 is 2,831 this represents 63.9% of the total presentations, this is higher than both February 2021 (62.7%) and February 2020 (60.2%).

ED Covid-19

- During the month of February 2022 there were 76 presentations where the patient was found to be either positive for COVID-19 when presenting or diagnosed shortly after presenting to ED.
- Out of the 76 presentation a total of 12 of the patients were admitted, 1 did not wait and the remaining 63 were discharged home.

Bed Utilisation

- The utilisation of available of adult beds in core wards in February 2022 was 89.1% which is slightly lower than the rate of 91.0% recorded in February 2021. The number of available beds in February 2022 (367) is higher than in February 2021 (338) and can be attributed largely to more beds being available at Kenepuru.
- The number of Elective theatre cases has decreased for the month of February 2022 by 1.4% (-11) when compared to February 2021.

CCDHB Activity Performance

Capital and Coast DHB: February 2022

HSS Inpatient Caseweight Activity

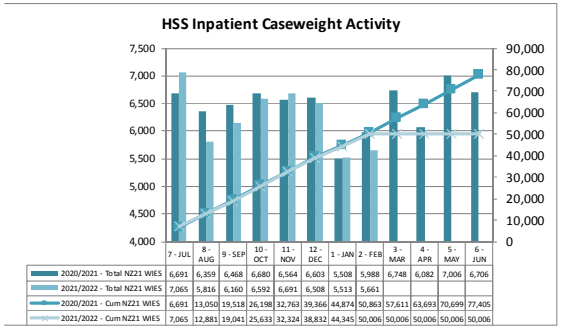
	2020/21	2021/22
YTD Totals	50,863	50,006
Change		-857
% Change		-1.7%

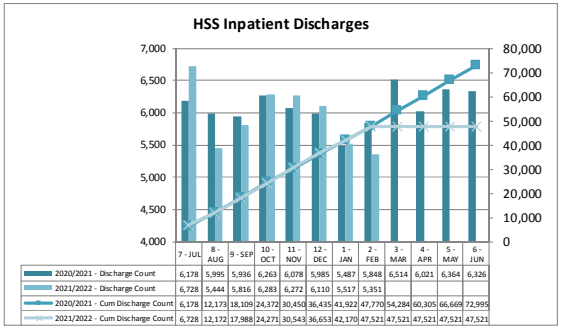
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2020/21	2021/22
YTD Totals	47,770	47,521
Change		-249
% Change		-0.5%

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



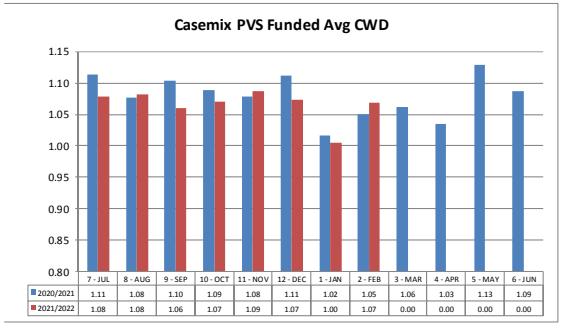


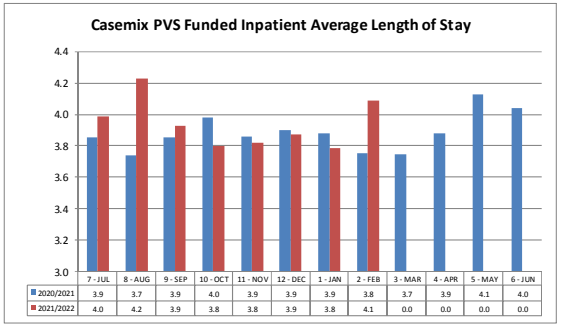
Casemix PVS Funded Avg CWD

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

Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	3.93
Change		0.05
% Change		1.2%





Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (336 CWDs) with an increase in discharges; a higher ALOS and a similar average CWD. The discharge increase is driven primarily by Emergency Medicine, Obstetrics, Paediatric Medicine, and Cardiology. The CWD increase is driven primarily by General Medicine, Paediatric Medicine, Neonatal and Emergency Medicine.
- Local Elective CWDs are lower than the previous financial year (-785 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by Cardiology, General Surgery, Orthopaedics and ENT. The CWD decrease is driven primarily by Orthopaedic Surgery, General Surgery, Cardiology and Neurosurgery.
- IDF acute CWDs are lower than the than the previous financial year (-267 CWDs) with a decrease in discharges (-40); a lower ALOS and a similar average CWD. The discharge increase is driven primarily by Haematology, Respiratory Medicine and Emergency Medicine. The CWD decrease is driven primarily by Haematology, Cardiology, Cardiothoracic Surgery and Neurology.
- IDF Elective CWDs are lower than the previous financial year (-166 CWDs) with less discharges; a higher ALOS and a similar average CWD. The discharge decrease is driven primarily by Paediatric Surgery, General Surgery and Vascular Surgery. The CWD decrease is driven by Cardiothoracic Surgery, Cardiology and Paediatric Surgery.
- In combination these four admission groups equate to a decrease of (-882 CWDs) compared to the previous year. The services that most significantly impact this shift are General Surgery (-488), Cardiology (-257), Haematology (-254) and Neurosurgery (-186) countered by increases in General Medicine (297), Paediatric Medicine (152), Urology (106) and Obstetrics (72).
- The decrease in General Surgery can be partly attributed to a significant acute outlier discharged in November 2020 which had a CWD value of 112.
- The decrease in Haematology can be largely attributed to a number of significant outliers discharged in 2020/2021 which saw a far greater mix of Bone Marrow Transplant and complex Leukaemia cases which have not been evident in 2021/2022.
- The increases in both General Medicine and Paediatric Medicine were apparent in July 2021 and August 2021 and relate to significant number of patient presenting with RSV.

Discharges:

- The number of publicly funded casemix discharges for the month of February 2022 has decreased by 512 (-8.3%) in comparison to the number of discharges recorded in February 2021. This decrease in the number of discharges is most evident in Emergency Medicine (-116 Acute), Cardiology (4 Acute, 48 Elective), Obstetrics (48 Mother, 47 Babies), Gynaecology (-41) and Haematology (40 Acute). The overall decrease was countered by an increase in Urology (34 Elective)
- The number of outsourced discharges recorded in February 2022 was 60 which is 55 lower than February 2021 CCDHB in February 2022 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Feb 21 to Feb 22

Domain	Indicator	2021/22 Target	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb	14/02/22	21/02/22	28/02/22	7/03/22
Care	Serious Safety Events	TBD	19	8	19	8	13	11	8	12	11	13	9	9	8				
	Total Reportable Events	TBD	1,483	1,458	1,426	1,540	1,369	1,487	1,260	1,170	1,445	1,460	1,381	1,118	1,084	312	303	269	254
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	95.5%	92.3%	93.7%	93.3%	87.9%	77.1%	89.5%	88.2%	86.4%	83.2%	70.3%	94.1%	96.3%	100.0%	100.0%	100.0%	100.0%
	% Discharges with an Electronic Discharge summary	TBD																	
Access	Emergency Presentations		5,047	5,499	5,276	5,486	5,432	5,668	4,937	4,837	5,514	5,331	5,320	5,227	4,422	1,126	1,134	1,083	1,163
	Emergency Presentations Per Day		180	177	176	177	181	183	159	161	178	178	172	169	158	161	162	155	166
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	62.5%	66.3%	63.3%	66.8%	64.0%	56.2%	66.6%	64.8%	61.9%	61.8%	65.7%	65.9%	68.0%	64.4%	64.2%	63.7%	62.3%
	ELOS % within 6hrs - non admitted	TBD	72.7%	77.5%	74.0%	78.3%	75.2%	66.4%	79.3%	75.9%	72.5%	72.0%	75.5%	74.8%	78.0%	74.2%	74.8%	75.5%	73.9%
	ELOS % within 6hrs - admitted	TBD	45.4%	47.2%	45.0%	45.6%	45.3%	39.6%	44.0%	41.4%	43.2%	44.9%	48.3%	50.4%	50.7%	47.9%	45.3%	43.6%	40.9%
	Total Elective Surgery Long Waits	Zero Long Waits	525	513	515	343	362	427	550	694	699	682	673	787	773				
	Additions to Elective Surgery Wait List		1,243	1,456	1,228	1,458	1,353	1,241	939	1,126	1,040	1,385	1,053	744	980	270	206	196	111
	% Elective Surgery treated in time	TBD	75.6%	72.2%	72.1%	75.0%	82.4%	83.2%	81.5%	72.4%	71.1%	75.5%	78.7%	79.6%	76.2%	79.6%	77.4%	82.5%	73.3%
	No. surgeries rescheduled due to specialty bed availability	TBD	6	11	7	13	21	16	6	0	9	7	2	13	7	2	0	1	0
	Total Elective and Emergency Operations in Main Theatres	TBD	1,076	1,270	1,063	1,190	1,085	1,209	807	1,062	1,145	1,229	1,001	869	1,071				
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	90.0%	88.0%	86.0%	83.0%	96.0%	85.0%	83.0%	85.0%	87.0%	93.0%	96.0%	81.0%	81.0%				
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	83.0%	96.0%	79.0%	84.0%	91.0%	76.0%	81.0%	87.0%	67.0%	93.0%	90.0%	94.0%	86.0%				
	Specialist Outpatient Long Waits	Zero Long Waits	355	302	244	211	265	295	412	607	735	697	775	1,177	1,431				
	% Specialist Outpatients seen in time	Zero Long Waits	88.0%	85.4%	80.0%	90.5%	90.2%	89.1%	88.4%	82.1%	80.0%	79.8%	82.7%	84.0%	78.6%	77.9%	76.0%	78.0%	77.2%
	Outpatient Failure to Attend %	TBD	7.7%	7.3%	7.2%	7.4%	7.1%	7.4%	7.2%	6.3%	7.1%	7.1%	6.9%	7.2%	7.7%	7.7%	7.6%	8.0%	7.4%
	Maori Outpatient Failure to Attend %	TBD	16.4%	15.8%	15.9%	15.2%	15.3%	16.8%	14.7%	15.2%	14.7%	16.0%	15.3%	15.7%	16.2%	15.3%	16.7%	17.9%	14.4%
	Pacific Outpatient Failure to Attend %	TBD	18.2%	16.9%	15.8%	16.5%	15.7%	15.8%	16.8%	15.3%	17.8%	17.8%	17.4%	17.5%	18.2%	17.8%	19.5%	22.0%	21.3%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($62.4m)	($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1.0m	$1.0m	$1.0m	$7.0m	$3.2m	$3.2m	$3.2m	$3.2m				
	Contracted FTE (Internal labour)		5,344	5,346	5,366	5,364	5,340	5,335	5,363	5,385	5,411	5,434	5,455	5,464	5,540				
	Paid FTE (Internal labour)		5,813	5,727	5,792	5,784	5,746	5,760	5,832	5,801	5,861	5,871	5,937	5,997	5,982				
	% Main Theatre utilisation (Elective Sessions only)	85.0%	80.0%	83.0%	83.0%	81.0%	80.0%	79.0%	79.0%	81.0%	79.0%	80.0%	80.0%	80.0%	81.0%				
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	21.9%	23.2%	25.3%	23.6%	25.3%	20.7%	21.8%	20.5%	22.6%	23.0%	21.2%	18.4%	19.7%	19.7%	18.8%	15.4%	24.4%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	38	41	37	35	38	44	40	30	40	38	34	29	43	47	43	50	44
	Adult Overnight Beds - Average Occupied WLG	TBD	373	381	381	386	387	383	355	349	362	367	363	353	367	370	374	350	346
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	14	19	19	22	17	32	34	21	26	25	25	19	22	24	24	26	25
	Adult Overnight Beds - Average Occupied KEN	TBD	71	69	72	73	73	79	83	80	82	81	76	69	76	77	78	76	74
	Child Overnight Beds - Average Occupied	TBD	19	22	22	22	25	30	23	19	24	22	22	21	20	20	19	21	23
	NICU Beds - ave. beds occupied	36	39	44	39	42	36	40	38	32	35	29	35	37	37	37	36	36	34
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.75	3.75	3.88	4.13	4.04	3.99	4.23	3.92	3.80	3.82	3.87	3.78	4.09	4.30	4.02	4.11	3.64
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	4.0%	3.5%	4.7%	4.6%	4.0%	4.0%	4.3%	4.0%	4.2%	4.3%	4.7%	4.2%	3.6%	3.0%	3.8%	4.9%	4.2%
	Presentations to ED within 48 hours of discharge	TBD	202	194	247	253	218	224	211	194	231	228	252	219	161	34	43	53	49
Staff Experience	Staff Reportable Events	TBD	185	165	157	149	159	157	130	143	170	198	161	128	91	26	26	29	25
	% sick Leave v standard	TBD	2.7%	3.5%	3.0%	3.6%	3.8%	4.3%	3.9%	2.7%	3.2%	3.6%	3.5%	2.0%	2.6%				
	Nursing vacancy	TBD	224	239	241	250	266	295	374	422	508	526	528	519	447				
	% overtime v standard (medical)	TBD	2.0%	1.9%	1.8%	2.1%	2.0%	2.5%	2.2%	2.0%	2.2%	2.2%	2.3%	2.1%	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.
- During the month of February 2022 there were 76 presentations where the patient was found to be either positive for COVID-19 when presenting or diagnosed shortly after presenting to ED.
- Out of the 76 presentation a total of 12 of the patients were admitted, 1 did not wait and the remaining 63 were discharged home.
- Throughout February Wellington was at 'Red' in the National COVID Protection Framework setting but was at COVID Ready and Stage One of the DHB COVID Hospital Response Plan.
- The average number of daily presentations in February 2022 was 158, this is significantly lower than the average of 180 presentations per day in February 2021.

How are we performing?

- Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.
- Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for January 2022 was 90%.
    - The total number of presentations to ED in January 2020 was 5,310 (this includes 312 DNWs)
    - The total number of presentations to ED in January 2021 was 5,237 (this includes 430 DNWs)
    - The total number of presentations to ED in January 2022 was 5,222 (this includes 443 DNWs)
- The average number of daily presentations in January 2022 was 169, this is the same as average of 169 presentations per day in January 2021.

Performance	DEC	JAN	FEB
2019-20	77%	80%	76%
2020-21	66%	69%	63%
2021-22	65%	66%	68%

Breaches	DEC	JAN	FEB
2019-20	1,137	997	1,180
2020-21	1,655	1,507	1,678
2021-22	1,671	1,619	1,316

ED Volumes	DEC	JAN	FEB
2019-20	5,020	4,998	4,822
2020-21	4,840	4,807	4,490
2021-22	4,830	4,781	4,079

What is driving performance?

- CCDHB SSiED performance for February 2022 is 27.3% lower than the Target for SSiED. The count of breaches in ED 1,316 in February 2022 is lower than the 1,679 recorded in February 2021.
- CCDHB performance for February 2022 was 67.7% which is higher than February 2021 (63.6%).

Management Comment

- CCDHB continues to face a significant capacity issue as demonstrated by the consistently high occupancy rate and the bed blockage experienced across hospital flow as a consequence. Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for February 2022 was 89%.
- The number of admissions decreased by 192 when you compare February 2021 to February 2022, and the percentage of admissions were similar with 33.4% in February 2021 and 33.8% in February 2022.
- The average number of beds utilised by planned admission for February 2022 was 69 per day which is lower than February 2021.
- In view of addressing bed blocks, the Complex Care Forum has been working closely with Clinicians to facilitate supported discharge at an early stage in order to vacate beds and facilitate flow of patients from ED. Similarly Clinicians are encouraged to do early rounding and nurse-led discharge processes are being reinforced.
- Charge Nurse Managers from General Medicine are meeting on a daily basis at 8am in view of assessing planned discharges and ensuring that a proper follow up is in place with the Medical Team.
- Our Medical Assessment and Planning Unit (MAPU) is working in partnership with our Emergency Department to drive the flow of patients from ED to MAPU through early assessment and referral.
- Similarly, working groups have been set up in relation to the Front of Whare project in order to identify the barriers and confirm the need for improved resources (facilities and personnel).
- During the month of February 2022 and additional assessment Unit with 4 Bed space has been set up adjacent to our ED in relation to COVID Response. This Unit serves as a dedicated zone for assessment of Medical and non-medical COVID positive patients with direct referral to the services they need so reducing the volume of presentation to ED.
- On the other hand, work is in progress for the setting up of a new Minor Care Unit which in turn will free up 6 bed space in EDOU. This work is inextricably linked to other ongoing work to assess and address overall hospital capacity.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

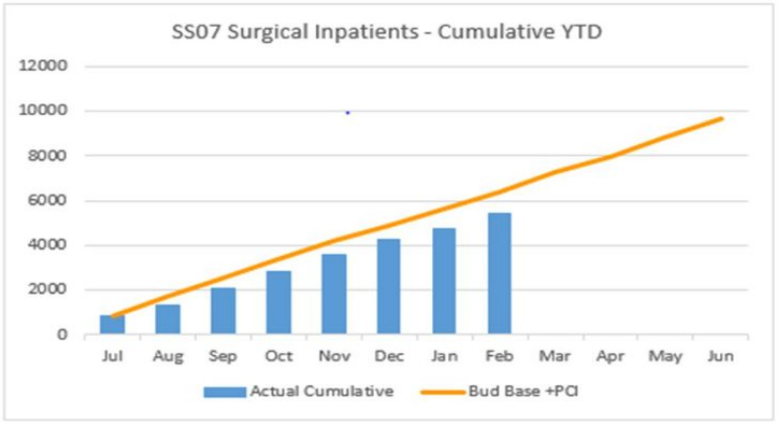
- Year to date we are reporting 1,042 discharges behind our target of 7,074.
- Total Planned care results for February month end show us 82 adverse to the 834 target.
- Our in-house elective surgical PUC results show 25 discharge ahead of the planned 488 and outsourcing 102 adverse to the planned 137. Elective non-surgical PUC adverse 4 to the planned 12, arranged surgical PUC met target with 94 discharges and arranged non-surgical 3 behind of the month's plan.
- IDF outflow results are 2 ahead of the planned 86 for February, elective surgical PUC 11 ahead of the planned 72. All other IDF measures were adverse to plan.
- Minor procedures in-house reporting 113 over the planned 357 for February.

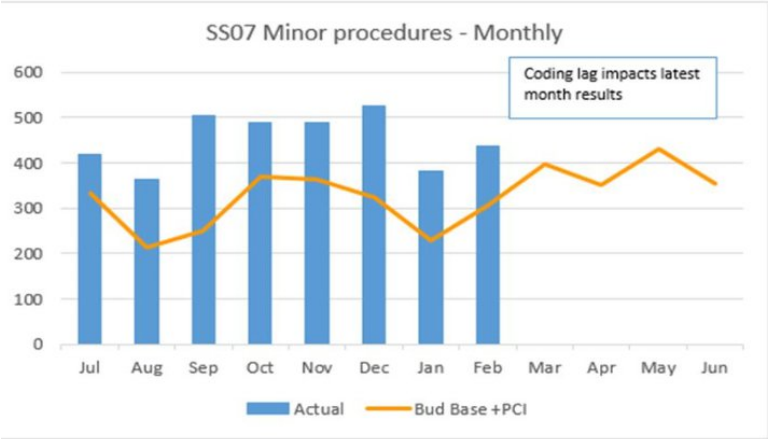
What is driving performance?

- February in-house discharge targets were met as were our arranged group, this is an improvement from the previous month as forecast. We experienced less theatre session cancellation due to on boarding technical staff.
- Our private providers are not able to provide the usual volume due to their own staffing restraints currently. Panel agreements are currently being worked through, however we anticipate ongoing deficits in outsourced volumes for the foreseeable future.

Management Comment

- February result were expected in the current climate. Significant work is being done in the COVID readiness space around screening pre surgery, to ensure surgery continues as much as possible when we experience a surge in COVID positive cases.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.





Planned Care – Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

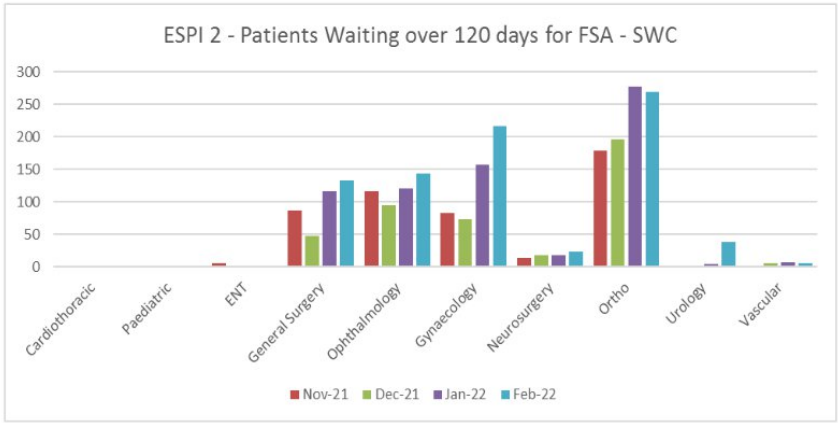
- February EPSI 2 results show a 220 deterioration from the previous month. The drivers of this adverse result are Cardiology and Gynaecology with the largest increase of non-compliant patients. Urology have lost ground along with Endocrinology and Ophthalmology. Orthopaedics managed to improve on their January result. All specialties continue to address the back log waiting and longest waiting patients.

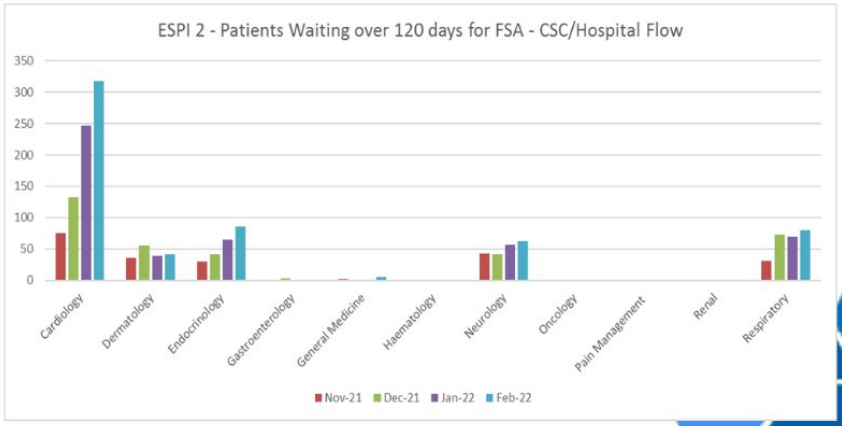
What is driving performance?

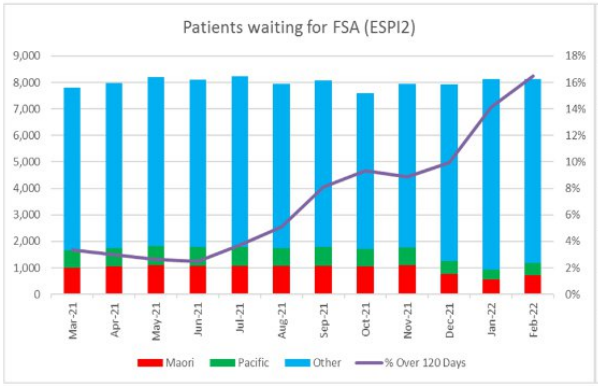
- Cancellation of face to face consultations will continue to deteriorate our FSA position. We continue arrange clinics for patients who require a face to face clinical assessment.

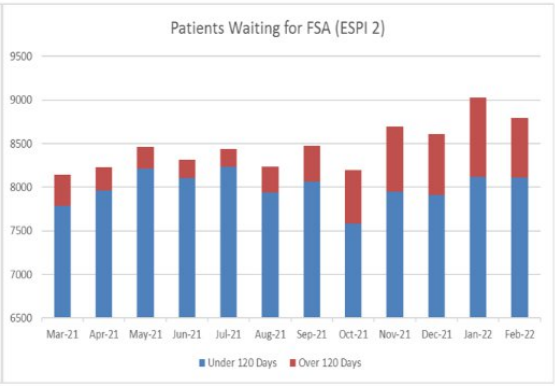
Management Comment

- All services have converted clinics to zoom and telephone calls where appropriate. We will resume face to face clinics when COVID levels allow.









Planned Care – Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB performance in ESPI 5 is shown in the table below. We have been non-compliant at an organisational level since January 2019. February is reporting 765 non-compliant, an improvement from the previous month. We expect to deteriorate due to normal seasonal patterns through to April and unpredictable staffing and capacity shortages due to COVID.
- Currently Maori are experiencing slightly longer delays in accessing treatment compared to Pacifica and others. We are currently investigating long waiting patients to identify reasons for this, so that issues can be addressed.

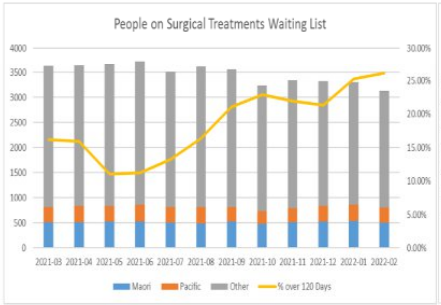
What is driving performance?

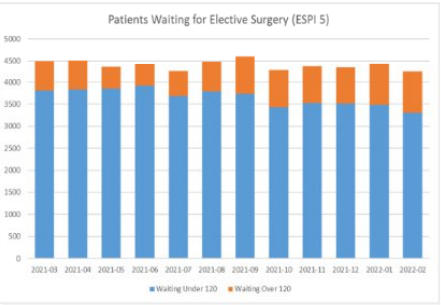
- Cancellation of theatres session is the main driver of our results, we continue to be prepared for Covid admissions, and currently we are experience staff shortages and cannot operate to capacity.

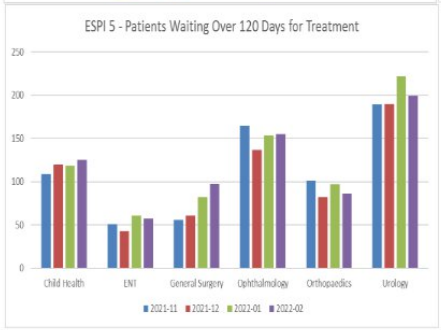
Management Comment

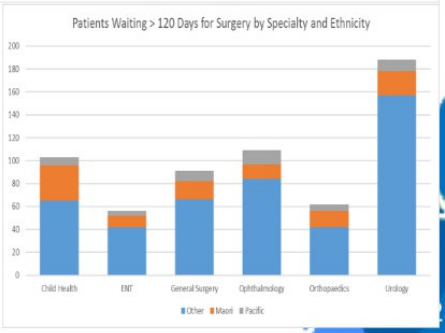
- There was an improvement in February, however due to current staff absence we are not forecasting to improve on that result in March. Saturday lists are improving on the numbers of non-compliant volume for Urology who managed to deduce the number of long waiters by 20 from the January result.

ESPI 5 monitoring 21/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb*
Organisation wide	**-515**	**-343**	**-362**	**-427**	**-550**	**-694**	**-699**	**-682**	**-673**	**-788**	**-765**
Cardiology	-9	-2	-2	-4	-4	-8	-6	-6	-5	-7	-6
Cardiothoracic	-4	-3	-4	-7	-12	-22	-23	-31	-34	-33	-36
Dental	-21	-18	-21	-15	-29	-45	-39	-38	-39	-33	-36
ENT	-32	-32	-31	-34	-40	-52	-56	-49	-44	-62	-53
General Surgery	-58	-30	-24	-34	-42	-47	-57	-53	-54	-75	-88
Gynaecology	-16	-5	-9	-16	-22	-25	-14	-13	-8	-12	-13
Neurosurgery	-10	-3	-3	-4	-5	-12	-13	-9	-15	-29	-21
Ophthalmology	-121	-87	-100	-95	-134	-155	-122	-100	-78	-92	-91
Orthopaedics	-38	-30	-39	-65	-89	-98	-96	-71	-56	-63	-53
Paediatric Surgical	-15	-16	-17	-24	-28	-39	-64	-83	-97	-91	-98
Urology	-142	-101	-106	-120	-129	-164	-166	-173	-175	-203	-183
Vascular Surgery	-49	-16	-6	-9	-16	-27	-43	-56	-68	-88	-87









MRI and CT Waiting Times

What is this measure?

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

Why is this important?

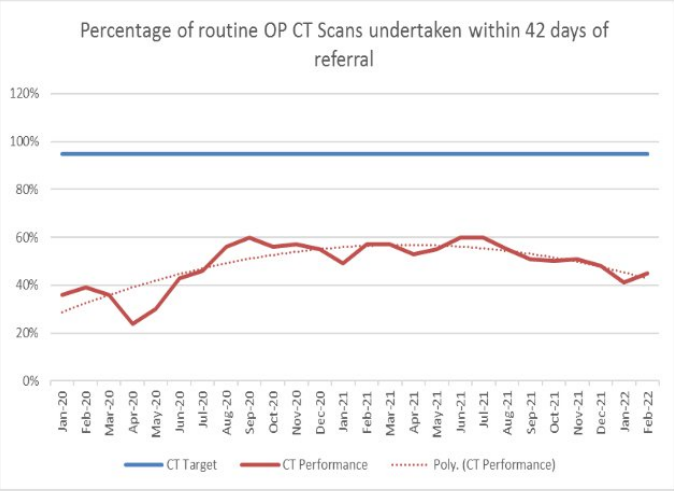
- Delayed diagnosis can lead to poorer health outcomes as a patient's condition may deteriorate while waiting. The period of 6 weeks (i.e. 42 days) is generally accepted as the reasonable clinical timeframe to receive imaging results for non-acute outpatient referrals.

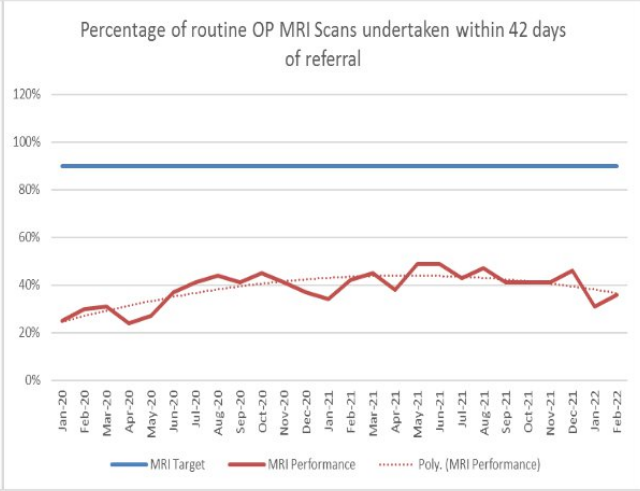
How are we performing?

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

What is driving Performance?

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





Management Comment

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

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

- Outsourcing continues at the maximum capacity across service providers available within the region and far in above DHB of $1.2m per annum (project spend 2021/22 $4.7m). Even at this rate of outsourcing we will not improve waiting times for the foreseeable future due to increased demand and imaging complexity.

- It is estimated that we will need to increase the outsourcing budget to $7m for FY 22/23 to keep waiting times around their current timeframes.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

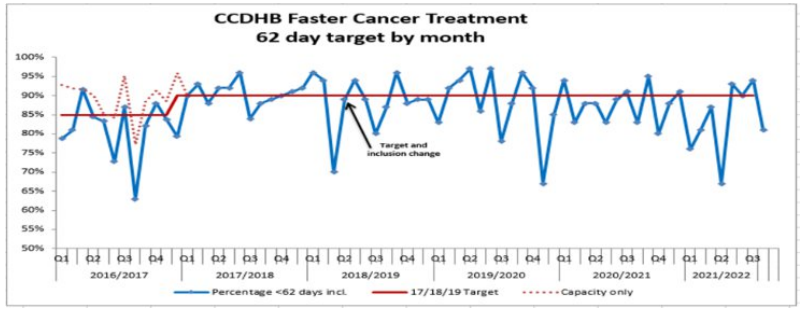
- CCDHB is non-compliant with the 62 day target for February at 78% which is below the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.

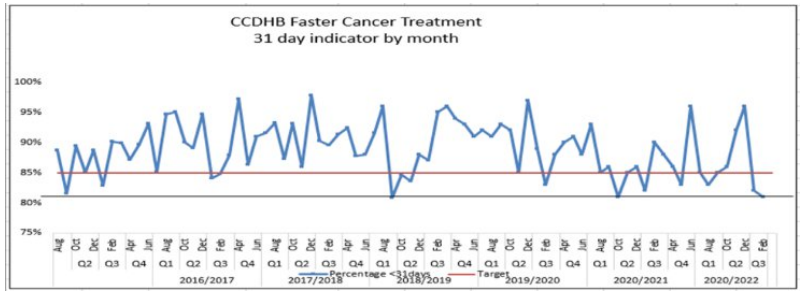
- CCDHB is non- compliant with the 31 day indicator for February at 81% which is below the aim of 85% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- There were 5 breaches for the 62 day target. Three experienced delays in the front end of the pathway, due to a combination in delays in histology reporting and the impact of statutory holiday interruptions, the remaining two were due to surgery wait times. The breaches were across a number of tumour streams which included breast, upper gastrointestinal, head & neck, gynaecology and skin. One Māori and three Pacifica patients were covered by the 62 day target. There were no Māori breaches and there were two Pacifica breaches. Note acute presentations are excluded from the 62 day target.

- There were 12 breaches in the 31 day indicator. All were due to capacity reasons relating to access to surgery. 31 day compliance was 60% for Māori (3/5), 66% for Pacifica (6/9) and 82% for other ethnicities 56/68). Average delay for all 31 day capacity breach patients was 45 days (range 32 - 71 days) a slight increase decrease from last month (41 days).





Management Comment

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

Work underway includes:

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

The largely manual process for prospectively tracking patients can make it difficult to intervene in a timely manner. Overall, February's data shows improved numbers.

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?

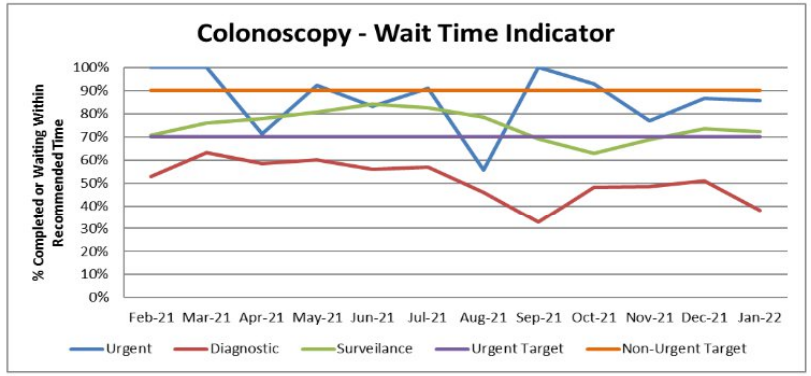
- CCDHB achieved the Ministry of Health target for urgent colonoscopies with a performance of 91% (target 90%). This was an improvement on the 86% achieved in January 2021. For diagnostic waits, we achieved 51% (target 70%) in February, which was an increase in the January performance of 38%.
- We met the Ministry of Health target for surveillance achieving 71% (target 70%). This is a slight drop against the December performance of 72%.

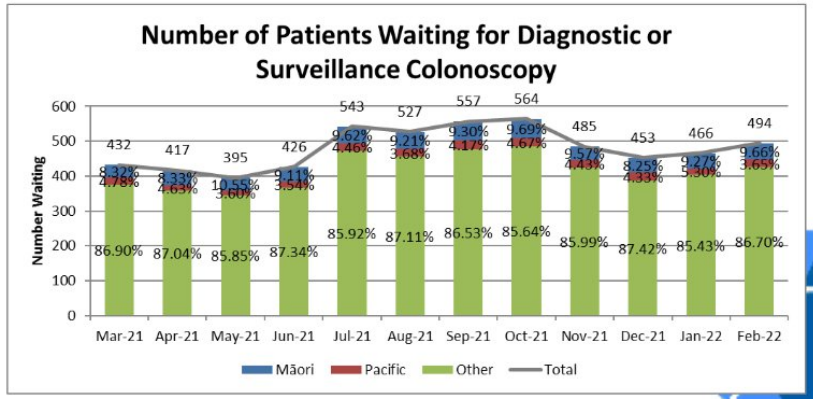
What is driving performance?

- With less AL being taken in February more lists were able to proceed, which has contributed to the improved performance. Outsourcing has continued and they were also able to run more lists in February with less staff on AL.

Management Comment

The slight improvement in performance was expected with less AL and fewer public holidays this month. Unfortunately as COVID levels in the community increase in March and we experience higher number of inpatients with COVID and staff absences, it will have an impact on planned care and the number of lists that can run each day.





Maternity and Neonatal Intensive Care services

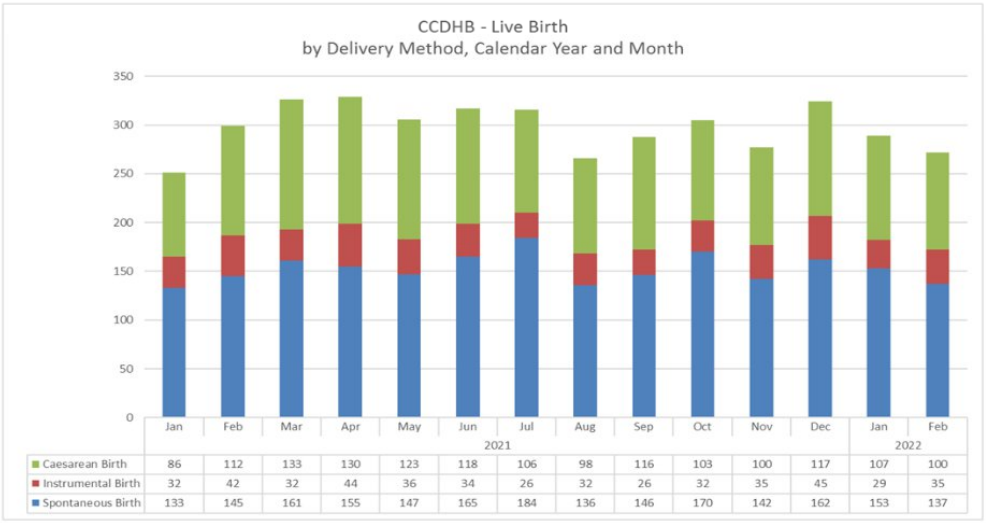
Maternity

What is the issue?

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

WHS Management Comment

- 271 births across all units for February
- February vacancy rate for 4NM and WRH Birthing Suite continues to sit high over February, currently at 29.6%. Staffing as a result COVID alongside the vacancy rate is impacting our ability to provide safe care.
- The service is working with HVDHB on recruitment and retention packages for midwives. We are pleased to confirm that this has been implemented.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Caesarean Birth	86	112	133	130	123	118	106	98	116	103	100	117	107	100
Instrumental Birth	32	42	32	44	36	34	26	32	26	32	35	45	29	35
Spontaneous Birth	133	145	161	155	147	165	184	136	146	170	142	162	153	137

Neonatal Intensive Care Unit

What is the measure?

To provide:

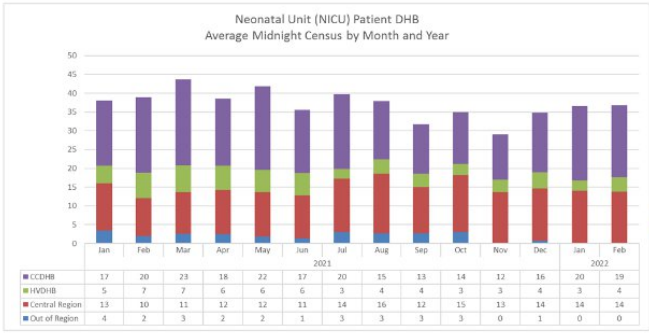
- A culturally and clinically safe 24/7 acute admitting service for infants from 23 weeks' gestation. Care is provided primarily for infants who are premature; those that require surgical intervention; perinatal intervention and support; and infants with congenital or metabolic abnormalities. These infants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

What is the issue?

- Over occupancy has been the issue in NICU for over 12 months.
- In January NICU saw an increase in occupancy to an average of 37 up from 35 the previous month.
- Acuity however has remained high over January with significant care hour's negative variance for most of the month.

How are we performing?

- CCDM RN staffing uplift of 20 RNs has not been recruited into as yet.
- NICU is safely managing the physical wellbeing of infants and families (with the above impacts).



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
CCDHB	17	20	23	18	22	17	20	15	13	14	12	16	20	19
HVDHB	5	7	7	6	6	6	3	4	4	3	3	4	3	4
Central Region	13	10	11	12	12	11	14	16	12	15	13	14	14	14
Out of Region	4	2	3	2	2	1	3	3	3	3	0	1	0	0

Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

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

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

Indicator	2020/21 Target	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb
Access Rate	3%	3.8%		3.9%			3.8%							
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	50.2%	61.4%	66.3%	72.2%	80.6%	73.3%	66.7%	59.7%	51.2%	36.9%	26.0%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	57.0%	47.2%	50.3%	49.9%	62.0%	64.4%	53.5%	60.4%	52.1%	74.0%	69.4%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	87.4%	87.8%	91.5%	89.6%	91.2%	86.2%	93.7%	84.9%	92.2%	71.5%	61.5%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	87.9%	84.3%	81.3%	90.1%	83.1%	80.2%	84.6%	86.5%	89.7%	84.4%	90.4%		
Community service users seen in person in last 90 days	95%	76.3%	80.3%	80.2%	80.5%	82.9%	82.4%	78.7%	76.7%	75.9%	79.2%	80.8%	76.5%	74.7%
Community DNA rate	<= 5%	9.6%	9.3%	9.1%	9.2%	8.8%	8.9%	8.0%	7.9%	8.1%	8.0%	7.9%	7.2%	8.3%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		450		458			472							
Wellness Plan Compliance	95%	47.2%		48.6%			47.4%			43.5%				
Wellness Plans - Acceptable Quality	95%	75.0%		71.5%			78.8%							
Community Services Transition (Service Exit) Plan Compliance	95%	51.0%		54.3%			56.9%			57.6%				
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	66.7%		67.5%			75.3%							

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

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

Indicator	2020/21 Target	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec	2022-Jan	2022-Feb
Pre-Admission Community Care	75%	72.7%	82.4%	78.6%	75.6%	79.1%	75.7%	75.0%	72.0%	69.6%	61.2%	60.8%	68.2%	65.6%
Post-Discharge Community Care	90%	78.3%	77.5%	73.8%	79.1%	78.1%	74.1%	82.1%	79.2%	75.0%	80.5%	60.7%	66.7%	62.0%
Acute Inpatient Readmission Rate (28 Day)	<= 10%	6.2%	7.7%	7.1%	5.3%	9.6%	3.0%	11.0%	9.5%	5.3%	10.0%	4.3%	3.8%	7.8%
Inpatient Services Transition Plan	95%	78.9%		77.8%			76.5%			74.8%				
Inpatient Services Transition Plan - Acceptable Quality	95%	84.6%		83.3%			86.3%							
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru	90%	89.3%	95.2%	101.3%	109.4%	100.7%	102.4%	102.8%	92.4%	105.9%	91.8%	89.4%	94.1%	84.4%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi	90%	97.8%	99.9%	106.0%	107.6%	104.6%	105.5%	111.5%	107.2%	108.2%	99.4%	99.8%	99.9%	88.3%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	550	763	431	289	226	296	684	454	178	253	79	48	274
Seclusion Hours - Māori		177	418	104	59	145	171	623	228	22	208	16	10	133
Seclusion Hours - Pacific Peoples		106	57	128	0	0	18	20	8	95	34	6	29	63
Seclusion Events		26	25	22	16	14	10	15	28	12	13	10	8	18
Seclusion Events - Māori		11	11	7	7	8	5	10	14	3	9	2	3	9
Seclusion Events - Pacific Peoples		3	2	4	0	0	1	2	1	6	3	1	3	1

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

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the eight month's to 28 February 2021 is $12m deficit, versus a budget deficit of $20.5m.
- Additional net COVID-19 related expenditure above funding, year to date is $16.9m.
- For the eight month's to 28 February 2021 the overall DHB year to date result, including COVID-19 costs is $29.5m deficit.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $56.2m year to date.
- The DHB has a positive cash Balance at month-end of $12.4 million including a positive "Special Funds" of $14.7 million net $27.1m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

COVID-19 Revenue and costs

Full Last Year		Capital & Coast DHB Operating Results - $000s	Part Year to Date		
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	YTD February 2022	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	COVID-19 change from MOH Unfunded
	(31,026)	Devolved MoH Revenue		(65,049)	
		Non-Devolved MoH Revenue			
693		Other Revenue	0		197
		IDF Inflow			4,343
		Inter DHB Provider Revenue			
693	**(31,026)**	**Total Revenue**	**0**	**(65,049)**	**4,540**
		Personnel			
(6,336)		Medical	(129)		(4,253)
(4,360)		Nursing	(2,193)		(5,051)
		Allied Health	(398)		(1,284)
		Support	(22)		(199)
		Management & Administration	(3,448)		(1,591)
(10,696)	**0**	**Total Employee Cost**	**(6,191)**	**0**	**(12,377)**
		Outsourced Personnel			
(88)		Medical	(254)		
		Nursing	0		
		Allied Health	0		
		Support	(2)		
		Management & Administration	(618)		
(88)	**0**	**Total Outsourced Personnel Cost**	**(874)**	**0**	**0**
(5,088)		Treatment related costs - Clinical Supp	(792)		
(564)		Treatment related costs - Outsourced	(178)		
(2,028)		Non Treatment Related Costs	(7,311)		
		IDF Outflow			
	(15,828)	Other External Provider Costs (SIP)		(49,703)	
		Interest Depreciation & Capital Charge			
		Recharging			
(7,680)	**(15,828)**	**Total Other Expenditure**	**(8,281)**	**(49,703)**	**0**
(18,464)	**(15,828)**	**Total Expenditure**	**(15,346)**	**(49,703)**	**(12,377)**
19,157	**(15,198)**	**Net result**	**15,346**	**(15,346)**	**16,917**

- The year to date financial position includes $77.4m of additional costs in relation to COVID-19.
- Revenue of $65m 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 – February 2022

Capital & Coast DHB Operating Results - $000s	Year to Date									Annual		
				Variance		Adjustments			Variance			
YTD February 2022	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend MOH Funded	COVID-19 change from Trend MOH Non Funded	Actuals exc COVID	Actuals exc COVID vs Budget	Annual Budget	Last year	Last year exc COVID
Devolved MoH Revenue	742,937	651,744	633,856	91,193	109,081	65,049	0	677,888	26,144	977,615	962,513	962,513
Non-Devolved MoH Revenue	31,285	30,981	29,210	304	2,074		0	31,285	304	48,353	42,517	42,517
Other Revenue	25,106	24,776	38,339	330	(13,233)	0	(197)	25,303	527	97,051	52,921	52,921
IDF Inflow	203,116	208,196	169,984	(5,080)	33,132		(4,343)	207,458	(737)	312,294	258,694	258,694
Inter DHB Provider Revenue	12,361	12,282	25,760	79	(13,399)		0	12,361	79	18,577	42,120	42,120
Total Revenue	**1,014,804**	**927,978**	**897,149**	**86,826**	**117,656**	**65,049**	**(4,540)**	**954,295**	**26,317**	**1,453,890**	**1,358,764**	**1,358,764**
Personnel												
Medical	133,844	129,824	123,042	(4,021)	(10,802)	129	4,253	129,463	361	198,568	191,666	191,666
Nursing	202,735	172,436	168,368	(30,298)	(34,367)	2,193	5,051	195,490	(23,054)	264,329	256,973	256,973
Allied Health	51,523	53,160	49,182	1,637	(2,341)	398	1,284	49,841	3,319	81,110	74,244	74,244
Support	7,974	7,670	6,968	(303)	(1,005)	22	199	7,753	(83)	11,772	10,747	10,747
Management & Administration	63,864	61,998	53,688	(1,866)	(10,176)	3,448	1,591	58,824	3,174	95,073	83,274	83,274
Total Employee Cost	**459,940**	**425,089**	**401,248**	**(34,851)**	**(58,692)**	**6,191**	**12,377**	**441,371**	**(16,282)**	**650,852**	**616,904**	**616,904**
Outsourced Personnel												
Medical	7,275	4,197	6,141	(3,078)	(1,134)	254	0	7,021	(2,824)	6,302	8,145	8,145
Nursing	470	804	392	334	(77)	0		470	334	1,206	897	897
Allied Health	1,278	1,135	995	(143)	(283)	0		1,278	(143)	1,702	1,704	1,704
Support	161	175	279	14	118	2		159	16	262	428	428
Management & Administration	3,658	1,913	2,780	(1,745)	(878)	618		3,040	(1,127)	3,005	4,491	4,491
Total Outsourced Personnel Cost	**12,842**	**8,223**	**10,587**	**(4,619)**	**(2,254)**	**874**	**0**	**11,968**	**(3,745)**	**12,477**	**15,664**	**15,664**
Treatment related costs - Clinical Supp	88,093	91,399	88,121	3,306	28	792		87,301	4,098	138,237	135,244	135,244
Treatment related costs - Outsourced	19,340	20,427	16,672	1,087	(2,668)	178		19,162	1,265	30,750	26,761	26,761
Non Treatment Related Costs	74,831	66,300	70,088	(8,531)	(4,743)	7,311	0	67,520	(1,220)	104,120	107,768	107,768
IDF Outflow	73,886	73,533	72,161	(353)	(1,725)			73,886	(353)	110,300	108,768	108,768
Other External Provider Costs (SIP)	277,126	226,438	228,018	(50,688)	(49,108)	49,703		227,423	(985)	339,657	338,357	338,357
Interest Depreciation & Capital Charge	38,203	37,028	37,254	(1,176)	(949)			38,203	(1,176)	60,468	55,798	55,798
Recharging	0	1	0	1	0					0	0	
Total Other Expenditure	**571,479**	**515,125**	**512,315**	**(56,354)**	**(59,164)**	**57,984**	**0**	**513,495**	**1,629**	**783,532**	**772,695**	**772,695**
Total Expenditure	**1,044,261**	**948,437**	**924,150**	**(95,824)**	**(120,111)**	**65,049**	**12,377**	**966,834**	**(18,398)**	**1,446,861**	**1,405,263**	**1,405,263**
Net result	**(29,456)**	**(20,458)**	**(27,001)**	**(8,998)**	**(2,455)**	**(0)**	**(16,917)**	**(12,539)**	**7,919**	**7,028**	**(46,499)**	**(46,499)**

Note
Adjustments are made for COVID-19

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($29.5m) compared to a budget deficit of ($20.5m).
- Included within this result is recognition of the adjustment to an estimated net impact of COVID-19 of ($16.9m).
- Excluding the COVID-19 above this brings the year to date deficit to ($12.5m) being $7.9m favourable to budget.
- Revenue is unfavourable by ($700k) YTD, after excluding COVID-19 & Pay Equity revenue.
- Personnel costs including outsourced is ($39.5m) unfavourable YTD, excluding COVID-19 related costs of ($19.4m) and Pay Equity ($22.4m) Personnel is $2.3m favourable YTD. Currently the DHB has a large number of vacancies which has been offset by ($27.4m) of vacancy savings targets.
- Treatment related clinical supplies is $3.5m favourable including favourable variances for Implants/Prostheses & Treatment disposables as volumes are down through the COVID-19 ($926k), which is offset by increase cost in Pharmaceuticals
- Outsourced clinical services is favourable YTD by $792k.
- Non treatment related costs ($9.7m) YTD unfavourable, however after excluding COVID-19 related costs of ($7.3m), the unfavourable variance was due to additional depreciation on 30 June building revaluation, seismic assessments costs, catch-up of deferred maintenance & Capital Charge
- The funder arm is favourable YTD due to additional revenue from spend requirements for the community COVID-19 response which is fully funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $86.8m favourable YTD
- The variance is due to revenue for special MHAIDS additional funding $1m, Pay Equity funding $22.4m The funder is also favourable by $86.2m revenue and the provider arm is favourable by $35.6m, however with offsetting community cost and COVID-19 related costs' including the reduction in IDF revenue of ($5.1m)

Personnel (including outsourced)

- Medical Personnel is ($1.3m) unfavourable for the month, ($7.2m) YTD. The unfavourable position for the month is driven by leave liability movement and vacancies across other services, most notably MHAIDS offset by centrally held vacancy savings targets and increased outsourcing in SWC & MHAIDS
- Nursing Personnel is ($2.6m) unfavourable to budget for the month. ($30m) YTD is driven by Pay Equity $22.4m. 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 $192k favourable to budget, $1.5m YTD as a result of vacancies.
- Support Personnel labour is ($36k) unfavourable to budget for the month, ($290k) YTD
- Management/Admin Personnel is unfavourable in the month by ($366k), ($3.6m) YTD Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings and increased outsourcing as a result of Vacancies and COVID

Section 4

Financial Position

Cash Management – 28 February 2021

Month : Feb 2022					Capital & Coast DHB Statement of cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Feb 2022	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating activities					
136,417	**115,823**	**122,997**	**20,594**	**13,420**	**Receipts**	**1,038,376**	**927,978**	**923,393**	**110,397**	**114,983**
					Payments					
51,607	50,928	46,949	(679)	(4,658)	Payments to employees	442,240	425,087	397,093	(17,153)	(45,147)
72,978	59,974	46,881	(13,004)	(26,097)	Payments to suppliers	586,751	483,947	496,912	(102,805)	(89,840)
-	-	9,735	-	9,735	Capital charge paid	9,048	22,204	21,845	13,156	12,798
(2,855)	-	7,778	2,855	10,633	GST (net)	2,922	-	(10,142)	(2,922)	(13,064)
121,729	**110,902**	**111,343**	**(10,827)**	**(10,387)**	**Total payments**	**1,040,961**	**931,238**	**905,708**	**(109,724)**	**(135,253)**
14,687	**4,921**	**11,654**	**9,766**	**3,034**	**Net cash flow from operating activities**	**(2,586)**	**(3,259)**	**17,685**	**674**	**(20,270)**
					Investing activities					
20	**16**	**4**	**(4)**	**(16)**	**Receipts**	**72**	**125**	**154**	**53**	**82**
					Payments					
5,659	34,445	5,080	28,786	(579)	Purchase of fixed assets	56,243	90,037	39,954	33,795	(16,289)
5,659	**34,445**	**5,080**	**28,786**	**(579)**	**Total payments**	**56,243**	**90,037**	**39,954**	**33,795**	**(16,289)**
(5,639)	**(34,429)**	**(5,076)**	**28,781**	**(595)**	**Net cash flow from investing activities**	**(56,170)**	**(89,912)**	**(39,800)**	**33,847**	**(16,206)**
					Financing activities					
-	30,920	-	(30,920)	-	Equity - capital	65,000	39,814	-	25,186	65,000
8,088	-	-	8,088	8,088	Other equity movement	36,317	61,840	7,382	(25,523)	28,935
-	-	-	-	-	Other	-	-	-	-	-
8,088	**30,920**	**-**	**(22,832)**	**8,088**	**Receipts**	**101,317**	**101,654**	**7,382**	**(337)**	**93,935**
					Payments					
-	-	-	-	-	Interest payments	-	-	8	-	8
-	-	-	-	-	**Total payments**	-	-	**8**	-	**8**
8,088	**30,920**	**-**	**(22,832)**	**8,088**	**Net cash flow from financing activities**	**101,317**	**101,654**	**7,374**	**(337)**	**93,943**
17,137	**1,412**	**6,578**	**15,716**	**10,526**	**Net inflow/(outflow) of CCDHB funds**	**42,561**	**8,482**	**(14,741)**	**34,184**	**57,467**
9,972	(17,064)	(3,083)	(27,036)	(13,055)	**Opening cash**	(15,452)	(24,134)	18,236	(8,682)	33,688
144,525	146,759	123,000	(2,242)	21,492	Net inflow funds	1,139,765	1,029,758	930,929	110,113	209,000
127,388	145,346	116,422	17,958	(10,966)	Net (outflow) funds	1,097,204	1,021,275	945,671	(75,929)	(151,533)
17,137	**1,412**	**6,578**	**15,716**	**10,526**	**Net inflow/(outflow) of CCDHB funds**	**42,561**	**8,482**	**(14,741)**	**34,184**	**57,467**
27,109	**(15,652)**	**3,495**	**42,761**	**23,613**	**Closing cash**	**27,109**	**(15,652)**	**3,495**	**42,761**	**23,614**

Reconciliation of net cash flow to operating balance

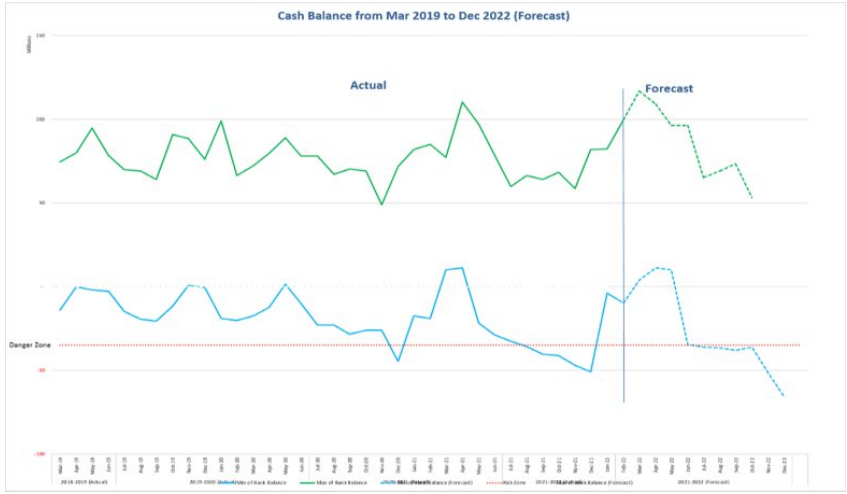
	YTD Feb 2022		
	Actual $000	**Budget $000**	**Variance $000**
Net cashflow from operating	(2,586)	(8,181)	5,595
Non operating financial asset items	98	-	98
Non operating non financial asset items	(2,325)	-	(2,325)
Non cash PPE movements	(24,306)	(22,168)	(2,137)
Working capital movement			
Inventory	3,463	-	3,463
Receipts and prepayments	20,808	-	20,808
Payables and accruals	(24,609)	10,358	(34,966)
Total working capital movement	**(338)**	**10,358**	**(10,695)**
Operating balance	**(29,456)**	**(19,991)**	**(9,465)**

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

Debt Management / Cash Forecast – 28 February 2021

Accounts Receivable
28-Feb-22

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	29,791	21,149	96	3,861	-	4,685	34,721
Other DHBs	3,129	873	501	58	28	1,669	3,361
Kenepuru A&M	194	35	13	22	124	-	209
ACC	223	89	45	(32)	3	118	43
Misc Other	3,875	1,586	440	84	39	1,726	4,186
Total Debtors	37,212	23,732	1,095	3,993	194	8,198	42,520
less : Provision for Doubtful Debts	(4,224)						(4,204)
Net Debtors	32,988						38,316



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 $1.57m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $124k

4. 'Misc Other' debtors includes non resident debt of approx. $1.87m. About 86.03% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash management

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

Statement of financial position as at 28 February 2022

Jan-22	Month : Feb 2022			Variance		Capital & Coast DHB Statement of financial position
Actual	Actual	Budget	At Feb 2020	Actual vs Budget	Actual vs Feb 2020	YTD Feb 2022
13	13	31	31	(17)	(17)	Bank
-	12,419	824	212	11,595	12,206	Bank NZHP
14,454	14,677	13,561	12,995	1,116	1,682	Trust funds
85,395	76,357	63,930	70,448	12,427	5,909	Accounts receivable
11,033	12,856	9,466	9,553	3,390	3,304	Inventory/stock
13,909	13,020	7,902	9,935	5,118	3,085	Prepayments
124,803	**129,342**	**95,714**	**103,173**	**33,628**	**26,169**	**Total current assets**
550,070	548,483	573,330	510,173	(24,847)	38,310	Fixed assets
16,058	5,875	5,875	14,796	-	(8,920)	Work in progress - CRISP
137,944	153,512	103,005	84,077	50,507	69,435	Work in progress
704,072	**707,870**	**682,211**	**609,045**	**25,659**	**98,825**	**Total fixed assets**
1,150	1,150	1,150	1,150	-	-	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**-**	**-**	**Total investments**
830,025	**838,362**	**779,075**	**713,368**	**59,287**	**124,994**	**Total assets**
4,495	-	30,067	9,743	30,067	9,743	Bank overdraft NZHP
85,660	88,547	72,575	102,297	(15,971)	13,750	Accounts payable, accruals and provisions
1,525	3,050	3,701	2,985	650	(65)	Capital charge payable
593	593	593	593	-	-	Insurance liability
11,452	12,359	11,441	114,454	(917)	102,095	Current employee provisions
183,494	194,142	180,467	63,680	(13,676)	(130,463)	Accrued employee leave
22,131	13,287	22,515	12,205	9,228	(1,082)	Accrued employee salary & wages
309,350	**311,978**	**321,360**	**305,956**	**9,381**	**(6,022)**	**Total current liabilities**
103	99	92	99	(6)	0	Restricted special funds
605	605	605	605	-	-	Insurance liability
6,222	6,222	6,564	6,564	343	343	Long-term employee provisions
6,929	**6,925**	**7,262**	**7,268**	**337**	**343**	**Total non-current liabilities**
316,279	**318,903**	**328,622**	**313,225**	**9,718**	**(5,679)**	**Total liabilities**
513,746	**519,458**	**450,453**	**400,144**	**69,005**	**119,315**	**Net assets**
864,668	933,856	900,697	817,122	33,159	116,733	Crown equity
-	-	-	-	-	-	Capital repaid
69,188	4,103	30,920	15,370	(26,817)	(11,267)	Capital injection
193,463	193,463	130,659	130,659	62,803	62,803	Reserves
(613,572)	(611,963)	(611,823)	(563,009)	(141)	(48,954)	Retained earnings
513,746	**519,458**	**450,453**	**400,143**	**69,005**	**119,315**	**Total equity**

Balance Sheet

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

Financial ratios

1. Current ratio – this ratio determines the DHB's ability to pay back its short term liabilities. DHB's current ratio is 0.41 (January - 0.40).
2. Debt-to-equity ratio - this ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 0.61 (January - 0.70).

Note

1. The 30 June 2021 revaluation of land and buildings are yet be recorded in CCDHB's financial statements. With final audit sign off now received in February, revaluations are planned to be uploaded into the Oracle financial system in March. Changes will be reflected in the statement of financial position, in particular the fixed assets and revaluation reserve.

Capital Expenditure Summary on Prior Year Approved February 2022

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

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

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

Capital Expenditure Summary 2021/22 February 2022

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

Key highlights to FY2021/22 Capital plan:

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

Board Decision – Public

30 March 2022

Health System Committee (HSC) update and items for approval from Committee meeting dated 16 March 2022

Action Required

The Boards approve the following decision endorsed by HSC:

Item 2.2: Health Care Home, Localities and Networks Funding

Note:

(a) The Health Care Home programme to transform primary care is in its sixth year of operation in CCDHB and its fifth year in HVDHB and has achieved significant population coverage and shown promising results.

(b) That the establishment of Community Health Networks has been identified as a solution to support the future sustainability in the CCDHB Long Term Investment Plan and as a key action within Taurite Ora. In HVDHB, in 2016, the Acute Demand Network and Alliance Leadership Team (Hutt INC) highlighted Community Integration as a priority area and endorsed the development of Neighbourhoods (now referred to as Networks) that geographically align primary, secondary and community services

(c) The principles driving the design and development of Community Health Networks and Neighbourhoods align closely with the strategic direction of the health and disability system reforms underway that seek to establish localities to plan and commission primary and community health services effectively and engage with communities at the appropriate level.

(d) Across our 2DHB's we are focused on aligning our approach to Locality and Network development and have been adapting our approach to planning and commissioning. As Health Care Home practices mature, our DHBs are investing the released funding in Locality and Network Development.

(e) The development and implementation of Localities and Provider Networks is a significant strategic programme of work that will require resourcing, to embed the new ways of working and to sustain the Network infrastructure.

Approve:

(a) The annual 2022/23 budget of $4,307,105 at CCDHB and $2,283,571 at HVDHB for the ongoing support of Health Care Homes and Localities and Network Development

(b) The continuation of the reinvestment over the next three years (until at least 2024/25) of Health Care Home funding into Localities and Network development as it is released from Health Care Homes.

The Boards note HSC received reports and noting recommendations on the following:

Item 2.1: 2DHB Localities Update

Note:

(a) the 2DHB Localities work comes under the Commissioning & Communities focus area, which is part of the 2DHB Strategic Priorities.

(b) the 2DHB Localities presentation provides an update on the development of the localities in Porirua, Wainuiomata, and Kāpiti.

(c) The presentation includes context about the health system reforms and shows how the Commissioning & Community localities work contributes to implementing the new health system.

Item 2.3 - 2DHB Maternal and Neonatal System Implementation Plan

Note:

(a) that on recommendation from the Health System Committee, the 2DHB Boards approved the 2DHB Maternal and Neonatal System Plan on 1 December 2021 and requested a progress update on implementation at the Health System Committee and Board meetings in March 2022.

(b) the 2DHB Maternal and Neonatal System Plan outlines the actions that must be taken to realise evidence-based, pro-equity care across the maternal and neonatal care continuum.

(c) that implementation of the 2DHB Maternal and Neonatal System Plan is underway, with a detailed status update provided in Appendix 1.

(d) that a significant number of actions are anticipated to be delivered on time, within existing funding and resources.

(e) that there are some actions that will require additional investment to achieve, which presents a delivery risk as noted in section 7 of this paper.

(f) that obtaining funding to deliver the 2DHB Maternal and Neonatal System Plan will be a top priority in our contribution to interim Health New Zealand's 2022/23 investment planning process, and this will be actioned when interim Health New Zealand has articulated the pathway for new investment.

Item 3.1 – Regional Public Health Update: August 2021 – February 2022

Note:

(a) The significant impact of the ongoing COVID-19 pandemic response on Regional Public Health's usual work programme, and on its workforce.

(b) The approach to reducing Food Insecurity in our communities building on the Fruit & Vege Co-op model.

Item 4.1 – CCDHB and HVDHB Non-Financial Performance Reports – 2021/22 Quarter 1 and Quarter 2

Note:

(a) This report provides a summary from two key reports:

i. CCDHB's and HVDHB's Non-Financial Quarterly Monitoring Reports for Q1 (July – September 2021) and Q2 (October –December 2021) 2021/22.

ii. CCDHB's Health System Plan dashboard and HVDHB's Vision for Change dashboard for Q1 and Q2 2021/22.

(b) CCDHB's and HVDHB's Q1 results are similar to Q4 2020/21, achieving compliance for most indicators.

(c) CCDHB and HVDHB improved their performance ratings over Q1 and Q2 for the 'Youth Mental Health initiatives', 'Shorter Stays in Emergency Departments', 'Shorter waits for non-urgent mental health and addiction services'.

(d) For the 48 indicators rated by MoH in Q2, CCDHB received, 1 'Outstanding' rating, 26 'Achieved' ratings, 12 'Partially Achieved' ratings and 9 'Not Achieved' ratings. This is a significant improvement on CCDHB's Q1 result.

(e) For the 49 indicators rated by MoH in Q2, HVDHB received, 27 'Achieved' ratings, 14 'Partially Achieved' ratings and 8 'Not Achieved' ratings. This is similar to HVDHB's Q1 result.

(f) Specific action plans are in place to improve performance against the 'Not Achieved' performance measures, including strategies to improve our immunisation, faster cancer treatment, long term conditions, and smoking cessation advice results.

(g) Overall results for CCDHB and HVDHB demonstrate:

iii. a community health system delivering well for the majority of indicators with a persistent pressure points posing challenges

iv. a hospital system working hard under increased demands from Covid-19 restrictions

v. a system under pressure with resources responding to the Covid-19 pandemic. .

(h) That recent changes, shortening the booster time frames and changing to 'red' under the traffic light system, have impacted the Q1 and Q2 2021/22 results, as some activities cannot be performed during lockdown and resources have also been temporary diverted into swabbing and vaccination efforts. This will likely continue to impact performance in Q3 2021/22.

(i) CCDHB received an 'Outstanding' rating for improving the 'quality of identity data within the National Health Index (NHI).

Presented by	Sue Kedgley, Chair - Health System Committee
Purpose	Provide the Boards with an update regarding the content of the meeting and recommend the Health Care Home, Localities and Networks Funding for approval by the 2DHB Boards.
Contributors	As noted in the HSC papers
Consultation	As noted in the HSC papers

Executive Summary

The Chair of the Health System Committee will provide an overview of the meeting agenda items and discussion.

Strategic Considerations

As noted in the HSC papers

Engagement/Consultation

As noted in the HSC papers

Identified Risks

As noted in the HSC papers

Attachment/s

Nil.

Board Information – Public

30 March 2022

3DHB Sustainability Strategy Update	
Action Required **The Boards note:** (a) the provided Environmental Sustainability update. (b) the 2DHB light vehicle fleet transition plan and the associated constraints.	
Strategic Alignment	This report refers to the 3DHB Environmental Sustainability Strategy approved by the 2DHB Board and to the Carbon Neutral Government Programme announced by the Minister for Climate Change in 2021.
Presented by	Mathew Parr, Acting Chief Financial Officer 2DHB
Purpose	Provide the 2DHB Board with an update on the Environmental Sustainability work programme, including risks and liabilities. Provide information following a request at the previous Board meeting to include forecast and timing for full switch to electric vehicles.
Consultation	Facilities Management (CCDHB and HVDHB)

Executive Summary

1. This paper provides an update on the Environmental Sustainability work programme following approval of the 3DHB Sustainability Strategy in 2021. Data provided is for the 2021 calendar year and covers only Capital and Coast DHB due to data availability. Future updates will include data from both Capital and Coast and Hutt Valley DHBs.
2. At the request of the Board, an update is provided regarding the forecast and timing for the transition to electric vehicles in the Light Fleet Transition section below. This includes a summary of key constraints and work underway to resolve them.

Energy and Carbon

3. Data for energy and carbon is currently only available for CCDHB. HVDHB (and possibly WrDHB) data will be available in the near future, with work underway to align data collection and organisational boundaries.
4. Operational energy management is the responsibility of the Property and Facilities Division, who contributed to this paper. This Division holds the operational funding that covers energy costs.
5. From January 2021-December 2021 CCDHB consumed 28.7GWh of Electricity and 36.6GWh of Natural Gas, resulting in to 11,079T of CO_2e. CCDHBs total emissions (including waste, fleet, air travel, medical gases etc) from this period are approximately 14,395T CO_2e meaning energy makes up around 80% of our emission profile. Prior to Covid-19 border restrictions preventing international travel, total emissions were approximately 22,000 T CO_2e and energy made up 51% of our overall emission profile.
6. Projects approved to date are expected to reduce emissions from energy by 580T CO_2e per annum, and projects being explored but not yet approved by a further 2051T CO_2e per annum.

7. Details of month to month energy consumption and overall carbon emissions (excluding air travel from Continuing Medical Education) are provided in Appendix 1.

Light Fleet Transition

8. A 2DHB Fleet Transition Plan has been approved by the 2DHB Chief Financial Officer and was supplied to the Ministry of Business, Innovation and Employment (MBIE) in December 2021, this is provided in Appendix 2. This Plan relies on co-funding from the State Sector Decarbonisation Fund to be affordable.
9. The major constraint for accelerating the transition to electric vehicles is electrical infrastructure to support charging. At the CCDHB Newtown campus there are a number of 'pinch points' relating to both physical size distribution board (too small – requiring increase in size), and secondly, the electrical capacity to these boards. CCDHB Engineering Services is working on the planning around both aspects, both the spatial requirements and making available additional capacity for EV charging.
10. One element to increasing electrical capacity requires engagements with external partners such as Wellington Electricity Limited (WEL) who manage the local distribution network. We are involved in a joint planning process with WEL to increase the capacity to the Newtown site, and improve resiliency. This process is technologically complex and requires significant planning and consenting work to be completed prior to work beginning.
11. Work is currently underway with WEL to increase electrical capacity at both the CCDHB Newtown campus and Hutt Hospital campus. It is expected that our contribution to these upgrades will be approximately $11m for Wellington Regional Hospital. A concept design has been completed for the electrical infrastructure and chargers to support 33% of the vehicles based at Hutt Hospital (38 vehicles) and is provided in Appendix 3. This work is expected to cost approximately $1.2m (including supply of chargers), this not yet funded and will be included in the next round of capital planning.
12. The additional capacity is a priority as in addition to supporting the transition to electrifying the fleet, it is also required to support the proposed Master Planning work which includes a significant increase in building footprint over the next decade/s.
13. If these upgrades are approved we expect work to begin in the 2023/24 financial year. Provision has been made in the 3 year capital plan for this investment.
14. Funding from the State Sector Decarbonisation Fund is not available for these upgrades.
15. Once the additional electrical capacity is online, electrification of the fleet can be accelerated, provided funding for installation of charging infrastructure is made available.
16. An electric vehicle charging infrastructure preferred provider procurement process is underway for 3DHB to provide flexibility and responsiveness in the deployment of this infrastructure as electrical capacity and funding becomes available. Sustainability, in partnership with the 2DHB Travel and Transport team, will provide an option in each business case for additional electric vehicle charging infrastructure that maximises the number of chargers (and therefore vehicles) able to be installed within available electric capacity.
17. Deployment of the 410 electric vehicle charging station required to electrify the 2DHB fleet is expected to cost between $3-4m, with approximately $1-2m of this total eligible for State Sector Decarbonisation Funding. More accurate and detailed costings will become available as further site investigations are undertaken as part of the preferred provider contract.

Strategic Considerations

Service	The information included in this report, and the risks highlighted are relevant to the DHB organisations as a whole. Particular strategic focus is given to the Property and Facilities and Non-Clinical Support and Delivery Divisions within FFABS. There are significant opportunities to reduce energy consumption (and carbon emissions from energy) and reduce emissions from the light vehicle fleet detailed in relevant attachments.
People	Engagement is required from subject matter experts (SME) and decision makers across the organisation on a case by case basis.
Financial	Realising the opportunities highlighted in this report will require significant capital investment. Some of this investment has been included in Capital Intention submissions, while other investment is expected from outside of Vote Health, such as co-funding from the State Sector Decarbonisation Fund. This report provides a high level overview of risks, opportunities and liabilities, and does not provide detailed cost estimates of specific projects.
Governance	Government policy is increasingly directive in regards to requirements to meet sustainability objectives. This Report aims to set out the major obligations established under changes to All of Government Procurement Rules and the Carbon Neutral Government Programme CNGP).

Engagement/Consultation

Patient/Family	NA
Clinician/Staff	Consultation with SMEs and relevant decision makers is ongoing.
Community	NA

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
1	Scope 1, 2 and 3 mandatory emissions must be measured and reported as part of the CNGP. HVDHB is not currently measuring any emissions and must first establish a base year. It is preferred that the base year is taken from before the impacts of Covid-19. Data may be difficult to obtain for past years.	Sustainability Team	If not all data is available for 2018/19 a blend year may be used where consumption has not been impacted by Covid-19		
2	It is expected that Public entities (including DHBs) will be required to offset residual emissions from 2025. This report includes analysis of	Finance	A “climate mitigation” scenario is also provided based on interventions highlighted in the		

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	potential liabilities under a business as usual scenario, where funding must be made available to cover offsetting costs.		CCDHB Energy Policy and the Fleet Transition Plan.		
3	Electric Vehicle charging infrastructure is a significant barrier to the transition of the light vehicle fleet. Should there be insufficient available electrical capacity, charging infrastructure for electric vehicles may be unable to be delivered. This would limit the number of electric vehicles able to be introduced.	2DHB Travel and Transport	Work is ongoing with Wellington Electricity Limited to expand the overall electrical capacity at Wellington Regional Hospital and Hutt Hospital.		
4	The Electric Vehicle market is facing international constraint and availability of vehicles is intermittent.	2DHB Travel and Transport	Early ordering of vehicles and partnering with lease companies to ensure adequate time for vehicles to be procured.		

Attachment/s

1. Attachment 1: Infrastructure Energy Efficiency and Decarbonisation
2. Attachment 2: Fleet EV Optimisation and Transition Plan template – *located in the Diligent Resource Centre (for Board members) and available to the public on request (board.secretary@ccdhb.org.nz).*

Attachment 1: Infrastructure Energy Efficiency and Decarbonisation

CCDHB Energy consumption and Costs

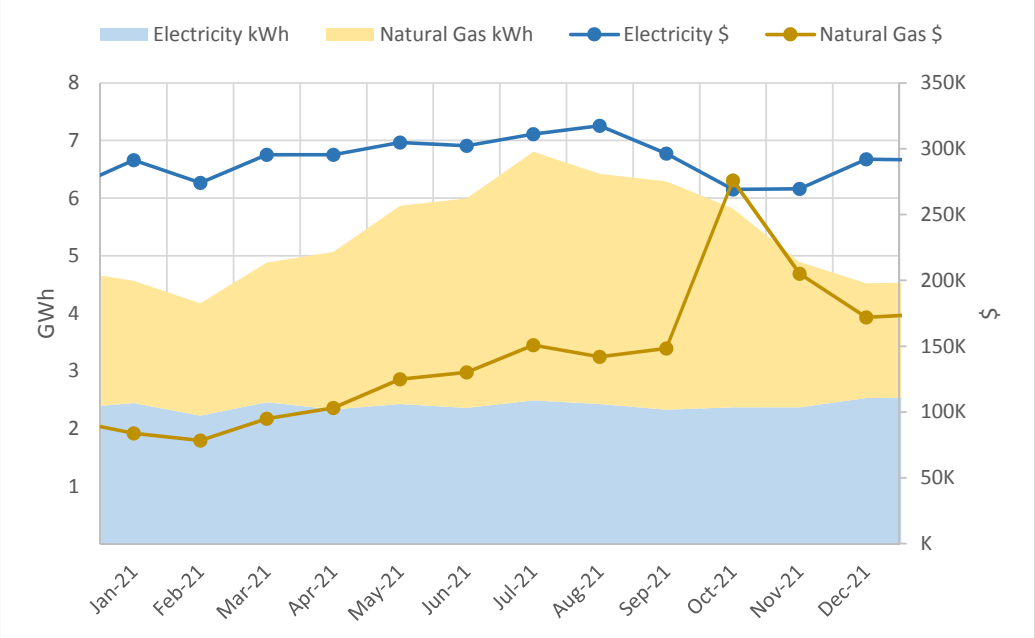
The shaded areas (stacked) in the below graph shows energy consumption across our sites broken own by energy type (electricity and natural gas) for the 2021 calendar year.

Natural gas is primarily used for space and hot water heating leading to peaks in June/ July (winter). Cooling from domestic/ commercial heat pumps and larger industrial chillers drives electricity consumption during warmer months (Nov/Dec). However, some sites that use electricity for space heating (electric resistance, heat pumps) increase the electrical load in winter, which results in a flatter trend in electricity consumption overall.

The two lines in the graph shows energy cost, also broken down by energy type. While electricity consumption is much lower, the cost per unit is much higher.

For applications excluding heating/ cooling such as medical equipment, electricity is the only option so the difference is largely irrelevant. When looking at the fuel switching opportunities for heating/ cooling the difference in unit cost is offset by the greater efficiency of heat pump technology compared with natural gas boilers (60-90% for natural gas 300%+ for heat pumps)

In October 2021 a new All of Government contract for natural gas almost doubled the per unit cost, which can be seen in the jump in expenditure for that month, the following reduction is due to warmer weather and lower heating requirements as seen in the consumption graph above.



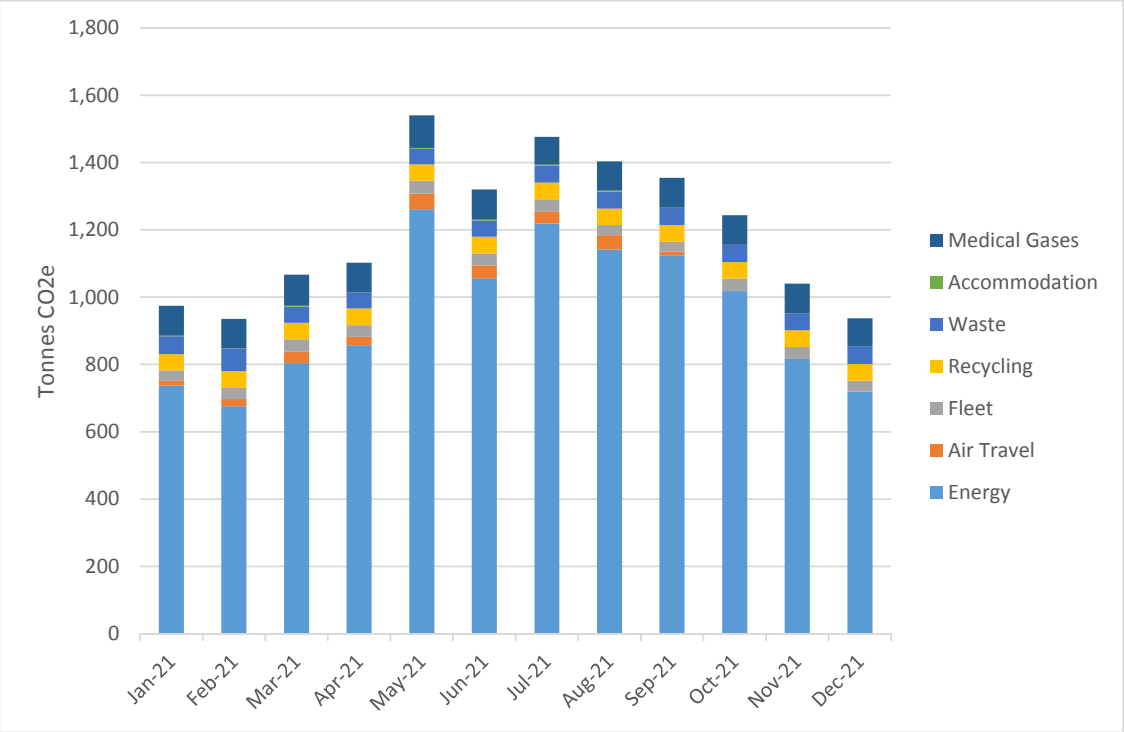
Carbon emissions

The graph below shows a breakdown of where total emissions are coming from for each month in the time period.

Across these six months, emissions from Energy made up 80% of total emissions, the next largest group of emissions is medical gases (used for anaesthesia) at approximately 7% of total emissions.

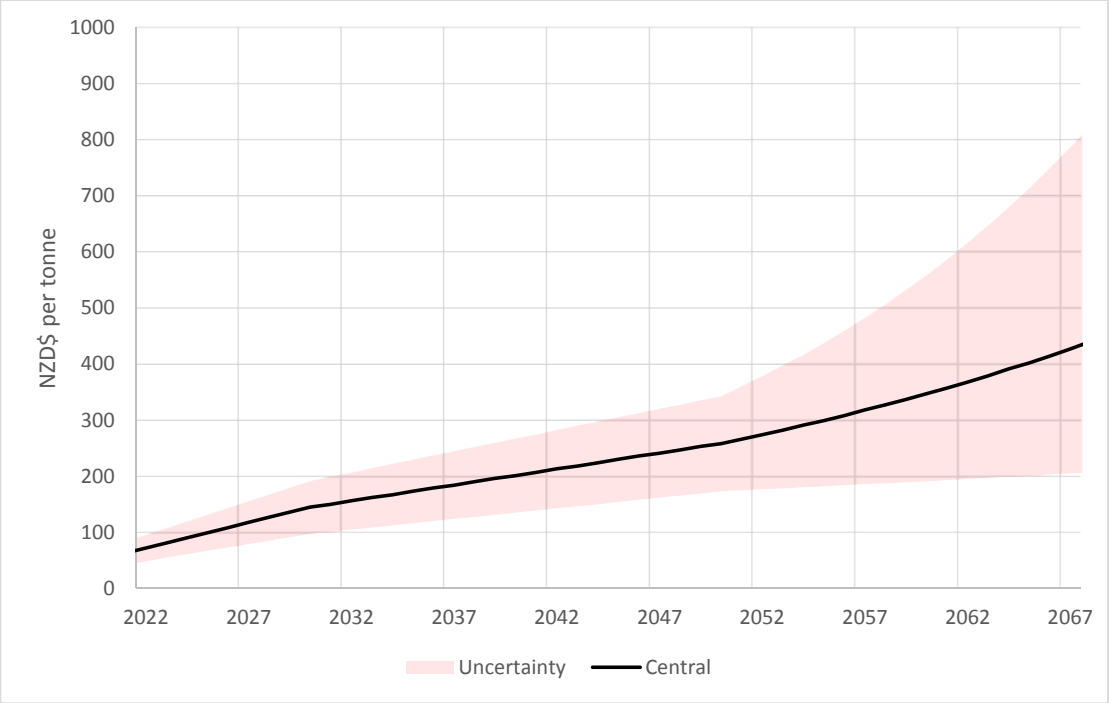
Covid-19 travel restrictions have largely removed emissions from air travel, accommodation and other sources associated with travel (particularly from Continuing Medical Education undertaken by Senior Medical Officers). Prior to these travel restrictions, CCDHB emissions were approximately 700T CO2e higher per month, with energy being just over 51% of total emissions.

The major opportunities for reducing the carbon footprint of CCDHB is in energy efficiency and fuel switching away from fossil fuels, and working to reduce air travel once restrictions end.



Carbon liabilities

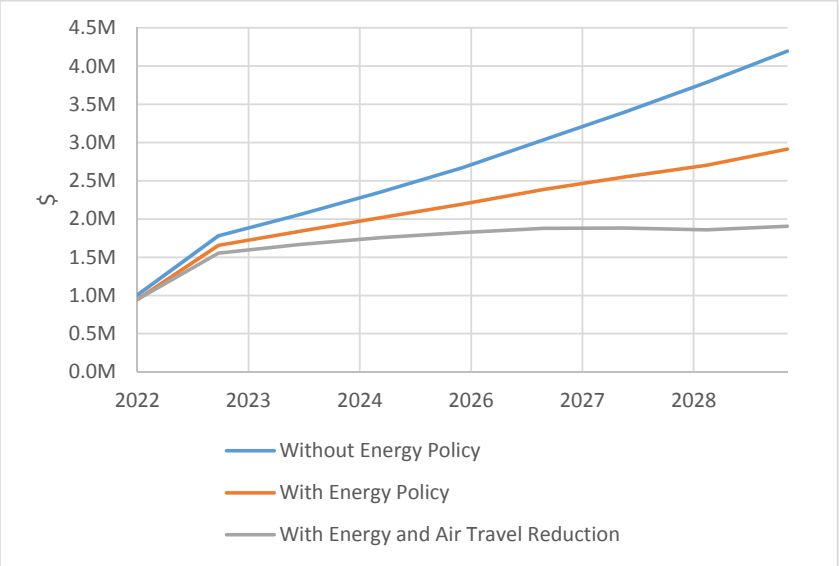
It is expected that from 2025, the public sector will be required to offset remaining emissions as part of the Carbon Neutral Government Programme. The below graph shows the cost of carbon based on shadow pricing provided by Treasury.



The below graph shows potential liabilities under the CNGP with and without implementation of the Energy Policy which was approved as part of the 3DHB Environmental Sustainability Strategy and included a 60% reduction in emissions from energy by 2030. It also shows the impact of implementing the energy policy and reducing all air travel emissions by 60% by 2030 (at a steady rate of 7% per year). The central cost in the graph above has been used for this purpose.

The graph below assumes a return to business as usual for CME travel in 2023, which is likely without changes in the Multi-Employer Collective Agreement and buy in from ASMS and other SMO organisation. It is noted that allowing offsetting to be reimbursed from the CME budget is being requested by union partners, however without stronger data collection tools or policies it is unlikely that these offsets would be able to count towards CNGP requirements.

Further reduction in offsetting costs will be seen in from other initiatives such as the electrification of the fleet, however these sources have a comparatively small impact on overall emissions and reductions will have a similarly small impact in offsetting liabilities.



Board Information – Public

30 March 2022

Disability Support Advisory Committee (DSAC) Items for Board Approval and Noting from Committee meeting dated 16 March 2022

Action Required

The Boards note:

(a) The papers are in the Diligent Board book for the DSAC meeting dated 16 March 2022

(b) DSAC received reports and passed the noting resolutions on items 2.1, 3.2, 4.1, 4.2, 4.3 and 5.1 as set out below.

(c) DSAC received report 3.1 (*Sub-Regional Disability Strategy 2017-2022 – Independent Review Findings*) and agreed to lay it on the table, to enable the Chair of DSAC to refine the wording of the resolutions for this item (based on what was proposed and discussed at the meeting) and circulate to members.

[***At the time of publishing the Board agenda, proposed wording had been circulated to members but feedback had not been received from all members***].

Strategic Alignment	Annual Plans, Te Pae Amorangi, Taurite Ora and Sub Regional Disability Strategy 2017-2022, Pacific Health and Wellbeing Strategy for the Greater Wellington Region. Suicide Prevention Postvention Annual Action Plan 2021/2022.
Endorsed by	Fionnagh Dougan, Chief Executive Disability Support Advisory Committee
Presented by	'Ana Coffey, Chair Disability Support Advisory Committee
Purpose	Obtain Board approval for the paper laid on the table at DSAC, note the noting decisions endorsed by DSAC, and provide an update on the meeting of the Committee.
Contributors	As noted in the DSAC papers
Consultation	As noted in the DSAC papers

Executive Summary

The papers can be located on the DHB websites or in the DSAC Diligent Book for 16 March 2022. The slides for the presentations are located in the Resource Centre on Diligent. The Chair of DSAC will provide an overview of the meeting agenda items and discussion.

Since the meeting, the Chair of DSAC has raised with the 2DHB Executive Leadership team the concern that there is not yet clarity on how the voices of our disabled communities will be heard in the new Health System. While these decisions are not our DHBs to make, the Chief Executive has confirmed that:

(a) our 3DHB disability team is working alongside their colleagues in both the Ministry of Health and interim Health New Zealand – and the Boards will be informed when more is known; and

(b) the Director Māori Health has taken responsibility for working alongside Tāngata Whaikaha to ensure their voice is an integral part of the future health structures with particular emphasis on the Māori Health Authority's Matauranga Māori and Rongoa Māori goals.

Noting recommendations from the Committee for items 2.1, 3.2, 4.1, 4.2, 4.3 and 5.1

Item 2.1 Mental Health and Addiction Change Programme Overview

The Committee noted:

(a) The overview of the Mental Health and Addiction Change Programme and progress update.

(b) request that the work program incorporate a partnership framework – working with networks as a collective rather than individuals.

Item 3.2 Disability Leadership Group's Strategic Plan for 2022

The Committee noted:

(a) The Disability Leadership Group has reviewed the 3DHB Sub-Regional Disability Strategy and updated it by developing a Strategic Plan for 2022.

(b) The Strategy Plan applies to all areas across our three DHBs, and the Enabling Good Lives Principles and the Accessibility Charter are tools to apply disability equity alongside capability and capacity building initiatives.

(c) A critical role of the Disability Leadership Group is to provide the 'thought leadership' needed to implement the Strategic Plan for 2022.

(d) The recommendations from the review conducted by Grant Cleland have been incorporated into the Disability Leadership Group's Strategic Plan for 2022 (see separate paper).

Item 4.1 3DHB Sub Regional Disability Strategy 2017 – 2022 Update

The Committee noted:

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

Item 4.2 MHAIDS Service Performance Update

The committee noted the attached report from MHAIDS.

Item 4.3 3DHB Mental Health and Wellbeing Strategy Update

The Committee noted:

(a) Hutt Valley District Health Board (HVDHB), Capital & Coast District Health Board (CCDHB) and Wairarapa District Health Board (WrDHB) have continued the implementation of *Living Life Well: A strategy for mental health and addiction 2019-2025*, with a focus on the expansion of services to include early intervention and growth in investment in Kaupapa Māori and Pacific services.

(b) Implementation of Living Life Well has been supported by continued roll out of expanded primary mental health care across the region (the 'Access and Choice' programme), which will double in investment by June 2023.

(c) Strategy, Planning and Performance (SPP) continue to support growth of the Primary Care Liaison Service, with recruitment and appointment of two nurse practitioner roles and upgrading of the two liaison roles in Wellington to nurse practitioner level.

(d) Investment in the Acute Care Continuum initiative has progressed with further capacity in mobile and after hours NGO services in the Hutt and commissioning of the planned new Crisis Respite Service in Wellington.

(e) The 2DHB SPP Mental Health and Addictions commissioning team is working with Kaupapa Māori and Pacific providers to grow community AOD counselling service capability and integrate with adjacent services to provide more integrated care.

(f) The 3DHB Suicide Prevention and Postvention Action Plan continues to be implemented with recent approval and support for this plan by the National Suicide Prevention Office.

Item 5.1 Research Report: Understanding Disabled People's Experiences of Local Healthcare Services in the 3DHB Region – Wellington, Hutt Valley and Wairarapa

The Committee noted:

(a) The attached research report was commissioned by the Strategy, Planning and Performance Directorate to understand the experiences disabled people have when accessing health care services at home, in the community, and in the hospital.

(b) This research report will be shared with Health New Zealand and will inform the design and development of services across localities, specialist services, and hospitals.

(c) The recommendations in the research report generally align with the strategic priorities and activities in the Strategic Plan for 2022 developed by Disability Leadership Group (see separate paper), although one of the recommendations about telehealth services is new and requires further consideration.

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 30 March 2022

Resolution to exclude the Public

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

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

TABLE

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

		iii. OIA s 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage negotiations
2DHB and MHAIDS Quality & Safety Report	As above	As above (i) and (ii)
2DHB Workplace Health and Safety Report	As above	As above (i) and (ii)
2DHB Hospital Network update	As above	As above (iii)
FRAC items for Board Approval from meeting dated 03/03/22	As above	As above (iii)
Provision of Adult and Paediatric Sleep Assessment Services	As above	As above (iii)
HVDHB Mental Health Unit Replacement –Change of Location	As above	As above (iii)
CCDHB Children's Hospital Building Project – Update and Funding	As above	As above (iii)
Chair's Report and Correspondence	As above	As above (i), (ii) and (iii)
Chief Executive's Report	As above	As above (i), (ii) and (iii)
General Business	As above	As above (i), (ii) and (iii)

NOTE

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

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