PUBLIC

AGENDA

Held on Wednesday 4 August 2021
Location: Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block
Time: 9am
Zoom Meeting ID: 876 5068 1844

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Time	Min	Pg
1	**PROCEDURAL BUSINESS**			**9.00**	**10**	
1.1	Karakia		All members			2
1.2	Apologies	**NOTE**	Chair			
1.3	Public Participation - Nil		Public			
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	**APPROVE**	Chair			9
1.6	Matters Arising	**NOTE**	Chair			14
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			15
1.9	Board Work Plan 2021	**NOTE**	Chair			36
2	**TE UPOKO O TE IKA MĀORI COUNCIL (TUI MC)**			**9.10**	**20**	
2.1	TUI MC – Agreement and Terms of Reference		Chair			38
3	**DHB Performance and Accountability**			**9.30**	**10**	
3.1	HVDHB Financial and Operational Performance Report – May 2021 3.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			44 47
3.2	CCDHB Financial and Operational Performance Report – May 2021 3.1.2 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			95 98
4	**STRATEGY**					
4.1	Update on Implementation of 2DHB Strategic Priorities	**NOTE**	Director Strategy, Planning and Performance	9.40	20	144
5	**REPORTING**					
5.1	Māori Health Update – Quarter Four	**NOTE**	Director Māori Health	10.00	15	152
5.2	Pacific Health & Wellbeing Strategic Plan 2020-2025 Update: A Focus on the 2DHB Pacific Health Workforce	**NOTE**	Director Pacific People's Health	10.15	15	168
6	**UPDATES**					
6.1	DSAC update and items for approval from meeting dated 21/07/2021	**APPROVE** **NOTE**	Chair of DSAC	10.30	10	179
6.2	HSC update and items for approval from meeting dated 28/07/2021	**NOTE**	Chair of HSC	10.40	10	182
6.3	COVID Vaccine Update	**NOTE**	Director Strategy, Planning and Performance	10.50	15	-
7	**OTHER**					
7.1	Board and Committee Meeting dates for 2022 and Board work plan	**APPROVE**	Board Secretary	11.05	10	184
7.2	General Business	**NOTE**				
7.3	Resolution to Exclude the Public	**APROVE**		**11.15**		191

Next 2DHB Concurrent Board Meeting:
1 September 2021, Zoom: 876 5068 1844, Location: **TBC** Time: 9:00am

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

29/07/2021

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

	• Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young • Staff seconded to Health and Disability System Review • Contact with Associate Minister for Health, Hon. Peeni Henare
Brendan Boyle	• Director, Brendan Boyle Limited • Member, NZ Treasury Budget Governance Group • 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	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group • 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) • Senior Research Fellow, University of Otago Wellington • Employee, University of Otago • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Consumer New Zealand Board
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council

	• Member, Christmas in the Hutt Committee • Member, Computers in Homes • Member, E tū Union • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust • Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Member, Muscular Dystrophy New Zealand (Central Region) • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

4 AUGUST 2021

Fionnagh Dougan *Chief Executive Officer 2DHB*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Rosalie Percival *Chief Financial Officer 2DHB*	• Trustee, Wellington Hospital Foundation
Joy Farley *Director Provider Services 2DHB*	• Nil
Rachel Haggerty *Director, Strategy Planning & Performance 2DHB*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Arawhetu Gray *Director, Māori Health 2DHB*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Junior Ulu *Director, Pacific Peoples Health DHB*	• Member of Norman Kirk Memorial Trust Fund • Paid Member of Pasifika Medical Association
Helen Mexted *Director, Communications & Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
John Tait *Chief Medical Officer 2DHB*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC • Director, Istar • Member, Health Practitioners Disciplinary Tribunal
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Steve Earnshaw *Acting Chief Digital Officer 3DHB*	• Member, Clinical Informatics Leadership Network (CiLN) National Advisory Board • Chair, Central Region Clinical Informatics Leadership Group
Sarah Jackson *2DHB Director Clinical Excellence*	• Nil

Wednesday, 28 July 2021

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
Paul Oxnam *Executive Clinical Director MHAIDS*	• Member, NZ College of Clinical Psychologists
Rachel Gully *Director People, Culture & Capability 2DHB*	• NIL
Sue Gordon *Transformation Director*	• Board Member, Netball New Zealand

PUBLIC

	MINUTES Held on Wednesday 7 July 2021 Location: Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room Zoom Meeting ID: 876 5068 1844 Time: 9:30am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

PRESENT

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

APOLOGIES

Stacey Shortall
Josh Briggs
Keri Brown
Kathryn Adams (for lateness)
Wayne Guppy (for lateness)

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Rosalie Percival	Chief Financial Officer
Rachel Haggerty	Director Strategy, Planning and Performance
Arawhetu Gray	Director Maori Health
John Tait	Chief Medical Officer
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Services
Sarah Jackson	Director of Clinical Excellence
Joy Farley	Director Provider Services
Declan Walsh	Director People, Culture and Capability
Helen Mexted	Director of Communication and Engagement
Sally Dossor	Director, Office of the Chief Executive and Board Secretary

PUBLIC

1 PROCEDURAL BUSINESS

Meeting commenced at 9.40am (late start due to technology issues and connecting zoom).

1.1 KARAKIA

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

Nil.

1.4 CONTINUED DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

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

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Boards **approved** the minutes (as amended) of Concurrent Board Meeting held on 2 June 2021 (public).

	Moved	**Seconded**	
HVDHB	Prue Lamason	Richard Stein	**CARRIED**
CCDHB	Brendan Boyle	David Smol	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

The boards noted the action items and there were no questions.

1.7 CHAIR'S REPORT AND CORRESPONDENCE – MINISTERIAL APPROVAL OF LEASES

The correspondence in the agenda papers was noted by the Board as required by the Minister.
The Chair updated the Board on the recent Chairs meeting, which covered the Covid response, the vaccination programme, and the pressure on the health system.

PUBLIC

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive noted the report which shows a snapshot view of various initiative across the organisation. There were a number of questions on the vaccine rollout and the programme for Group 3 in particular.

1.9 BOARD WORK PLAN 2021

The updated Board work plan for the remainder of 2021 was introduced. The Executive explained that assuming final approval of the strategic priorities (agenda item 3.1) the Board work plan will be updated to provide updates and decision papers as the programme of work under each of the strategic priorities is implemented. The Board Chair noted that as the strategic priorities are consistent with the direction of Health NZ, the objective is to hand over the 2 DHBs to Health NZ with the work progressed as is possible and practical in the remaining (little over) 11 months.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB APRIL 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

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

Both Boards noted:

(a) The DHB had a $3.3m deficit for the month of April 2021, being ($1.8m) unfavourable to budget

(b) The DHB year to date had a deficit of ($8.9m), being ($415k) unfavourable to budget

(c) The DHB year to date deficit excluding $1.1m unfunded COVID-19 Costs and $2.3m Holidays Act provision was a deficit of ($5.5m), being $3.4m favourable to budget,

(d) The Funder result for April was ($0.3m) unfavourable, Governance $0.02m favourable and Provider ($1.2m) unfavourable to budget;

(e) Total Case Weighted Discharge (CWD) Activity was 8% ahead of plan.

	Moved	**Seconded**	
HVDHB	Ken Laban	Prue Lamason	**CARRIED**

2.2 CCDHB APRIL 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

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

The Capital & Coast DHB Board noted:

(a) Both Boards note:

(b) The DHB had a ($6.6m) deficit for the month of April 2021, being $306k favourable to budget before excluding COVID-19 and Holidays Act [2003]

(c) The DHB year to date had a deficit of ($41.7m), being ($11.1m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(d) In the ten months we have incurred $13.1m additional net expenditure for COVID-19 and $6.8m against provision for Holidays Act [2003]

(e) This means that the DHB has an overall YTD deficit of ($21.8m) from normal operations (excluding COVID-19 and Holidays Act) being $8.9m favourable to our underlying budget.

PUBLIC

	Moved	Seconded	
HVDHB	Dr Chris Kalderimis	Vanessa Simpson	**CARRIED**

Notes:

- Performance is on track with forecast, with the exception of Covid-19 and Holidays Act.
- Performance is being communicated to the Ministry

3 DECISION

3.1 STRATEGIC PRIORITIES

CCDHB and HVDHB Boards noted:

(a) The Boards have agreed two overarching goals:

i. Improving Equity and health outcomes

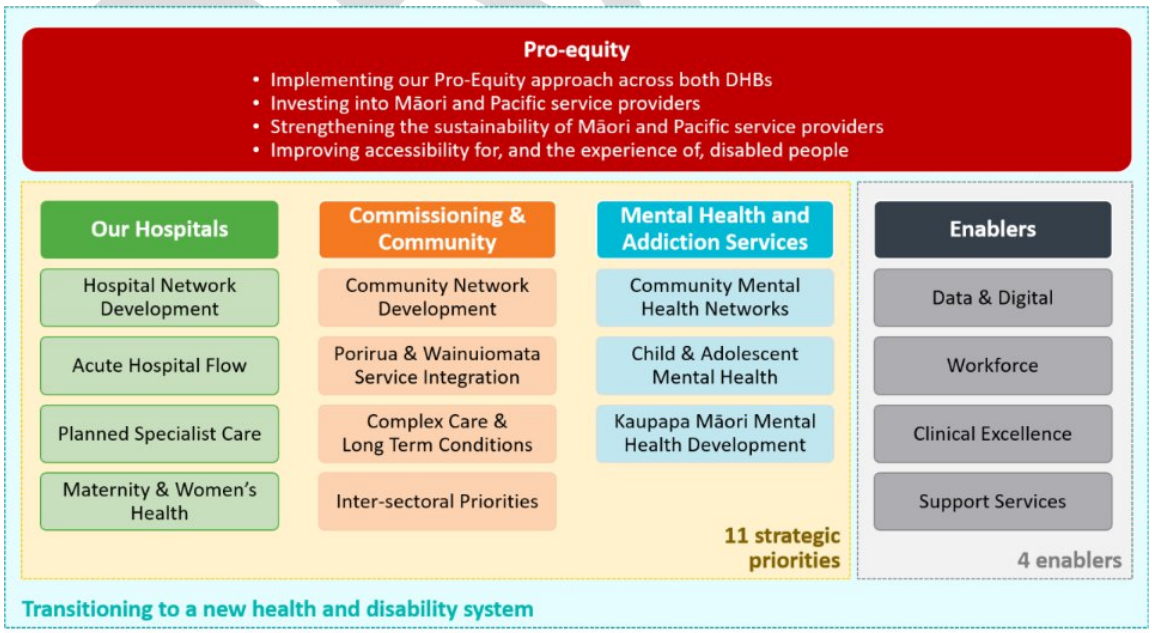
ii. Improving financial sustainability

(b) the Boards reached consensus on the strategic priorities, including the enablers, identified to drive system transformation (at the workshop in January 2021 and at the Board meetings on 3 March 2021 and 7 April 2021)

(c) that management have reflected on those priorities in the context of health system reform announced on 21 April 2021.

(d) that the names of the priority areas have been refined to give greater clarity to the workstreams and work programmes.

CCDHB and HVDHB Boards approved the eleven strategic priorities and four enablers (grouped under four focus areas with an overarching pro-equity approach to each):



PUBLIC

Notes:

- The strategic priorities were introduced by the Chief Executive, who gave an overview of the process that the Executive and the Boards had worked through to develop them, and noted that while there had been some changes since the Board workshop in January 2021 (and subsequent discussions at the March and April Board meetings) that the changes were in the nature of refinements as the programmes of work are developed and the Executive have considered them in the context of health system reform.
- Pro-equity is across all streams of work – and the diagram articulates that everything we do has a pro-equity approach.
- It was noted that programmes of work are being worked on under each of the 4 focus areas, and that progress will be reported to the Boards.
- It was noted that the strategic framework will shape the work of the Boards in the next period and provide a focus for all internal and external communication, and the prioritisation of resource and Board and Committee time.
- It was noted that public health is covered within the priorities, under the localities priority.

	Moved	**Seconded**	
HVDHB	Ken Laban	Prue Lamason	**CARRIED**
CCDHB	Roger Blakeley	Brendan Boyle	**CARRIED**

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Ken Laban	Naomi Shaw
CCDHB	Sue Kedgley	Hamiora Bowkett

Meeting concluded at 10.15am

5 NEXT MEETING

4 August 2021, **Zoom:** 876 5068 1844, **Location:** Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block, **Time:** 9am

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

DATED this day of 2021

David Smol
BOARD CHAIR

Action Number	Date of meeting	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status
21-P03	7-Apr-21	Chief Digital Officer	In progress		Board - Public	3.2	Māori Health Strategy Reporting	Māori data sovereignty paper to be shared with Board when it is appropriate.	The issue is still a work in progress with all regional Directors Maori, Iwi, and the Ministry of Health continuing discussions. Refer update oral update at 7 July 2021 Board meeting at item 6.3 of the minutes.
21-P07	2-Jun-21	Director Provider Services Director Strategy, Planning and Performance	In progress		Board - Public	4.1	HSC Update	Management to continue to raise lowering of the age for screening for Māori and Pacific with the Ministry and provide keep Board members informed of any progress.	Oral update from management to be provided as appropriate.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 25 June 2021 to 22 July 2021.

2 COVID-19 Update

2.1 Current cases

Number of cases:
Number of days without cases, HVDHB: 246
Number of days without cases, CCDHB: 253

2.2 Managed Isolation Facilities

Number of COVID-19 cases in managed isolation:
Number of guests (as 23/07/2021): 45

- Bay Plaza: 45
- Grand Mercure:

2.3 Testing statistics (to end 23/07/2021)

	2DHB	HVDHB	CCDHB
Tests performed to date	201,079	51,038	150,041
People tested to date	124,934	33,338	91,596
Testing coverage	27%	29%	26%
Tests performed last week (17/07 – 23/07)	3,337	880	2,457

2.4 Testing statistics by ethnicity (to end 23/07/2021)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	23,216	15,792	8,055	4,801	15,161	10,991
People tested to date	14,960	9,963	5,321	3,059	9,639	6,904
Testing coverage	31%	31%	26%	28%	34%	33%
Tests performed last week (17/07-23/07)	374	261	118	79	248	182

2.5 Vaccinations (to end 23/07/2021)

	2DHB	HVDHB	CCDHB
Total immunisations	108,249	42,120	66,129
Dose 1 total	64,128	24,936	39,192
Completed total	44,121	17,184	26,937

Group 1 people served	4,397	604	3,852
Group 2 people served	24,763	6,977	18,134
Group 3 people served	25,403	12,842	12,580
Group 4 people served	7,313	4,103	3,258

2DHB group	Coverage
Māori	22%
Pacific	28%
Asian	19%
Other	14%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

Our proactive engagement focus continues to be focused on ongoing events and engagement for the COVID-19 vaccination programme, including openings of new community vaccination centres and Pacific festival days. We also met with the new Mental Health & Welllbeing Commission, and presented to the July Mayoral Forum on the health system changes and our 2DHB strategic focus areas for the next 12 months.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	COVID-19	Update for media and public on COVID-19 testing figures.
2DHB	COVID-19	Update for media and public on COVID-19 testing figures.
2DHB	COVID-19	Alert level 2 continuation and what it means for our hospitals.
2DHB	COVID-19	Change in alert levels and what it means for visitation, etc at our hospitals.
2DHB	Child health	Information about RSV, its impact on our hospitals, patient numbers, and visitor restrictions.
2DHB	COVID-19	Highlighted the Pacific Festival Day that saw 830 people vaccinated.
2DHB	Research	Highlighted research into traumatic brain injuries.

3.3 Health promotion campaigns

COVID-19 vaccination

Our priority through July was vaccinating people in Group 3, which includes older people, disabled people and those with long-term conditions.

In partnership with PHOs, we now have Community Vaccination Centres open in each of our localities: Wellington (x2), Porirua, Lower Hutt (x2), Upper Hutt and the Kāpiti Coast. Each of these sites has been secured until the end of the year.

The second half of July also saw new vaccination centres open up. Centres in Johnsonville (based in general practice) and Kilbirnie (based in community pharmacy) are open to anyone currently eligible for vaccination, while other clinics based in general practice are only vaccinating people enrolled at that practice.

Ongoing vaccination capacity for new staff at our DHBs remains available at Hutt and Wellington Regional hospitals through the Occupational Health teams.

Supporting our equity populations

Our Māori-led clinics continue to operate effectively, providing a kaupapa Māori approach to vaccinating, incorporating an all-of-whānau approach.

We have two marae-based clinics located at Wainuiomata Marae (Lower Hutt) and Maraeroa Marae (Porirua), as well as a Māori-led clinic at Waiwhetū in Lower Hutt. Our Porirua Community Vaccination Centre is run by Ora Toa, a Māori PHO, and Māori provider Hora Te Pai has partnered with Tū Ora PHO to set up our Kāpiti-based Community Vaccination Centre.

As at 22 July, we have provided at least one dose of the vaccine to more than 20.8% of all Māori in our region. This is proof that our pro-equity focus is working – both in our Māori-led vaccination centres and across our broader programme.

Our Pacific team working alongside Pacific providers and PHOs are organising Pacific Festival Days – bloc-booking for Pacific people.

After a short delay due to the change in alert levels, our biggest Pacific festival day yet was held in Porirua at EFKS Church. More than 800 people were vaccinated at this event – the most our programme has vaccinated in one day and place so far.

25.9% of Pacific people in our region have received at least one dose as at 22 July, a tremendous achievement. We will continue to hold festival days throughout the remainder of the year across our region, working with Pacific providers, PHOs, churches and community groups.

Our Disability team is learning from the success of the Pacific festival days, and started holding similar events from late July for Disabled communities. At these events, specific supports and accommodations will be provided to make vaccination as accessible and safe as possible. This includes organising NZSL interpreters for Deaf and hard-of-hearing community events, low-sensory options (dimmer lighting, no music) for Autistic people, and other modifications to our usual practices.

Moving from Group 3 to Group 4

On 28 July, the first cohort of Group 4, those aged 60 – 64, became eligible for vaccination. In conjunction with this, Book My Vaccine, an online self-booking tool built by the Ministry of Health, and Whakarongorau, the national call centre, will become the method of appointment booking for all of our vaccination centres. Medical practices who are only vaccinating their enrolled populations may continue to use their own booking systems.

Vaccinate Greater Wellington

In cooperation with Wairarapa DHB, we run the Vaccinate Greater Wellington website and weekly pānui.

The website is the hub for information about our local vaccination rollout, and is not intended to replace the information on the Unite Against COVID-19 website. It is regularly updated with information about who we are vaccinating and how people can book, with news stories, video content and other information about the vaccination rollout in the region.

Our weekly pānui is read by thousands of people each week, and contains the latest updates and stories from our programme. People can subscribe to this newsletter online.

Promoting National Bowel Screening Programm

Almost 6000 people in the CCDHB region have been invited to take part in the bowel screening programme. 2100 results have been received, 129 positives (meaning traces of blood have been found) and 27 colonoscopies have been performed at Kenepuru Hospital. The good news is three cancers have been detected. Discovering cancers at an early stage gives our people a much higher chance of survival. We are taking a 2DHB approach to raising awareness of the importance of bowel screening which means we can consolidate our efforts and make more efficient use of our resources.

Our three advertising buses (the one above was spotted near Wellington Railway Station) are making an average of 30 trips a day around Kapiti, Lower Hutt, Porirua and the inner city. Giggle TV is displaying around 7000 ads per day across 262 screens across the CCDHB and HVDHB regions. Social media is also an important part of promoting the message.

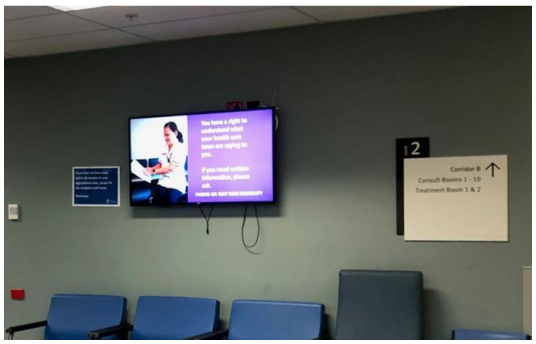
Measles Campaign

To date 1,728 young people in CCDHB and 918 young people in Hutt Valley DHB have been immunised for MMR since the campaign started. Ministry of Health has confirmed that the campaign will be extended until 31 March 2022.

Our YOSS (Youth One Stop Shops) have focused MMR immunisations on schools and workplaces to promote and book young people their MMR vaccination.

We have the Ora Toa MMR coordinator now on board who has so far contacted more than 700 young people with 36% being successfully referred to their GP/ Pharmacy or pop up immunisation clinic.

Outpatients TV Screen



Our Disability Strategy team identified an opportunity for unused televisions in waiting areas. The first of three planned screens is up and running in the main CCDHB Outpatients area primarily encouraging disabled people to ask for support when they need it. Disability messages run alongside health promotion messages. We will continue to add topical health messages and information such as the measles campaign, rheumatic fever, influenza, and bowel screening. It is another channel in our health promotion arsenal to complement ongoing in-hospital messaging via Health TV in ED.

RSV and Winter Illness

In response to winter illness and RSV in our communities RPH drafted targeted messaging documents for:

- Early Learning Centre staff
- Parents and caregiviers at Early Learning Centres
- Schools – provided on request

In partnership with 2DHB comms developed key messaging for:

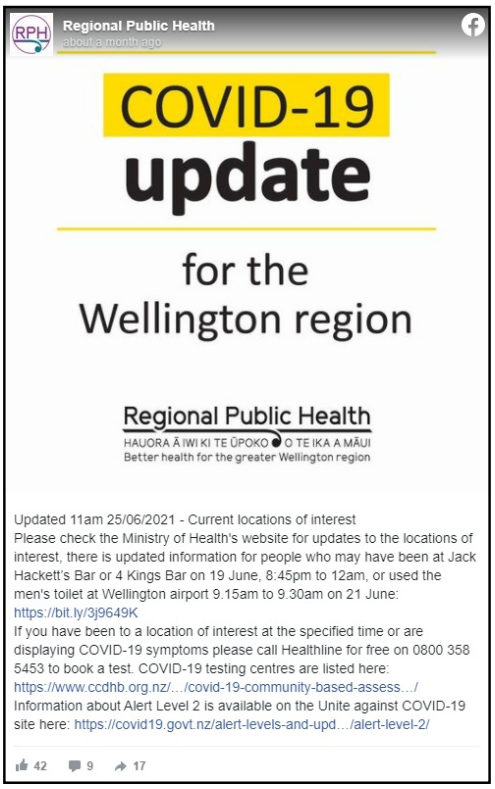
- ARCs
- ARC facility door posters to restrict visitor numbers

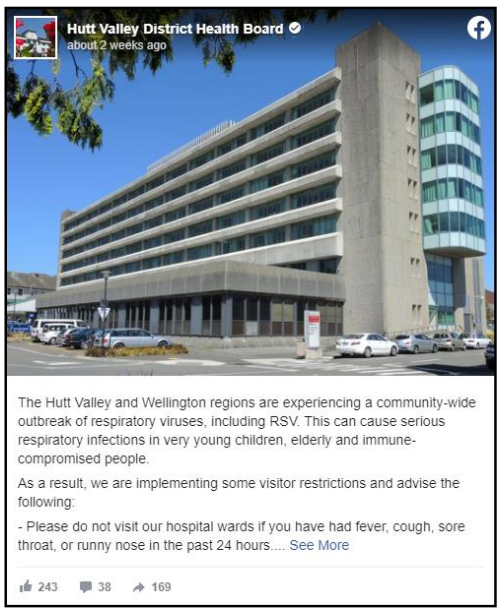
3.4 Social media views and stories

3.4.1 Top social media posts

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 218,542 Twitter: 37,744 LinkedIn: 21,093	Facebook:185,118 Hutt Maternity Facebook: 5,299 Twitter: 19,611 Instagram: 5,983 LinkedIn: 13,824	Facebook: 45,128


Capital & Coast District Health Board (CCDHB)
about 3 weeks ago
👋 Meet some of our brilliant Pacific doctors who work in hospitals across the Wellington Region. 🚢💙
Our Pacific Health Director Junior Ulu (📷 far left) has been getting to know the doctors and learning more about how we care for Pacific people.
117 4 2


Regional Public Health
about a month ago
COVID-19
update
for the
Wellington region
Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region
Updated 11am 25/06/2021 - Current locations of interest
Please check the Ministry of Health's website for updates to the locations of interest, there is updated information for people who may have been at Jack Hackett's Bar or 4 Kings Bar on 19 June, 8:45pm to 12am, or used the men's toilet at Wellington airport 9.15am to 9.30am on 21 June:
https://bit.ly/3j9649K
If you have been to a location of interest at the specified time or are displaying COVID-19 symptoms please call Healthline for free on 0800 358 5453 to book a test. COVID-19 testing centres are listed here:
https://www.ccdhb.org.nz/.../covid-19-community-based-assess.../
Information about Alert Level 2 is available on the Unite against COVID-19 site here: https://covid19.govt.nz/alert-levels-and-upd.../alert-level-2/
42 9 17


Hutt Valley District Health Board
about 2 weeks ago
The Hutt Valley and Wellington regions are experiencing a community-wide outbreak of respiratory viruses, including RSV. This can cause serious respiratory infections in very young children, elderly and immune-compromised people.
As a result, we are implementing some visitor restrictions and advise the following:
- Please do not visit our hospital wards if you have had fever, cough, sore throat, or runny nose in the past 24 hours.... See More
243 38 169


Capital & Coast District Health Board (CCDHB)
about 2 weeks ago
EXIT
Crew
Vaccinator
Thanks to three of the members of SIX60 for popping in to our Pacific vaccination festival day in Porirua yesterday. 😮💜
It was a great surprise for everyone, and we appreciate you giving up some of your morning to support the COVID-19 vaccination programme and take a lot of selfies. 📷
120 5 7

3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
138,282 page views	42,671 page views	118,294 page views	11,778 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

- Staff login
- COVID-19 Community based assessment centres (CBACs)
- Careers with CCDHB
- Wellington Regional Hospital
- After hours and emergency care

Top five webpages HVDHB

- Staff login
- COVID-19 Community based assessment centres (CBACs)
- Contact us
- Centres open to provide COVID vaccines in the community
- Hutt Hospital campus map

Top five webpages RPH

- Vaccinate Greater Wellington
- Getting vaccinated
- The COVID-19 Vaccine rollout in Greater Wellington
- Latest updates
- Coronavirus (COVID-19) frequently asked questions

Top five webpages MHAIDS

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

3.5.1 Website stories and releases

Research underway to improve diagnosis of traumatic brain injury

Our People

Research carried out at Te Pae Tiaki Wellington ED and the Hutt Hospital ED, with the support of the University of Otago, Wellington, could soon see traumatic brain injuries (TBI) screened for using a blood test without the need for a CT head scan.

TBI are a leading cause of death and disability in New Zealand and range from mild injuries such as concussion, to severe injuries including brain bleeding or swelling. They can be difficult to identify, and ED doctors rely on clinical skills to decide if patients require a CT head scan to rule out a more severe injury.

For more than a year, ED registrar Dr Alice Rogan (pictured) has been conducting a pilot study investigating the use of blood biomarkers as a test to rule out severe TBI.

"Requests for CT scans are increasing, however only around 10 percent patients who have a CT head scan have more severe injuries identified," Dr Rogan said.

"When the brain is injured, biomarkers are released into the blood stream and can be measured. At this early stage of the research, we are asking patients to consent to have a blood test taken if they require a CT head scan. We then observe how well those biomarkers can predict injuries seen on CT. The patients care in ED does not change. If the biomarkers can predict injuries safely, in future we are aiming to introduce their use into clinical pathways for TBI. If blood biomarker levels are not raised, we would not expect to see any injury on CT, and therefore the new pathway would recommend not to perform a head CT."

To date, almost 300 people have consented to take part and it is hoped the pilot biomarker data will be available by the end of July – Soon the trial will be expanded to include other EDs in New Zealand with the aim of recruiting 1000 people to the study by 2022.

"No ED in Australasia is currently using biomarkers as part of routine management of TBI. This research will provide novel Australasian data that could lead to the incorporation of biomarkers into ED clinical guidelines.

"If biomarkers are found to safely predict that a patient does not have a more serious injury, it could mean these patients can be safely discharged from ED without waiting for a CT – improving the quality of care patients with TBI receive in ED, reducing patient waiting times, ED workload demand and healthcare costs as well as helping patients who do need a head CT to get one more quickly."

Clinical Nurse Specialist Doug King recognised internationally for concussion research

Clinical nurse specialist and concussion expert Doug King has been recognised in the top 0.5 percent of experts worldwide on brain concussion and football codes by Expertscape—placing him third internationally for his research.

Doug works as a clinical nurse specialist in Hutt Hospital's Emergency Department, and has spent over 20 years researching sports-related concussion and head impact biomechanics. His research informs practices and guidelines across New Zealand and internationally.

"Concussion and traumatic brain injury is a silent epidemic—I have spent many years researching the impacts of concussion in sport and understanding how findings can be applied across broader contexts", said Doug.

"We know that the impact of a head injury is accumulative and that every concussion should be viewed based on an individual's history and risk factors".

Doug has recently completed his latest PHD research on injury epidemiology in women's rugby union in New Zealand, where he found that women take longer to recover from concussion than males and experience more concussion symptoms over a longer duration.

He found that on average, females took 30 days longer to recover whereas males recovered sooner—leading to a shift in thinking on recovery time and graduated return to activity.

His findings reinforce previous research undertaken internationally and highlights the need for a change in guidelines, both in sport, and in the wider management and monitoring of concussion.

"While my findings have been obtained through a study of women's rugby, the results clearly show that we need to change the way we view and treat concussion, across all contexts—particularly for women.

"There needs to be flexibility in the guidelines we use and recognition that no head injury is the same".

Doug's latest research can be found here: https://www.jscimedcentral.com/PhysicalMedicine/physicalmedicine-5-1014.pdf

Regional Public Health toast the introduction of folic acid in bread

Regional Public Health (RPH) welcome today's Government announcement to approve the mandatory addition of folic acid to bread-making flour. The announcement aligns with RPH's submission to the Ministry for Primary Industries from 2019, which advocated for the mandatory addition of the B vitamin to all non-organic wheat flour. The move will protect more babies and reduce instances of neural tube defects (NTDs) that result in the death of babies, or life-long disability, which is caused by low folate levels in expectant mothers. RPH view the announcement as a step in the right direction to improve health equity outcomes for Māori and provides the greatest benefit for all pregnancies, planned or unplanned throughout New Zealand.

"The higher rates of NTDs experienced by Māori whānau, means they carry the greater burden of this preventable condition in Aotearoa. This is the right action to be taking, as by implementing this change, we will see a significant reduction in the rates of NTDs in New Zealand, which is a completely preventable condition," said Dr Stephen Palmer, Medical Officer of Health. "As a public health unit our core role is to protect the health of our communities and minimise the impacts of nutrition-related diseases. This simple measure protects more of our population from neural tube defects."

"An NTD can have far-reaching and significant impacts on whānau. For a child with NTD it can mean on-going doctor and hospital visits, wheelchair and mobility supports, while limiting educational and social opportunities," said Dr Palmer. Effective lifetime management of NTD may include remodelling a house and accessing modified vehicles. "This can bring additional financial pressure on whānau who may already be experiencing other significant financial and social pressures," said Dr Palmer.

As approximately half of all pregnancies in New Zealand are unplanned, the addition of folic acid adds a layer of protection for women and pregnant people who may be unaware that they are pregnant, early on in their pregnancy. "In this instance, pregnant people will be unlikely to take a folic acid supplement until late in their first trimester. So the mandatory nature of this decision is great, as it adds an additional layer of security, that they are getting the right nutritional elements they need to protect against NTDs prior to becoming pregnant," said Emmeline Taptiklis, Nutritionist and Health Promotion Advisor. "For the rest of the population it means that they'll get a little extra vitamin B in their diet when they eat bread, which will help those who have a lower level of red blood cells, anaemia."

"Adding folic acid to flour is an effective public health measure that protects the health of our population and provides for improved equity outcomes. In Australia, the introduction of mandatory folic acid to flour saw a 14% reduction in NTDs. We look forward to seeing similar results from this move in our communities," said Dr Palmer.

COVID-19 alert level update for Wellington and Hutt Valley regions

Our Services

Following the Government's announcement this afternoon that alert level 2 will remain in place for a further 48 hours, Hutt Valley and Capital & Coast DHBs will keep additional testing capacity operating across the region. Alert level 2 door screening and visitor provisions will also remain in place at our three hospitals, at this stage until 11.59pm on Tuesday 29 June.

The DHBs will continue to operate the COVID-19 pop-up testing sites at Wellington Regional Hospital, Hataitai Park, and Lower Hutt's Riverbank car park on Monday 28 June and Tuesday 29 June. The Te Papa site is open until 6pm Sunday 27 June, and will then close as Te Papa prepares to reopen for business.

The Government are encouraging those in the Wellington region who were at a location of interest last weekend or those who are symptomatic to get tested.

"Testing will continue to be offered at pop-up sites, Community Testing Centres (CTCs), and at GPs across the region. There is some capacity at pop-up sites and CTCs should people need to get tested this afternoon, and there will be capacity at all pop-up sites and CTCs on Monday and Tuesday," says Rachel Haggerty, Director of Strategy, Planning and Performance for Hutt Valley and Capital & Coast District Health Boards.

676 COVID-10 tests were administered on Saturday 26 June in the Greater Wellington region.

"Our two DHBs, along with our PHO partners, have worked tirelessly since Wednesday to ensure that our community testing centres (CTC) remained well resourced and staffed for the Wellington region. We would like to thank the people of the Wellington and Hutt Valley for getting out and getting tested."

Locations and hours for our CTCs are available on the two DHBs' websites: www.ccdhb.org.nz/our-services/covid-19-community-based-assessment-centres-cbacs and www.huttvalleydhb.org.nz/your-health-services/covid-19-community-based-assessment-centres-cbacs.

Testing priority continues to be given to those individuals who were at a location of interest or are symptomatic. Anyone who was at a location of interest or is symptomatic should ring Healthline on 0800 358 5453 or their GP for advice on testing and referral to book a test.

People are asked to book in advance for a test.

Biggest vaccination festival yet sees 830 vaccinated in Porirua

A Pacific vaccination festival day in Porirua saw 830 people receive their first COVID-19 vaccination at EFKS Porirua Church on Saturday.

Part of a series of 'festival days' – where the Pacific community is vaccinated together in a welcoming environment – this event saw more vaccinated in one place than had previously been done in the Greater Wellington region.

Capital & Coast DHB worked with Ora Toa PHO, the church community and Pacific health providers on the event.

"Our Pacific vaccination programme is based on trusted faces in trusted places. We know that hosting vaccinations in places like our churches helps people to feel welcome and safe, and that's why they are so successful," said Junior Ulu, Director of Pacific People's Health at Hutt Valley and Capital & Coast DHBs.

"Nearly a quarter of all Pacific people aged 16 and over in our region have received at least one dose already. We know the health system has not always worked well for Pacific people, but this programme is showing us how we can do better."

"Thanks to Ora Toa PHO who provided a fantastic vaccinator and administrator team for this event. Greeting everyone with a big smile, while music played and food was served, it felt more like a wedding party than a health clinic," said Junior Ulu.

The community will return at the end of July for their second doses, and more festival days are scheduled in Porirua, the Hutt Valley and Wellington in the coming weeks.

Full steam ahead without chemicals

A commitment to cleaning with steam and microfibre has transformed the cleaning regime at a New Zealand hospital.

Going chemical-free in a hospital seems like a brave call. However, it is a move that has paid off for Hutt Hospital since it overhauled its cleaning strategy in 2016. The hospital introduced chemical-free cleaning, using steam cleaning and microfibre cloths.

Manager Domestic Services Debbie Jennings, identifies that some rates of infection from bacteria that are known to be resistant to chemicals were higher than expected. So, it made sense to trial a new form of cleaning that did not rely on bacteriacidal action.

Today, cleaners use dry steam under pressure at 140 degrees for cleaning and sterilisation. Microfibre cloths are the key to tackling organic matter and dirt. Jennings says the microfibre cloths are the "work horse" under the new approach. "We focus on picking up bioburden rather than killing it with chemicals." Curtains are also steamed and do not have to be taken down each time for cleaning, solving problems across the hospital.

Jennings states that the results speak for themselves. For example, the number of Clostridioides difficile diarrhoea cases at Hutt Hospital have dropped dramatically, and ATP tests across high touch-point areas have also reported a massive improvement. Furthermore, an analysis of the changes conducted has seen financial savings in cleaning time and chemical costs.

Initial reservations from clinicians at the hospital have been turned around. "At first they asked 'why are we cleaning theatres with water?' but we just had to show them our infection data to convince them," Jennings says.

Other benefits include being able to clean sensitive equipment with microfibre cloths and having the ability to steam-clean textiles that cannot be cleaned with hypochlorites bleach and disinfectants. Such outcomes have led to interest from other hospitals and healthcare operations.

To ensure all nurses, workers and cleaners are up to speed with the chemical-free cleaning regime, Hutt Valley DHB has implemented a robust training programme.

All cleaners are shown best-practice techniques for steam and microfibre cleaning, and they also go back to basics to learn the key principles of proper hygiene, sterilisation and sanitisation.

"We've actually been teaching cleaners how to clean properly," Jennings says. "Too many people just rely on chemicals and don't use them properly. They just spray and wipe."

The one concession Hutt Valley DHB has made since the outset of the pandemic is to increase the frequency of steam and microfibre cleans where appropriate.

Jennings says the old approach of adhering to Victorian cleaning standards that simply recommended a 'visual standard' of cleanliness for hospitals has been proven to be flawed, with visual indicators being a poor indicator of cleaning efficacy and microbiological cleanliness.

Conscious of potentially losing a valuable client, chemical-wipe manufacturers have come on board to make the disposable microfibre cloths the hospital needs. As Jennings explains: "They know it's the future."

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
237,258 page views	156,010 page views

3.6.2 Staff posters

3.6.3 Top intranet stories

Midwifery initiatives aim to strengthen workforce

Our Hospitals

Associate Minister of Health Ayesha Verrall announced funding to support establishment of two initiatives.
New measures announced this week aim to improve recruitment and retention of midwives, and encourage former midwives back to their profession.

"New Zealand's midwives are committed to the wellbeing of women and whānau, but they're facing significant challenges," said Associate Minister of Health Ayesha Verrall.

"The DHB midwifery workforce has been shrinking, while demand for their services and expertise is increasing."

She spoke at an event at Te Herenga Waka - Victoria University of Wellington, attended by DHBs, academic partners, midwifery staff, and members of the Midwifery Accord Group - a commitment between the Government, DHBs, and midwifery unions to ensure better support for midwives.

She announced funding to support establishment of two initiatives:

Midwife Clinical Coaches programme
This programme is an innovative approach that has been identified by the Midwifery Accord Group as a potential solution to stabilise the workforce. Clinical coaches will provide clinical and pastoral support for midwives. "They will stand shoulder to shoulder with midwives caring for women, and create a new career path," said Ayesha.

"New graduate midwives, those coming back into the workforce, and other midwives who need some extra help, will have access to a coach - an experienced DHB midwife who can provide both clinical and wider support."

Return to Practice Programme
Work is also being done to encourage former midwives back into their vocation. Midwives who wish to practice after an absence of three years or more are required to complete the Return to Practice Programme to make sure they have the latest training and certifications.

To overcome the financial barrier to midwives, who have previously had to self-fund this education, the Government will now fund partial or full costs, depending on how long they have been away from the profession. "We want to make it easier and more attractive for midwives to return to work," said Ayesha.

CCDHB's director of midwifery Carolyn Coles, who is also part of the Midwifery Accord Working Group, said the workforce issues were multifactorial, and would need a multi-pronged approach to solve. "These initiatives are an important step, but are not a silver bullet," she said.

"Our midwifery managers are working hard, using a variety of strategies, to fill current vacancies. Our upcoming recruitment campaign will also have a big part to play."

"I am in awe of the work of midwives, and am looking forward to these initiatives making a difference," said 2DHB Chief Executive Fionnagh Dougan, who is also CE lead on the Midwifery Accord. "I am hopeful that these measures will help to stabilise the midwifery workforce and bring people back to the profession."

Kiribati Language Week important for identity

Our People

This week we celebrate Wikin te Taetae ni Kiribati/Kiribati Language Week.

Registered nurse Margaret Schutz is one of our I-Kiribati staff members at CCDHB. Margaret was born and raised in Kiribati, but migrated in 2006 through the Pacific Access Category in order to obtain better education for her children.

She has worked at CCDHB for seven years since finishing her nursing degree and joining the dialysis unit through the Nurse Entry to Practice programme. She now works in dialysis units across Wellington, Kenepuru, and the Hutt.

During Kiribati Language Week she suggests people at CCDHB take the opportunity to learn some of the language, and make sure to include the Kiribati greeting, Mauri, on lists of greetings.

"It's been good for I-Kiribati living in New Zealand, to have this language week and be recognised," says Margaret. "Kiribati is not well known in the world, so it's a really important week for our identity."

Fittingly for a mother of six, the theme of this year's language week is *Maubonian te teei i nanon te mwenga bon karekean te maiuraoi, te ongotaeka ao te tangira,* which means the home is where we nurture our children towards a healthy, responsible, loving, and prosperous future.

The theme acknowledges the important role of the Kiribati mothers, both within their families and the wider community. Margaret says "our children are the future of representing Kiribati, so nurturing them is important."

The Kiribati community is very dedicated to the language week. A big celebration is planned for the country's national holiday on 12 July, which marks the anniversary of Kiribati's independence from the United Kingdom in 1979. This will be marked in Wellington by raising the flag at various locations around the city, at ceremonies attended by dignitaries.

Margaret misses the laid-back atmosphere of Kiribati and its traditional food, so is looking forward to participating in next week's gatherings with dancing, singing of the national anthem and traditional food, as well as catching up with her community. "It's the next best thing to being in Kiribati," she says.

"I'm happy we are recognised more, and can celebrate our independence."

Hutt Buddies recognised by Minister for important peer support role

The award-winning Hutt Buddies Peer Support Service was recognised by the Minister of Health during the launch of the 2021 Minister of Health Volunteer Awards at Kites Trust in Newtown.

The Buddies team was formally recognised at the launch for the important work they do at Hutt Valley's mental health inpatient unit, Te Whare Ahuru.

"Hutt Buddies was recognised at the 2020 Ministry of Health Volunteer Awards," Minister of Health Andrew Little said.

"Because of the COVID-19 pandemic, the awards ceremony didn't go ahead last year—so I am delighted to be able to publicly recognise Hutt Buddies today."

Hutt Buddies is a team of culturally diverse volunteers who work with people receiving care at Te Whare Ahuru. The group of volunteers have all experienced some form of mental distress in their lives and work to form empathetic bonds and understanding.

The Buddies team has undergone specialised peer support training, which has involved participating in workshops focused on areas such as de-escalation techniques, ethics and reframing language.

"The Buddies volunteers provide invaluable support by using their own lived experience", says Mental Health, Addiction and Intellectual Disability Executive Director Karla Bergquist.

"They have the opportunity to make an important connection with the people we provide care for and help support positive outcomes for people when they need it the most".

You can read more about the Buddies Peer Support Programme on the Kites Trust website: http://kites.org.nz/buddies/

Equipment pool keeps patients moving

Our People

The Central Equipment Pool (CEP) team does its best every day to make sure equipment gets to patients who need it.

The team coordinates requests for equipment from clinical staff across Wellington, Kenepuru and Kāpiti, for use on the ward or in the community. It's most often used to help with discharge or rehabilitation of patients.

A long list of pool equipment includes crutches and wheelchairs, pressure-relieving cushions, and bariatric equipment such as hoists and large-scale beds - anything patients need to be mobile and comfortable at home or on the wards.

Occupational therapists or other staff fill in a form to request, transfer or return equipment. CEP staff check availability and locate the item, which is then either collected by clinical staff or transported to the location it's needed, sometimes within the hour.

Team leader Nicole Hendricks oversees the small Wellington-based team, consisting of an administrator and five coordinators, two of whom are also team drivers delivering equipment to locations in greater Wellington.

The majority of the equipment is stored in the main equipment pool, but "we have pockets of storage all over the campuses – which can make it hard to keep track," says Nicole.

The team are soon to trial a small equipment pool at Kenepuru Community Hospital, to ensure a faster delivery to northern CCDHB sites. This will speed up patient rehabilitation and discharge, streamlining the flow of patients through and out of our hospitals.

Other challenges for the team include people not returning equipment as efficiently as they should – meaning someone else may miss out. An amnesty is scheduled for later in the year to encourage staff and patients to return equipment.

With her customer service background, Nicole is looking for opportunities to streamline the CEP process and improve communication with clinical staff. Technological upgrades are imminent to help the team better track equipment, meanwhile you can help the team by filling in forms accurately.

"We're constantly working to improve our efficiency and service level," says Nicole. "If you communicate clearly with us, we will try our best to help if we can."

2DHB BOARD WORK PLAN 2021 – AS AT 29 JULY 2021

	1-Sep	6-Oct	3-Nov	1-Dec
	Offsite – TBC	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight	**Child Development (AHST) – Tentative**	**ENT**	**Rheumatology**	**Cardiology**
Quality and Safety/Health and Safety				
2DHB Quality and Safety	2DHB Quality and Safety	2DHB Quality and Safety Report and focus area (Improvement)	2DHB Quality and Safety Report Gap analysis on the Health and Disability Standards Update on the corrective actions from the surveillance audits	2DHB Quality and Safety Report
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting				
Financial and Operational Performance HVDHB	Report for July 2021	Report for August 2021	Report for September 2021	Report for October 2021
Financial and Operational Performance HVDHB	Report for July 2021	Report for August 2021	Report for September 2021	Report for October 2021
Scheduled reporting				
People and Culture Report		People and Culture Report		People and Culture Report
Facilities and Infrastructure Report inc. Enviro Sustainability	Facilities and Infrastructure Report		Facilities and Infrastructure Report	
3DHB Digital Report	End of Year Update		Q1 Report	
Māori Stratey (Te Pae Amorangi and Taurite Ora)			Q1 Report	
Pacific Health and Wellbeing Strategic Plan			Q1 Report and selected focus area	

	1-Sep	6-Oct	3-Nov	1-Dec
Strategic Priorities				
Pro-Equity	Pro-Equity Commissioning Policy Communications and Engagement Strategy			
Strategic Priorities Overview	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC work plan for 29 September 2021 and 24 November 2021 – and will be reported to the Boards via HSC.*			
Our Hospitals		*Planned Care		*Maternity and Women's Health *2DHB Hospital Network
Commissioning and Community		*Integrated Primary Care and Acute Demand		*Complex Care and Frailty *Inter-sectoral Priorities
Mental Health and Addiction Services		*Community Mental Health and Addictions Networks		*Kaupapa Māori and MHA development
Enablers				
Committees				
FRAC items for Board Approval	FRAC items for Board Approval from meeting dated 25/08/21		FRAC items for Board Approval from meeting dated 27/10/21	FRAC items for Board Approval from meeting dated 26/11/21
HSC update and items for Board Approval		HSC update and items for approval from meeting dated 29/09/21		HSC update and items for approval from meeting dated 24/11/21
DSAC update and items for Board Approval		DSAC update and items for approval from meeting dated 29/09/21		DSAC update and items for approval from meeting dated 24/11/21
MCPAC update	MCPAC update from meeting dated 25/08/21	MCPAC update from meeting dated 28/09/21	MCPAC update from meeting dated 27/10/21	MCPAC update from meeting dated 26/11/21
Engagement				
Te Upoko o te Ika Māori Council (TUI MC)		Boards meet with TUI MC		Boards meet with TUI MC
Sub-Regional Disability Advisory Group	Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group
Annual Planning and Reporting				
Budgets/Annual Plan	Annual Plan 2021/2022	Planning process for 2022/2023 – subject to confirmation of process required for HNZ		
Annual Report			Annual Report 2020/2021	
Other items				
Sustainability Strategy	Sustainability Strategy			
Procedural and Board process issues				Delegations for Summer Break
Action log items	Woburn Masonic Report			
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)				
Workshop		Risk Workshop - TBC		
Site Visit		Te Wao Nui/Children's Hospital – TBC		Te Wao Nui/Children's Hospital – TBC

Board Information – Public

4 August 2021

Te Upoko o te Ika Māori Council	
Action Required **The Boards note:** a) the establishment of Te Upoko o te Ika Māori Council (TUI MC) b) the Agreement and Terms of Reference for TUI MC	
Strategic Alignment	Taurite Ora Māori Health Strategy 2019-2030 Te Pae Amorangi, Māori Health Strategy 2018-2027
Author	Arawhetu Gray, Director Māori Health
Purpose	To present the TUI MC Agreement and Terms of Reference to the HVDHB and CCDHB Boards

Executive Summary

At a meeting held on 3 December 2020, the HVDHB and CCDHB Māori Partnership Boards agreed to amalgamate and form a new entity, to be known as Te Upoko o te Ika Māori Council (TUI MC).

TUI MC comprises up to two representatives from each of the following iwi entities:

- Te Runanganui o Te Atiawa
- Taranaki Whānui ki te Upoko o te Ika (PNBST);
- Ngāti Toa Rangatira;
- Te Atiawa ki Whakarongotai;
- Wellington Tenths Trust – Te Atiawa/Taranaki;
- Palmerston North Māori Reserve – Te Atiawa; and
- Taurahere Iwi.

The Agreement and Terms of Reference for TUI MC have been agreed and will be presented to the Boards at the concurrent meeting on 4 August 2021.

Attachment/s

1. Te Upoko o te Ika Māori Council – Agreement and Terms of Reference

TE UPOKO O TE IKA MĀORI COUNCIL (TUI MC)

Agreement and Terms of Reference

1. VISION

Equitable health outcomes for Māori in the Te Upoko o te Ika takiwa.

2. PURPOSE

The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within Capital and Coast District Health Board and Hutt Valley District Health Board 2DHB, and the wider community.

3. OBJECTIVES

TUI MC will operate under and maintain a solid relationship with the 2DHB Board and Executive Management Team built on the following principles:

- Whakautu Respect
- Whakamārama Understanding
- Whakapono Trust
- Ngākau Taputahi Integrity
- Ngākau Pono Honesty

TUI MC has the vital role of ensuring 2DHB meet its legislative and ethical obligations to:

- Enable Māori to participate in decision-making processes;
- Achieve health equity for Māori;
- Identify and progress Māori aspirations and needs for wellbeing;
- Actively participate in and engage with the 2DHB Board in the development of strategic priorities, and DHB funding and accountability mechanisms;
- To monitor the performance of 2DHB delivered and funded services, to ensure they are responsive to the aspirations and needs of Māori, and eliminate inequities;
- Promote and enhance whānau models of care that support whānau to determine their journeys toward wellness; and
- Monitor the experiences of whānau to ensure that Māori receive high quality equitable health and disability care.

4. MEMBERSHIP

Members of TUI MC shall comprise up to two representatives from each of the following Iwi entities:

- Te Runanganui o Te Atiawa;
- Taranaki Whānui ki te Upoko o te Ika (PNBST);
- Ngāti Toa Rangatira;
- Te Atiawa ki Whakarongotai;
- Taurahere Iwi;
- Wellington Tenths Trust – Te Atiawa/Taranaki; and
- Palmerston North Māori Reserve – Te Atiawa.

The Chair shall be appointed by the TUI MC members, and reviewed annually. The quorum will be three.

5. MEETINGS and COMMUNICATIONS

TUI MC will meet every two months either in person or via electronically. A draft meeting agenda will be sent out a week before every meeting and minutes will be taken and then distributed in the week following a meeting.

6. PERIOD COVERED

This Agreement will be from the date the Agreement is signed and will continue indefinitely or until it is terminated by mutual agreement.

7. REMUNERATION

The TUI MC Board members will receive a fee of $250.00 per meeting. A fee of $312.50 will be paid to the Chair. In addition, payment of actual and reasonable travel expenses incurred by members of the Board for attending meetings will be met.

8. CONFLICTS OF INTEREST

Members of the TUI MC Board who become aware of a conflict of interest must disclose the nature and extent of the interest to the other board members. They should then withdraw, abstain or otherwise conduct themselves in a way that ensures that the matter being considered by the TRB is unbiased.

9. RESOLVING PROBLEMS

In the event that a dispute or differences arise, members of TUI MC will in the first instance make every endeavour to resolve the dispute themselves. If no resolution is found an independent mediator can be brought in to help settle the issue. If this is unsuccessful the matter will be resolved in accordance with the Health Sector Mediation and Arbitration Rules (1993).

10. SIGNED ON BEHALF OF:

TUI MC Represented by:

Te Runanganui o Te Atiawa

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Taranaki Whānui ki te Upoko o te Ika (PNBST)

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Ngāti Toa Rangatira

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Te Atiawa ki Whakarongotai

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Taurahere Iwi

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Wellington Tenths Trust – Te Atiawa/Taranaki

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Palmerston North Māori Reserve – Te Atiawa

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Name: ……..

Signature: ……

Represented by: …….. Date: ……..

Board Information – Public

4 August 2021

Hutt Valley DHB Financial and Operational Performance Report – May 2021

Action Required

The HVDHB Board notes:

(a) The DHB had a ($6.4m) deficit for the month of May 2021, being ($5.5m) unfavourable to budget;

(b) The DHB year to date had a deficit of ($15.3m), being ($6m) unfavourable to budget;

(c) The DHB year to date deficit excluding $1.8m unfunded COVID-19 Costs and $2.5m Holidays Act provision was a deficit of ($11m), being ($5m) unfavourable to budget, which includes a $6.5m impairment of the RHIP;

(d) The Funder result for May was $1.7m favourable, Governance $0.01m favourable and Provider ($7.4m) unfavourable to budget;

(e) Total Case Weighted Discharge (CWD) Activity was 8% ahead of plan.

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

Executive Summary

There are ongoing costs due to the COVID-19 response into the 20/21 financial year. Uncertainty remains around how much of the DHB COVID-19 response costs will be funded in 20/21. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

Excluding the COVID-19 net expenses and the Holidays Act provision the DHB's result for the eleven months to 31 May 2021 is a ($11m) deficit, versus a budget deficit of ($9.4m).

Additional net COVID-19 related expenditure above funding, year to date is $1.8m.

The monthly provision for increasing Holidays Act liability is $227k and year to date the impact on the result is $2.5m

For the eleven months to 31 May 2021 the overall DHB year to date result, including COVID-19 and Holidays Act costs is a ($15.3m) deficit compared to a budget deficit of ($9.4m), this also include a write down of the RHIP of $6.5m.

Key underspends are in the funder demand driven costs including Aged Residential Care (ARC) and Other Health of Older People (Other HoP). Mental health contacts are also underspend due to timing of contracts.

Capital Expenditure was $6.6m year to date with $27.4m remaining including projects that are delayed and funding will be transferred to next financial year.

The DHB has a positive cash Balance at month-end of $29.9 million with an equity injection for deficit support received in October 2020 of $35m. Overall the DHB cash balance is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is now expected in 2021/22 to line up with forecast expenditure.

Hospital: In May activity remained was high over ED attendances and both discharges and caseweights for all services. Our winter bed plan to increase capacity by using every available space over the winter months is being implemented the focus being to manage across our acute pathways and ensure continuation of planned care.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients and at month end we are at 99 % of our planned care target. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Our Maternity Units across the region continue struggling with midwifery vacancies - 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.
- FTEs are down from last month with particular concerns around Nursing, Midwifery and Allied Health specialities. 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.
- Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Funder COVID-19 Vaccine programme is progressing well with a strong focus on equity. Other key areas of performance with a focus on core services and achieving equity:

- The number of specialist mental health and addiction interventions that are culturally specific have reduced since 2018/19.
- More people presenting to ED for mental health reasons are seen by a mental health nurse. This has increased to over 20% for all ethnicities since 2018/19. As part of the Acute Care Continuum project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity.
- We are working to improve access to mental health services so that they are responsive to the needs of our communities.
- The proportion of 10-24 year olds enrolled in primary care is relatively high for all groups; 95% for Māori, 103% for Pacific, and 91% for non-Māori, non-Pacific alongside increased use of primary care. ED presentation rates for youth has increased in 2021.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 194 below plan with additional costs in outsourced personnel for roles employed by CCDHB for MHAIDs and IT.
Financial	Planned deficit for HVDHB $10.6 million with no COVID-19 or Holidays Act provision impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A					

Attachments

3.2.1 Hutt Valley DHB Financial and Operational Performance Report – May 2021

Monthly Financial and Operational Performance Report

For period ending
31 May 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There are ongoing costs due to the COVID-19 response into the 20/21 financial year. Uncertainty remains around how much of the DHB COVID-19 response costs will be funded in 20/21. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.
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- Capital Expenditure was $6.6m year to date with $27.4m remaining including projects that are delayed and funding will be transferred to next financial year.
- The DHB has a positive cash Balance at month-end of $29.9 million with an equity injection for deficit support received in October 2020 of $35m. Overall the DHB cash balance is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is now expected in 2021/22 to line up with forecast expenditure.

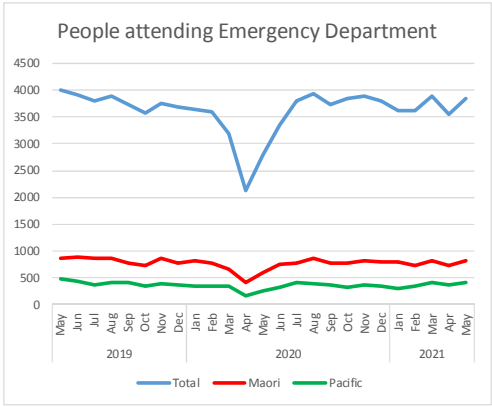
Executive Summary (continued)

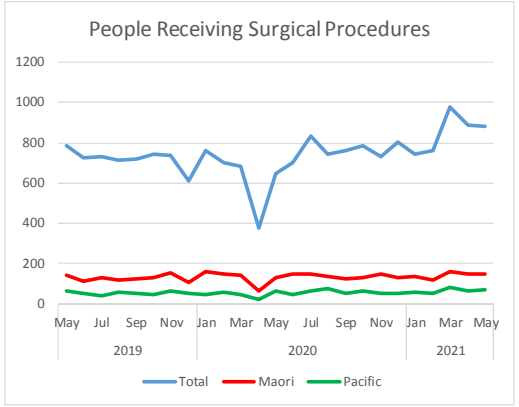
- **Hospital:** In May activity remained was high over ED attendances and both discharges and caseweights for all services. Our winter bed plan to increase capacity by using every available space over the winter months is being implemented the focus being to manage across our acute pathways and ensure continuation of planned care.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients and at month end we are at 99 % of our planned care target. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Our Maternity Units across the region continue struggling with midwifery vacancies - 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.
- FTEs are down from last month with particular concerns around Nursing, Midwifery and Allied Health specialities. 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.
- Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.
- **Funder** COVID-19 Vaccine programme is progressing well with a strong focus on equity. Other key areas of performance with a focus on core services and achieving equity:
- The number of specialist mental health and addiction interventions that are culturally specific have reduced since 2018/19.
- More people presenting to ED for mental health reasons are seen by a mental health nurse. This has increased to over 20% for all ethnicities since 2018/19. As part of the Acute Care Continuum project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity.
- We are working to improve access to mental health services so that they are responsive to the needs of our communities.
- The proportion of 10-24 year olds enrolled in primary care is relatively high for all groups; 95% for Māori, 103% for Pacific, and 91% for non-Māori, non-Pacific alongside increased use of primary care. ED presentation rates for youth has increased in 2021.

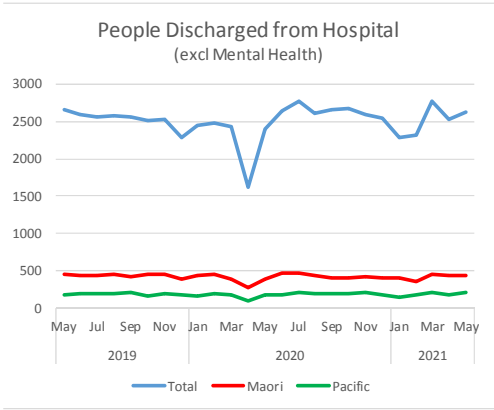
Performance Overview: Activity Context (People Served)

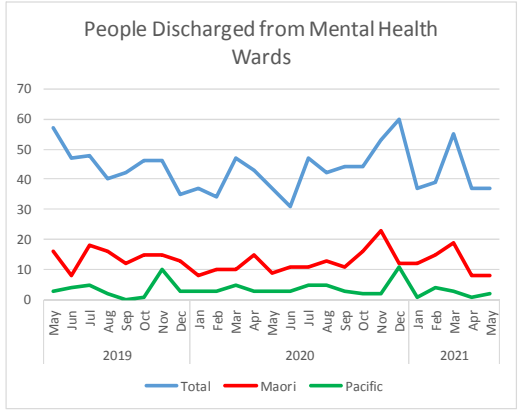
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions. March was busy in all services but April was quieter with the Easter break

People attending ED	**3,847**	811 Maori, 407 Pacific
People receiving Surgical Procedures	**884**	146 Maori, 68 Pacific
People discharged from Hospital (excl Mental Health)	**2,627**	429 Maori, 202 Pacific
People discharged from Mental Health wards	**37**	8 Maori, 2 Pacific



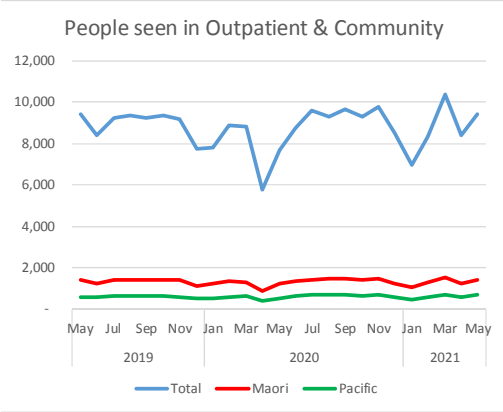


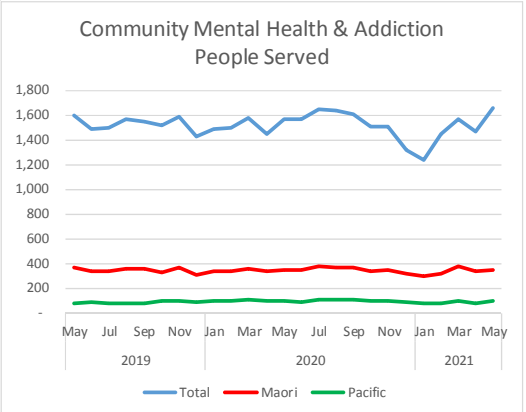


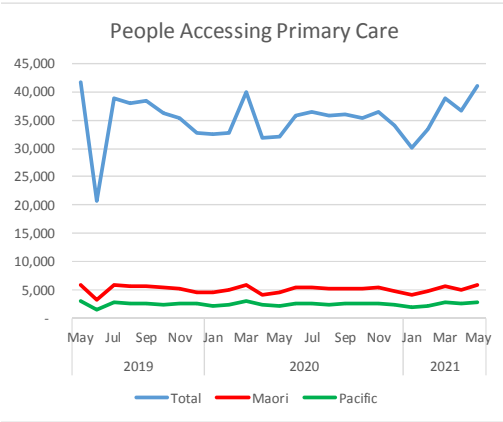


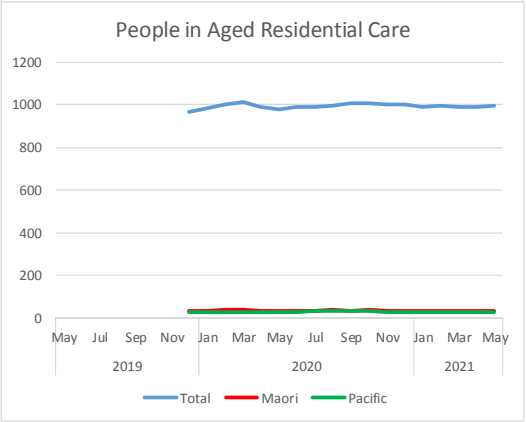
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**9,435**	1,424 Maori, 681 Pacific
Mental Health and Addiction Contacts	**1,656**	347 Maori, 101 Pacific
Primary Care Contacts	**41,099**	5,762 Maori, 2,728 Pacific
People in Aged Residential Care	**996**	36 Maori, 30 Pacific









Financial Overview – May 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$15.3m deficit	$22.1m deficit	$5.7m surplus	$7.1m
Against the budgeted deficit of $8.5m.	Against the budget deficit of $9.8m.	Against the budget surplus of $0.1m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
8% ahead	1,864	$21.1m
363 CWDs ahead PVS plan for May. IDFs were 19 CWD over budget for the month	YTD 194 FTE below annual budget of 2,058 FTE. Note: The MHAIDS & ITS restructures and change of employer contributed 148 FTE to this variance	This is an increase of $0.1m on prior period.

Hospital Performance Overview – May 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
82%	1,020	808	100%
13% below the ED target of 95%, Similar to March 2020, but well below May 20 93% impacted by Covid.	Against a target of zero long waits a monthly decrease of 157.	Against a target of zero long waits a monthly decrease of 202	We have achieved the 62 day target this month. The 31 day target was achieved at 90%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
8% ahead	1,863	0
363 CWDs ahead PVS plan for May. IDFs were 19 CWD over budget for the month	191 below YTD budget of 2,037 FTE. Month FTE was 174 under budget and downwards movement from April of 10.7 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $1.7m for the month and $5.6m year to date, with revenue for IDFs being ahead of budget by $1m due to wash-ups from last year and increased volumes for the current year. In addition COVID-19 revenue, which is offset by costs also means we are ahead of revenue by a total of $5.2m YTD.
- Aged residential care costs are $139k favourable for the month and $1.4m year to date. Other Health of Older People costs are favourable $257k for the month and $2.1m YTD.
- Mental Health costs are unfavourable ($51k) for the month but favourable $1,216k YTD, reflecting timing of contracts which will be rectified with the acute care continuum funding.
- The COVID-19 Vaccine programme is progressing well and in preparation for the significant expansion of the programme post July is well underway. There remains a strong focus on equity for Māori and for our Pacific and Disability communities.
- 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:
  - The number of specialist mental health and addiction interventions that are culturally specific have reduced since 2018/19.
  - Overtime, more people presenting to ED for mental health reasons are seen by a mental health nurse within an hour. This has increased to over 20% for all ethnicities since 2018/19. As part of the Acute Care Continuum project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity to contribute to achieving the 30% target.
  - We are working to improve access to mental health services so that they are responsive to the needs of our communities. CCDHB are establishing a Kaupapa Maori Forensic Step Down 6-bed service and investment in the primary mental health including Tū Ora's development of Piki Services and the Access and Choice. We are still waiting for MoH decisions on investing in kaupapa Maori and Pacific programmes. These decisions were due at the end of 2020.
  - The proportion of 10-24 year olds enrolled in primary care is relatively high for all groups; 95% for Māori, 103% for Pacific, and 91% for non-Māori, non-Pacific alongside increased use of primary care. ED presentation rates for youth has increased in 2021.
  - CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care including the YOSS in Porirua; the four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds and Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.
  - There is significant level of detail on acute flow on following slides. Reflecting the growing demand; displacement of planned care and the positive impact of the prototypes in improving early intervention in our community.

Funder Financial Statement – May 2021

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

Month					$000s	Year to Date					Annual						
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Previous	Variance	Last Year	Variance
					Revenue												
37,924	37,970	(46)	34,735	3,189	Base Funding	417,159	417,667	(508)	382,081	35,078	455,083	455,637	(554)	455,083	0	416,816	38,267
2,351	2,341	10	4,622	(2,271)	Other MOH Revenue	30,195	25,749	4,446	33,893	(3,698)	32,305	28,090	4,215	32,716	(411)	38,006	(5,702)
40	36	5	72	(32)	Other Revenue	693	391	301	479	213	728	427	301	723	5	619	109
9,063	9,229	(166)	7,752	1,311	IDF Inflows	102,487	101,514	973	92,973	9,513	111,653	110,742	911	111,948	(295)	102,280	9,373
49,378	**49,575**	**(197)**	**47,181**	**2,196**	**Total Revenue**	**550,533**	**545,321**	**5,212**	**509,426**	**41,107**	**599,768**	**594,895**	**4,873**	**600,470**	**(701)**	**557,721**	**42,048**
					Expenditure												
386	416	30	383	(3)	DHB Governance & Administration	4,271	4,571	300	4,214	(58)	4,652	4,987	335	4,652	0	4,597	(55)
20,832	21,113	281	19,994	(838)	DHB Provider Arm	231,776	231,529	(247)	219,688	(12,087)	252,656	252,577	(79)	252,956	300	241,131	(11,525)
					External Provider Payments												
3,097	3,217	119	2,587	(511)	Pharmaceuticals	37,479	35,490	(1,988)	31,887	(5,592)	41,004	38,866	(2,138)	41,273	269	37,365	(3,640)
4,401	4,369	(32)	4,286	(116)	Laboratory	48,220	48,055	(164)	46,620	(1,600)	52,572	52,424	(147)	52,522	(49)	50,903	(1,668)
2,571	2,541	(30)	2,554	(16)	Capitation	28,595	27,954	(641)	27,054	(1,541)	31,165	30,495	(669)	31,163	(2)	29,563	(1,602)
1,187	1,235	48	1,091	(96)	ARC-Rest Home Level	12,727	13,348	620	10,753	(1,974)	13,923	14,543	620	13,971	48	11,877	(2,046)
1,829	1,920	91	1,784	(45)	ARC-Hospital Level	19,999	20,746	747	17,503	(2,496)	21,908	22,604	697	22,049	141	19,154	(2,754)
2,472	2,730	257	3,141	668	Other HoP & Pay Equity	27,830	29,925	2,095	31,976	4,146	30,500	32,654	2,154	30,699	198	35,365	4,865
1,140	1,089	(51)	1,220	80	Mental Health	10,740	11,956	1,216	8,630	(2,110)	11,885	13,045	1,160	11,500	(385)	9,580	(2,305)
134	0	(134)	1,325	1,190	COVID-19	4,362	0	(4,362)	3,281	(1,081)	4,362	0	(4,362)	4,228	(134)	4,183	(179)
1,872	2,266	394	2,073	201	Other External Provider Payments	18,824	20,972	2,148	18,841	17	20,496	22,901	2,405	20,543	47	20,595	99
8,210	9,151	941	7,884	(326)	IDF Outflows	100,005	100,656	651	90,618	(9,386)	107,521	109,807	2,285	109,389	1,868	101,298	(6,223)
0	0	0	(43)	(43)	Provision for IDF Wash-ups	0	0	0	0	0	0	0	0	0	0	0	0
48,132	**50,045**	**1,913**	**48,280**	**148**	**Total Expenditure**	**544,829**	**545,202**	**374**	**511,066**	**(33,763)**	**592,644**	**594,905**	**2,261**	**594,943**	**2,299**	**565,610**	**(27,034)**
1,245	**(471)**	**1,716**	**(1,098)**	**2,344**	**Net Result**	**5,705**	**119**	**5,586**	**(1,640)**	**7,345**	**7,124**	**(9)**	**7,134**	**5,526**	**1,598**	**(7,889)**	**15,014**

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 ($46k) to budget for the month and ($508k) year to date, reflecting the various changes for Capital Charge impacting both Income and expenditure for the DHB.
- Other MoH revenue is favourable $10k for May and $4,446k year to date, including COVID-19 funding and Planned Care.
- IDF inflows are ($166k) unfavourable for the month driven by current year wash-ups and favourable $973k year to date.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel (prior years)	(127)	(441)
In- Between Travel (2020/21)	11	120
Capitation Funding	12	407
Planned Care	64	873
Admin & clerical Pay Equity	-	319
COVID-19 Funding	41	4,314
COVID-19 Funding - RPH	(127)	(1,400)
Crown funding agreements		
B4 School Check Funding	(2)	28
Hospice - Cost Pressure funding	12	130
More Heart and diabetes checks	(6)	(85)
Additional School Based MH Services	(10)	(108)
Maternity Quality and Safety Programme	11	118
Rheumatic Fever Prevention Services	(9)	(72)
Well Child/Tamariki Ora Services	6	67
Other CFA contracts	(133)	(178)
Year to date Variance $000's	**10**	**4,446**

Expenditure:

Governance and Administration is favourable $30k for May. Provider Arm payments variance includes; IDF Wash-up Payments to the Provider and Capital Charge rate reduction.

External Provider Payments:

Pharmaceutical costs are favourable $119k for May and unfavourable ($1,988k) YTD, reflecting a combination of passing rebates back to the provider arm and seasonal variations. We have received $1,679k for increased pharmaceutical costs due to COVID-19.

Capitation expenses are ($30k) unfavourable for the month, partially offset by changes to revenue.

Aged residential care costs are $139k favourable for the month.

Other Health of Older People costs are favourable by $257k for the month and favourable $2,095k YTD.

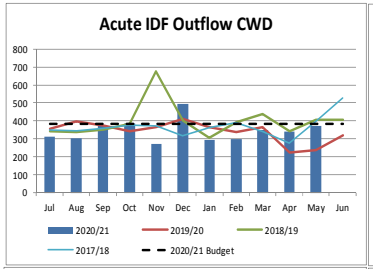
Mental Health costs are unfavourable ($51k) for the month, favourable $1,216k YTD, reflecting timing of contracts.

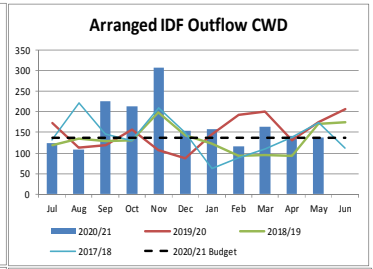
COVID-19 Payments were ($134k) for the month and ($4,363) YTD.

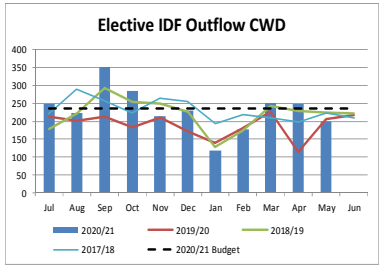
Other external provider costs are favourable to budget $394k for the month.

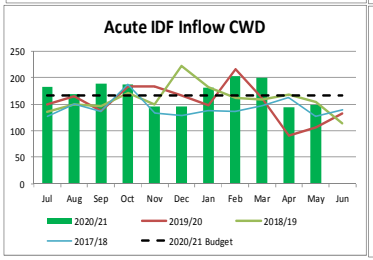
IDF Outflows are favourable $941k, due to Current Year Wash-up payments for volumes and PCT's.

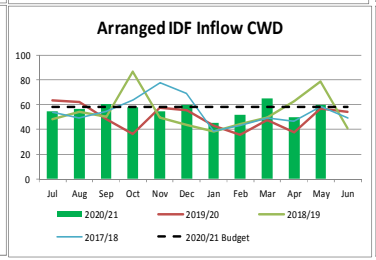
Inter District Flows (IDF)

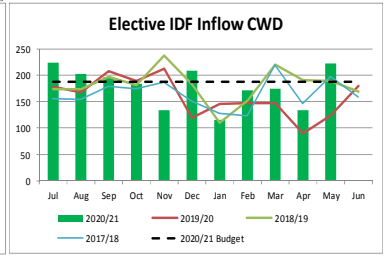












IDF Wash-ups and Service Changes May 2021			
IDF Outflows $000s	Variance to budget		
	Month	YTD	Forecast
Base	(0)	(2)	(2)
CCDHB - Advance Care Planning	(5)	(55)	(60)
CCDHB - Mental Health (provider)	-	-	
	-	-	
Wash-ups			
2020/21 Outflows - inpatient	(135)	(414)	(178)
2020/21 Outflows - outpatient	400	400	951
2020/21 Outflows - PCT	681	681	1,364
2020/21 Outflows ATR	-	-	169
2020/21 PHO	-	(226)	(226)
2020/21 FFS	-	14	14
2019/20 Wash-ups	-	254	254
	-	-	-
Rounding (timing) differences	-	-	-
IDF Outflow variance	**941**	**651**	**2,285**

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 over budget YTD by $973k. Inflows for other services under budget ($1,034k) and inpatient ($311k) under budget. Inpatient inflows are under budget mainly in Plastics, Medical and Cardiology.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are under budget by $651k year to date mainly due to PCT's and outpatient wash-ups. Inpatient outflows being over budget by ($414k), mainly in Neonates, elective Cardiology and Vascular Surgery at Capital Coast.

Commissioning: Families & Wellbeing

What is this measure?

Youth health and wellbeing

- Percentage of youth (10-24 year olds) enrolled in a PHO
- Percentage of youth (10-24 year olds) who have used primary care services
- Youth (10-24 year olds) ED presentation rate per 1,000 population

Why is this important?

- Compared to other age groups, young people are less likely to be enrolled in a PHO and have access to core primary care services to maintain their health wellbeing. Some benefits associated with belonging to a PHO, include cheaper doctors' visits and reduced costs of prescription medicines.
- Compared to other age groups, young people are also less likely to be engaged with primary care services and more likely to present to ED for reasons that could be managed in a primary care setting.

How are we performing?

- Enrolment in primary care is lower for Māori (80%) and Pacific (86%) compared to non-Māori, non-Pacific 10-24 year olds (104%), and are below the 95% target.
- Primary care utilisation in youth decreased for all ethnicities over the summer period, and has increased for all groups. Utilisation for Pacific youth is much lower than other groups (14%, compared to 19% for non-Māori, non-Pacific.
- ED presentations for youth has increased to pre-lockdown rates and not increased further. Māori 10-24 year olds presenting at the highest rate (97 per 1,000 in Q3). Rates in Pacific youth have decreased slightly in Q3 and are lower than for non-Māori, non-Pacific.

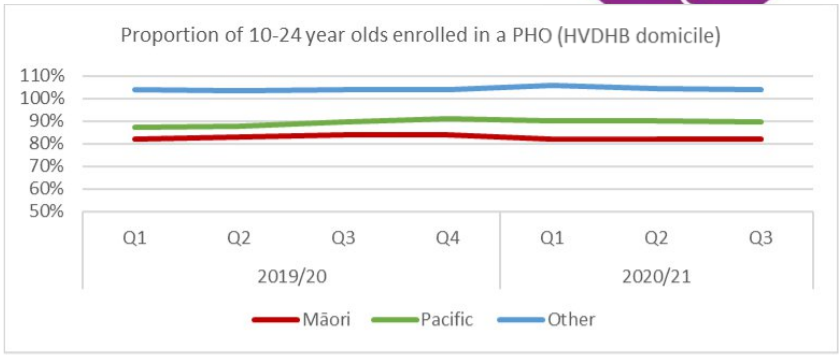
What is driving performance?

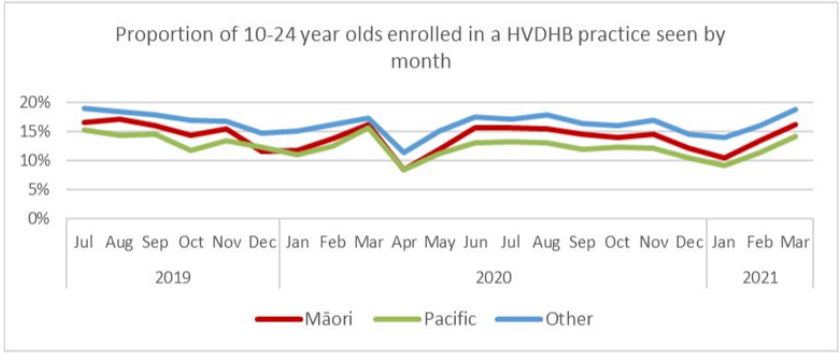
- Young people require a unique mix of social and health services which traditional and mainstream primary care services are not always best equipped to respond to.

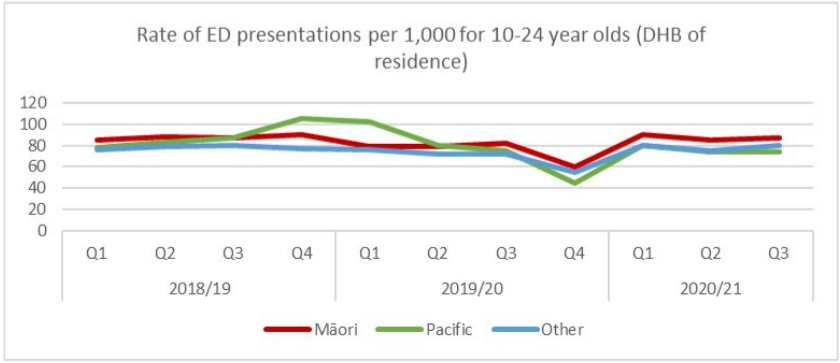
Management comment

HVDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care.

- Vibe continues to reach young people in need of youth appropriate access to primary care services.
- The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds.







Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

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

Why is this important?

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

How are we performing?

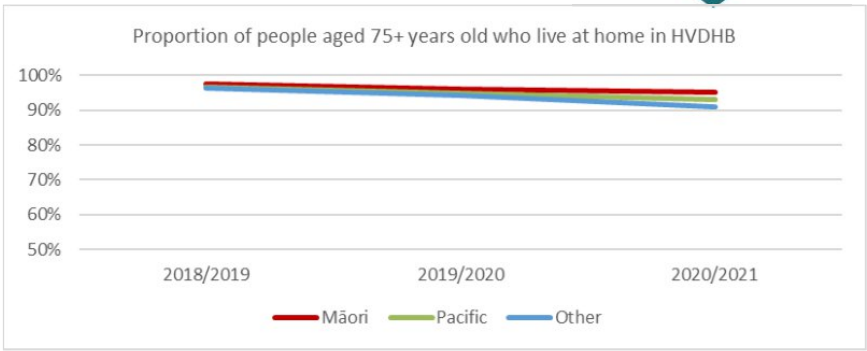
- The proportion of the HVDHB 75+ year old population who live at home is relatively stable and over 90% for all ethnicities.
- The current acute bed day rate for 75+ year olds is highest for Māori (1,654), and are similar for Pacific (1,573) and Non- Māori, non-Pacific (1,506). Acute bed day rates have been decreasing since 2018/19.
- The 28 day readmission rate for 75+ year olds accessing care at HVDHB facilities is highest for Pacific (14.7%) and Māori (13.7%), compared to non-Māori, non-Pacific (12.1%).

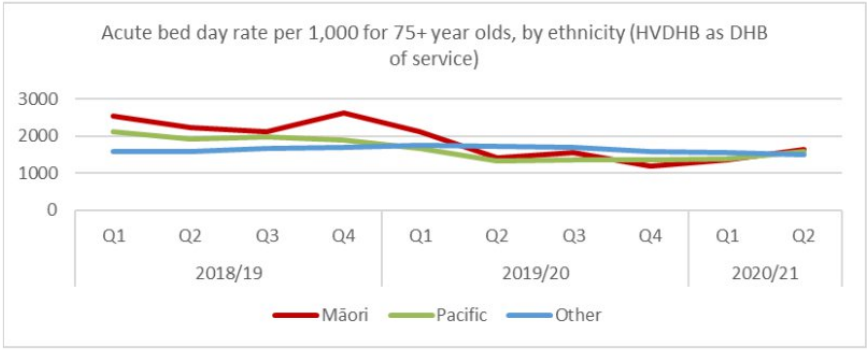
What is driving performance?

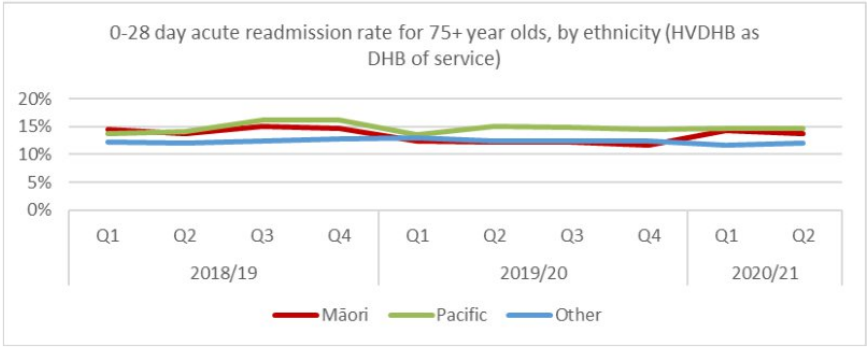
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

Management Comment

- Our main lever to reduce demand is to invest in community services to support frail elderly at home for longer. Investment in a whole of system approach to managing frailty will assist older people to live longer in independence. This will also support improved coordination of services across the region.
- Hutt Hospital ED has introduced an electronic screening tool to identify frail patients early and provide them with appropriate care and support, including activities to reduce deconditioning (loss in muscle strength).







Commissioning: Hospital & Speciality Services

What is this measure?
- Acute flow at Hutt Hospital

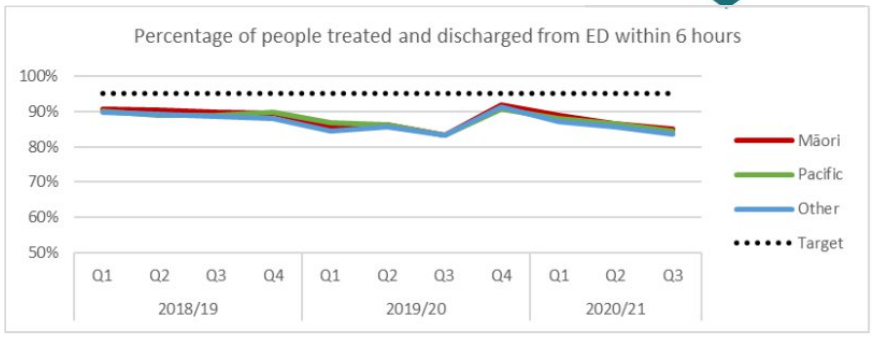
Why is this important?
- Recently, there has been increased attention and discussion about acute demand and presentations to hospital Emergency Departments across New Zealand. Addressing capacity constraints and mitigating rising acute demand is important for making sure that people receive appropriate and timely access to acute care with equitable health outcomes.
- At the request of the Ministers of Health and Director General Health, the Ministry of Health is developing a programme of work around acute demand. This work takes a whole sector perspective and includes community, primary care and hospital services. CCDHB and HVDHB are supporting the Ministry of Health deliver this programme and providing analytics and insights.

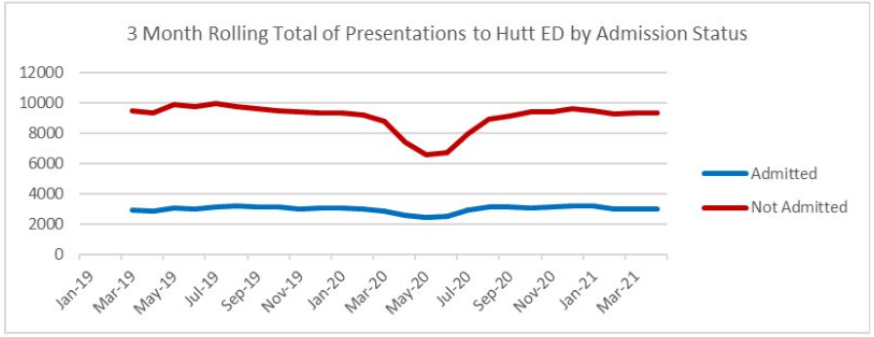
What do we mean by acute flow?
- **Acute care** is urgent or unplanned health care that a person receives for an illness or injury. It is usually time-sensitive, and can result in death or long-term disability if the person does not receive the care they need in a timely manner.
- **Acute flow** at an individual level describes the journey a person takes through our health system to receive care for their urgent or unplanned event. **Acute flow** at a system level describes the flow of all acute patients through our health system.
- **Acute demand** measures how many people require acute care in a particular period of time.

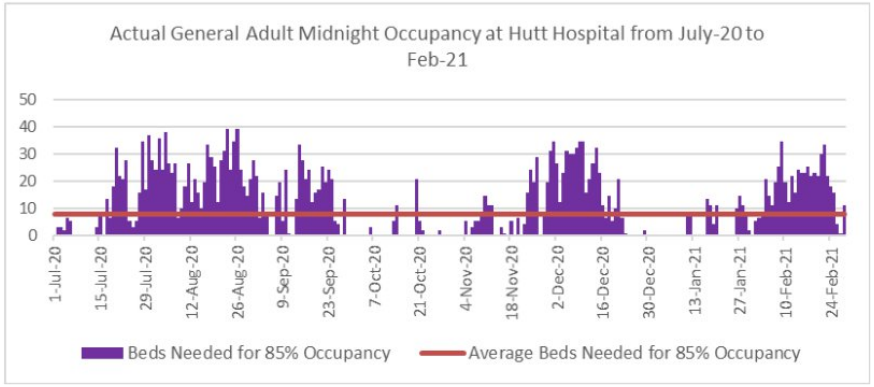
How are we performing?
- Our performance against the Shorter Stays in Emergency Departments measure is decreasing. The target is 95% of people are seen, treated and discharged from ED within 6 hours. Our performance was 91% in Q4 of 2019/20 and is currently 84% as at Q3 2021. This means people are waiting longer in ED to be admitted to hospital. A consequence of this is people who do not require admission to hospital are also waiting longer. Overall, more people are waiting in ED for longer

What is driving performance?

Overall, our performance is driven by the current capacity constraints across our 2DHB Hospital Network:
- The average general adult bed deficit is 8 at Hutt Hospital in 2020/21.
- We have analysed our data across our 2DHB Hospital Network and have identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system.







Commissioning: Hospital & Speciality Services

Primary care presentations are stable:

- There has been no change in primary care capacity in HVDHB. Between January and March 2021, there were around 111,000 visits to a primary care doctor or nurse.

The total number of people visiting Hutt ED is decreasing over time:

- Presentations to Hutt ED are decreasing for all ethnicities.
- The decrease is driven by decreasing presentations for the 0-15 years age group.
- Presentations to ED for all other age groups are stable or increasing over time.
- Increasing presentations by adults is accompanied by an increase in the average time spent in ED.
- There have been a decrease in the number of did-not-waits at Hutt ED

People who are presenting to ED are higher acuity.

- There are more triage 1, 2 and 3 presentations and fewer triage 4 and 5 presentations.
- Triage 1 and 2 presentations now comprise 18% of presentations.
- With increasing acuity in ED, there are more adults being acutely admitted for medical and surgical events.
- The proportion of adults admitted acutely to Hutt Hospital is increasing.
- Acute admissions are increasing for all ethnicities and specialties.

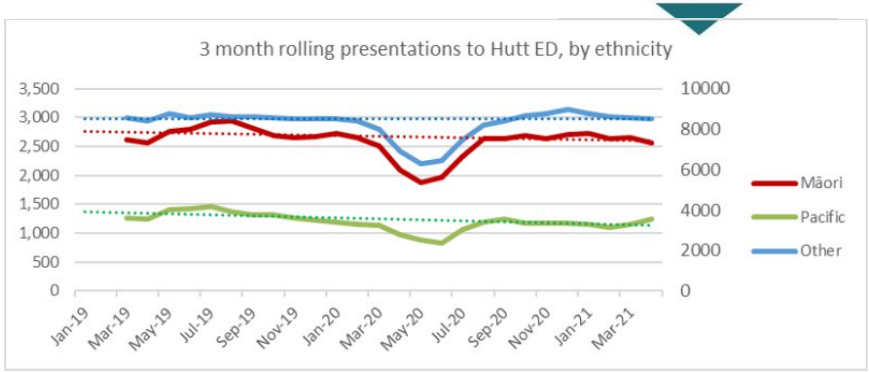
Note: Graphs for the commentary below are on the next page

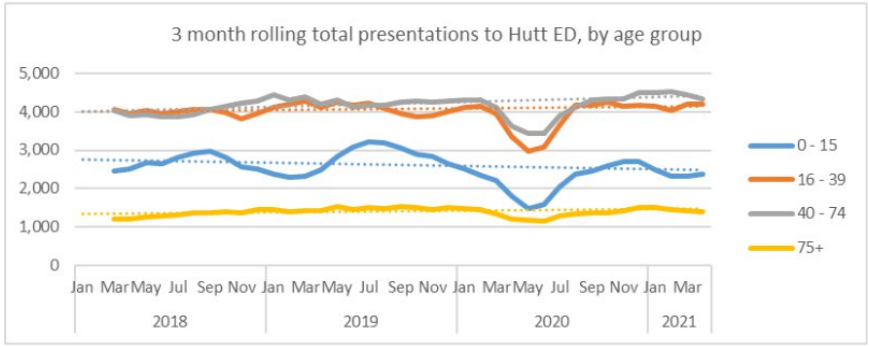
Surgical admissions from Emergency Departments are increasing for Hutt ED:

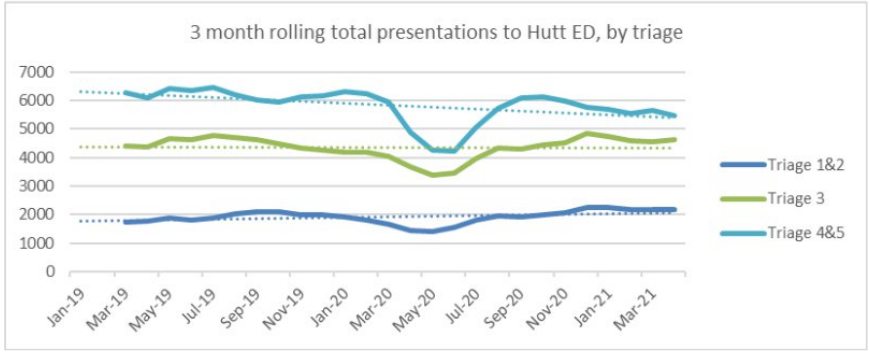
- More people are being admitted to ED under surgical specialities.
- Increasing acute surgical admissions increases requirements for ward beds as the average length of stay (ALOS) is highest for acute surgical patients (3.5 days) compared to planned surgical patients (1.0 days).
- The increase in acute surgical presentations also displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced examples are in General Surgery and Orthopaedics The example provided is for General Surgery.

The increased acute surgical activity is impacting planned surgery provision:

- More people are waiting longer than four months for surgical treatment than in March-April 2020.
- In Budget 2020 the Government made available investment for DHBs to recover waiting lists impacted by the COVID-19 Level 4 lockdown. HVDHB requested to focus our $2.3million service delivery investment in areas of greatest need to reduce waitlists, mainly general surgery and orthopaedics.
- The 2DHBs are focused on addressing our bed and theatre capacity to ensure access to planned care and surgical treatment is maintained in 2021 and beyond.







Commissioning: Hospital & Speciality Services

Note: Commentary for the graphs on this page are on the prior page

We have invested across our health system to reduce acute demand:

- **Health Care Homes** operate alongside our **Community Integration Model** to blend the delivery of primary care and specialist care services to support the delivery of a comprehensive service in the community. The levels of care offered change in response to different levels of need.
- **Primary Options for Acute Care (POAC)** is a funding arrangement developed to support the management of acute conditions and some planned care procedures to reduce the number of people presenting to ED that could have been managed in a community setting.
- **Early Support Discharge** works to reduce the functional decline of patients. It optimises our allied health workforce and is able to reduce the length of stay of patients in hospital.

These investments have reduced acute demand, however our acute flow is still under pressure

We are investing to address capacity constraints across our 2DHB Hospital Network in 2020/21:

Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.

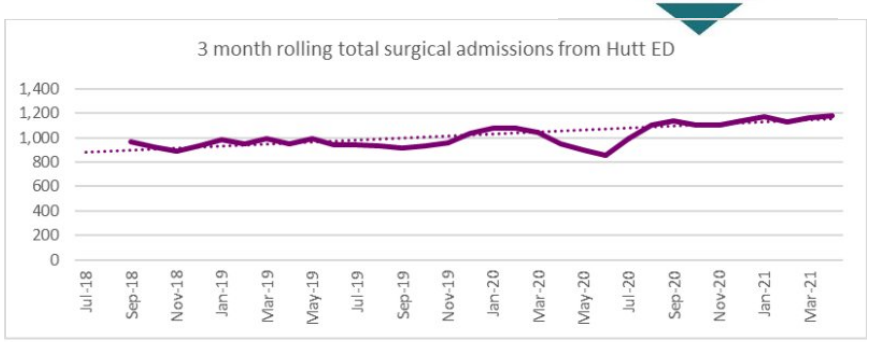
We are investing in redesigning the front doors of our hospitals to ensure smoother flow of people receiving care through the system, and making most effective use of resources by delivering the appropriate level of care in the lowest cost setting (cost being time & travel for patients and cost of delivering care).

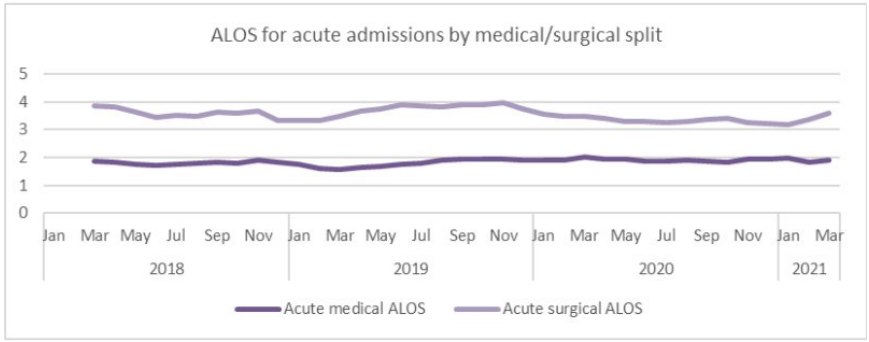
In response to capacity constraints we are undertaking the following projects:

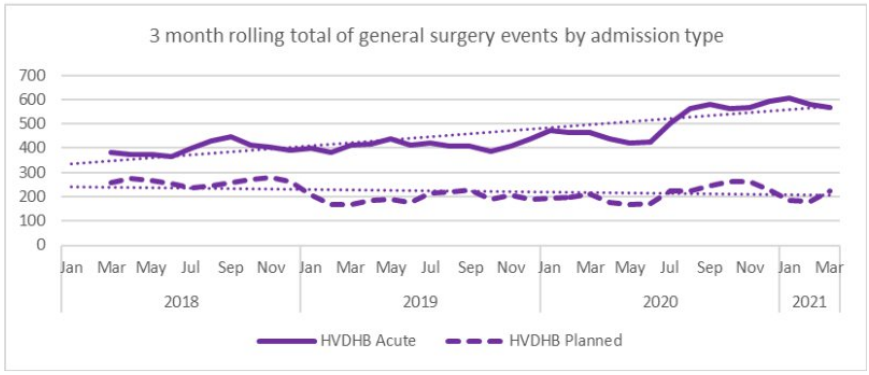
- **Bed & Theatre capacity** – identifying options for increasing theatre and bed capacity across our three hospitals within the next two years while optimising use of current capacity
- **Front of Whare** – identifying options for increasing capacity and flow through Hutt ED and acute assessment areas

A range of strategies underway to manage acute demand in both community and hospital settings:

- **Winter Planning:** During winter there is normally an increase in acute medical demand. HVDHB is planning to use existing capacity and resources to manage surges in acute demand.
- **Community Investments:** Subject to finalising budget 2021/22, we are Investing in our communities to deliver more care closer to home







Commissioning: Mental Health & Addictions

What is this measure?

- Number of specialist NGO and MHAIDS cultural interventions for Māori and Pacific
- Number of primary mental health and addiction interventions for Māori and Pacific
- ≥30% of mental health presentations to ED seen by an ED mental health nurse within an hour

Why is this important?

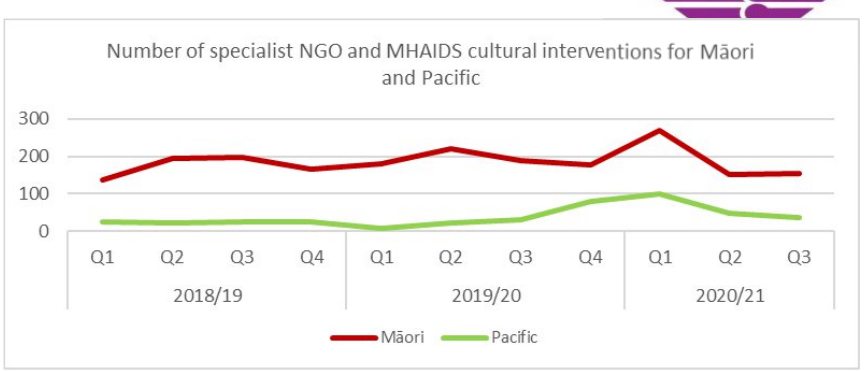
- In order to provide an equitable system of care, providers need to deliver solutions that are designed with people in mind. One such service is culturally specific interventions which are found throughout MHAIDS and NGO specialist services.
- Primary mental health and addiction services aims to provide timely care for people close to home. Investment in this area will address people with lower levels of acuity earlier on.
- Emergency departments are under-equipped to resolve mental health presentations in a timely manner. The extensive wait times for mental health consultations often results in increasing distress and readmissions.

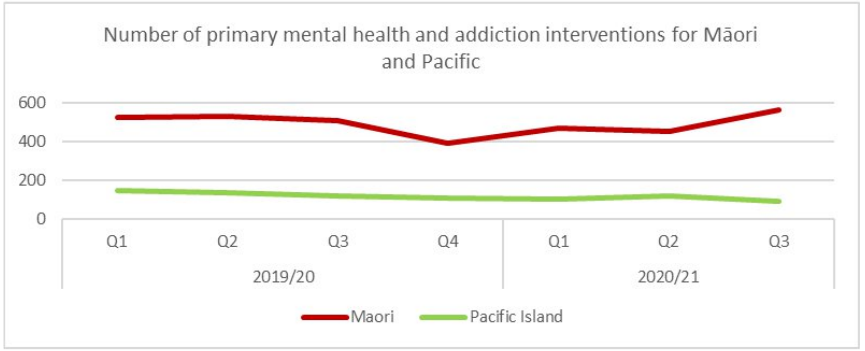
How are we performing?

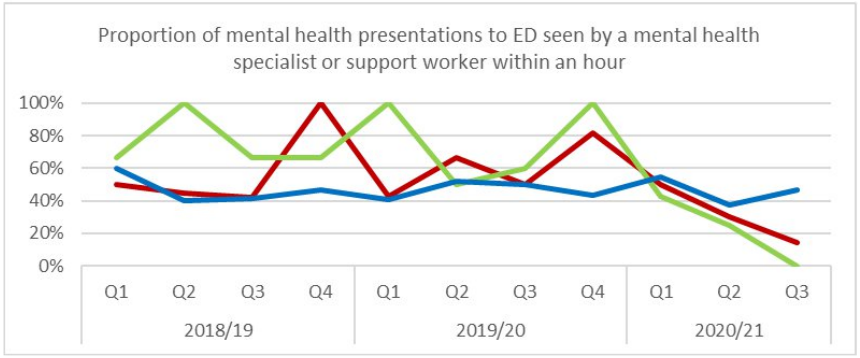
- The number of specialist mental health and addiction interventions that are culturally specific has not changed for Māori and has increased for Pacific since 2018/19.
- The number of primary mental health and addiction interventions has started to increase after a reduction during COVID-19 lockdown.
- Overtime, more people presenting to ED for mental health reasons are seen by a mental health nurse within an hour. This has increased to over 20% for all ethnicities since 2018/19. Our target is ≥30% of presentations seen by an ED MH Nurse within 1 hour

Management comment

- We are working to improve equitable access to mental health services that are responsive to our communities. In HVDHB we are developing a **Kaupapa Maori service response**.
- Investment in the primary care space is an integral part of our system development plan. Investments like Tū Ora's development of Piki Services and the Access and Choice service aim to equip primary care services with the tools they need to address mental health and addiction needs earlier on.
- As part of the **Acute Care Continuum** project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity. The intent of this is to reduce wait times for those requiring mental health assessment by offering earlier access through improved capability in ED and alternative locations for known clients (ACC CR).







2DHB COVID-19 Response

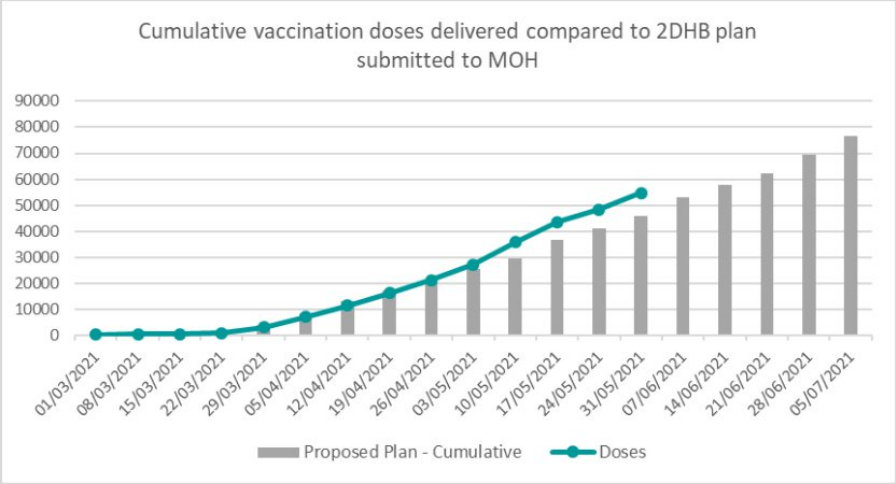
What is this measure?
- Vaccination roll-out

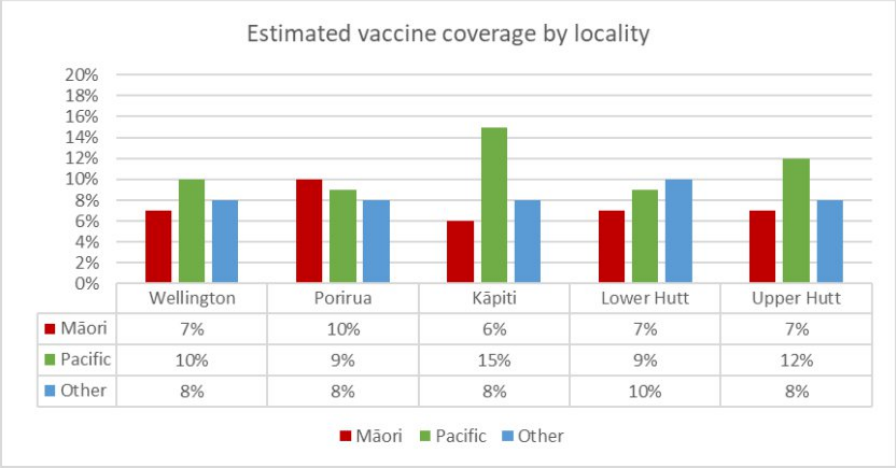
Why is this important?
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equal access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of catching COVID-19 in their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

How are we performing?
- **Group 1:** Border, MIFQ workers and people they live with
- **Group 2:** Frontline health workforce interacting with patients and supporting in high-risk places, residential care workers, emergency response services
- **Group 3:** people with elevated risk, including people who are 65 years or older, people with underlying conditions, disabled people, people in custodial settings
- **Group 4:** general rollout (including early vaccine access)
- Equity is the priority for access. Our Pacific population is progressing well; our Māori population is progressing well with our Māori provider partners.

2DHB group	Dose 1	Dose 2
Group 1	3,729	2,821
Group 2	21,998	15,978
Group 3	3,653	508
Group 4	3,887	2,037
CCDHB total	21,701	14,800
HVDHB total	11,681	6,594

Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 30/05/2021
Data current at: 31/05/2021 @11:00am





Section 3

Hospital Performance

Executive Summary – Hospital Performance

- In May activity remained was high over ED attendances and both discharges and caseweights for all services. Our winter bed plan to increase capacity by using every available space over the winter months is being implemented the focus being to manage across our acute pathways and ensure continuation of planned care.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients and at month end we are at 99 % of our planned care target. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Our Maternity Units across the region continue struggling with midwifery vacancies - 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.
- FTEs are down from last month with particular concerns around Nursing, Midwifery and Allied Health specialities. 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.
- Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD May-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,172	1,158	(14)	942	(230)	Surgical	12,673	11,879	(794)	11,071	(1,602)	12,950	12,797
1,880	1,784	(96)	1,657	(223)	Medical	20,612	18,068	(2,544)	19,163	(1,449)	19,737	19,506
491	432	(59)	475	(16)	Other	5,325	4,940	(385)	4,985	(340)	5,374	5,474
3,543	**3,374**	**(169)**	**3,074**	**(469)**	**Total**	**38,610**	**34,887**	**(3,723)**	**35,219**	**(3,391)**	**38,061**	**37,777**
					CWD							
1,233	1,189	(44)	941	(292)	Surgical	13,466	12,742	(724)	11,998	(1,468)	13,889	12,852
1,002	935	(66)	903	(99)	Medical	10,845	9,865	(980)	10,313	(532)	10,719	11,991
577	421	(156)	533	(44)	Other	6,203	5,352	(851)	6,067	(136)	5,811	4,698
2,811	**2,546**	**(266)**	**2,377**	**(434)**	**Total**	**30,514**	**27,958**	**(2,555)**	**28,378**	**(2,135)**	**30,419**	**29,540**
					Other							
4,315	4,171	(144)	3,104	(1,211)	Total ED Attendances	45,875	44,529	(1,346)	42,338	(3,537)	48,696	47,491
991	965	(26)	829	(162)	ED Admissions	11,132	10,383	(749)	10,295	(837)	11,386	11,847
841	828	(13)	673	(168)	Theatre Visits	8,740	8,632	(108)	7,781	(959)	9,370	9,271
112	161	49	139	27	Non- theatre Proc	1,487	1,388	(99)	1,412	(75)	1,500	1,891
7,918	7,211	(707)	6,425	(1,493)	Bed Days	81,939	75,843	(6,096)	77,945	(3,993)	82,873	85,515
4.62	4.50	(0.12)	4.22	(0.40)	ALOS Inpatient	4.52	4.50	(0.02)	4.53	0.00	4.50	4.29
2.14	2.18	0.04	1.99	(0.16)	ALOS Total	2.07	2.18	0.11	2.20	0.13	2.18	2.20
7.81%	8.02%	0.21%	7.99%	0.19%	Acute Readmission	7.78%	8.02%	0.23%	7.89%	0.10%	7.31%	7.36%

For the month of May, Surgical and Medical discharges and caseweights were close to plan but much higher than the same time last year when the country was coming out of the COVID lockdown. Discharges for Other services are higher than budget for the month for Neonate Special Care and Mental Health. Year to date, caseweights for Surgical services are over plan due to higher General Surgery, Orthopaedics and Gynaecology volumes. For Medical year to date is higher than budget, due to an increase in Gastroenterology and Rheumatology compared to last year offset by lower volumes for Paediatrics. Other services are higher than plan due to more discharges under Maternity.

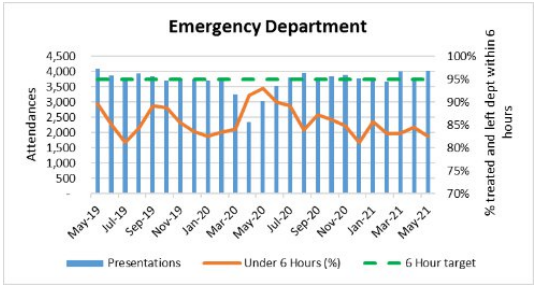
In May, ED visits were higher than budget and much higher than last year as we were coming out of the national COVID lockdown. The number of patients who were admitted from ED were higher than plan. Theatre visits were slightly higher than budget for the month, but close to plan year to date. Non-theatre procedures were much lower than budget for the month but higher year to date. Bed days were significantly higher than plan for the month and higher year to date. Inpatient ALOS in May was longer than budget and the same time last year. The acute readmission rate was lower than plan for the month and the same time last year.

Operational Performance Scorecard – 13 mths

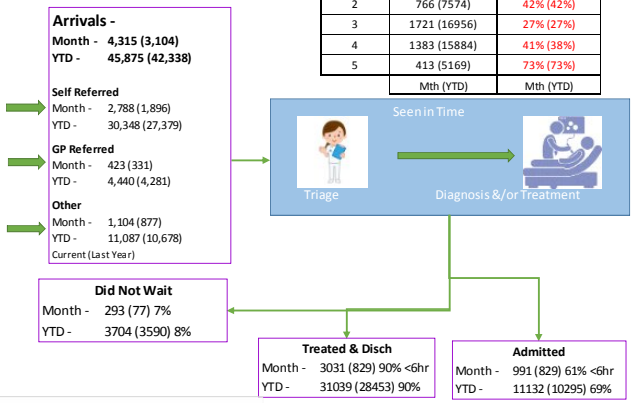
			13 Months Performance Trend												Last 4 Weeks			
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	10/05/21	17/05/21	24/05/21	31/05/21
Safe	Serious Safety Events[1]	Zero	2	2	3	3	1	2	3	0	1	3	3	3	0				
	SABSI Cases [2]	Zero	0	0	1	0	1	2	1	1	1	0	1	0	0				
	C. difficile infected diarrhoea cases	Zero	2	0	3	4	1	1	4	0	1	0	1	2	1				
	Hand Hygiene compliance (quarterly)	≥ 80%	87%		82%			79%			79%								
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		16.3	13.8	27.7	36.7	11.4	13.3	1.4	43.6	7.6	22.4	39.8	13.6	21.0				
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%																	
	Patient reported experience measure[5] (quarterly)	≥80%	N/a		N/a			N/a			N/a								
Timely	Emergency Presentations	49,056	3,104	3,721	4,039	4,281	3,997	4,273	4,328	4,259	4,059	4,026	4,315	3,982	4,315	914	1,045	958	987
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	93.0%	89.9%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.4%	80.0%	80.7%	78.4%
	SSiED % within 6hrs - non admitted	≥95%	97.0%	94.7%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	88.3%	88.2%	87.6%	85.8%
	SSiED % within 6hrs - admitted	≥95%	82.4%	76.1%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	60.1%	53.5%	58.8%	54.7%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	1,077	1,130	1,082	913	915	992	1,002	1,115	1,251	1,328	1,238	1,177	1,020	1,049	1,037	1,012	997
	No. Theater surgeries cancelled (OP 1-8)		72	98	140	148	154	142	128	138	87	139	198	124	127	20	30	30	8
	Total Elective & Acute Operations in MainTheatres 1-8[6]		673	733	868	792	805	824	775	744	664	712	898	817	841	197	214	192	24
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,384	1,240	1,096	798	674	723	704	758	1,016	1,124	1,093	1,015	808	859	822	768	766
	Outpatient Failure to Attend %	≤6.3%	7.4%	8.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.5%	5.3%	8.0%	6.1%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($13.59)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	($19.72)	TBC	TBC				
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($15.64)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	($14.25)	TBC	TBC				
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	85.2%	87.6%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.8%	88.5%	87.3%	84.2%	84.2%	84.2%	84.2%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.26	4.44	4.39	4.76	4.52	4.26	4.72	4.79	4.50	4.37	4.89	4.35	4.65	4.22	4.43	4.80	5.18
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	15	14	16	21	17	15	21	24	21	34	20	23	29	28	27	29	28
	Overnight Beds (General Occupancy) - Average Occupied	≤130	118	136	141	151	144	130	138	144	130	149	146	143	148	144	150	148	150
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	73.1%	84.2%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	93.5%	97.6%	96.3%	97.3%
	All Beds - ave. beds occupied[8]	≤250	207	241	244	254	249	231	240	240	229	253	253	243	255	253	263	254	258
	% sick Leave v standard	≤3.5%	6.9%	3.1%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%				
	% Nursing agency v employee (10)	≤1.49%	3.3%	2.0%	1.6%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	13.0%	TBC	TBC				
	% overtime v standard (medical) (10)	≤9.22%	9.7%	9.2%	6.7%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	7.9%	TBC	TBC				
	% overtime v standard (nursing)	≤5.47%	12.6%	12.3%	10.8%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	11.2%	TBC	TBC				

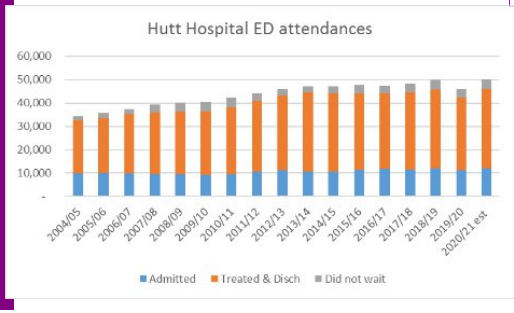
Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 20/21.

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	32 (292)	100% (100%)
2	766 (7574)	42% (42%)
3	1721 (16956)	27% (27%)
4	1383 (15884)	41% (38%)
5	413 (5169)	73% (73%)
	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 planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - The month of May has seen an overall increase in ED presentations when compared to April 2021. A combination of increased presentation numbers and acuity saw a 1% decrease in the patients treated and discharged within 6 hours. A 3% decrease in the number of patients admitted for ongoing treatment was achieved
- **What is driving Performance**
  - The ongoing impact of GP recruitment and retention in the community is reflected in the sustained triage 4 and increasing triage 5 presentations.
  - Our two new Nurse Practitioners are now in affect and have certainly supported the service to see, treat and discharge these patients whom present to ED for care.
- **Management Comment**
  - May saw the launch of the renewed 'bed meeting' now known as the 'Patient Flow Meeting'. The meeting focuses on identifying opportunities in order to achieve the predicted flow out of the hospital for the day. In turn this focus alleviates the system to deliver the right care, in the right place, at the right time.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

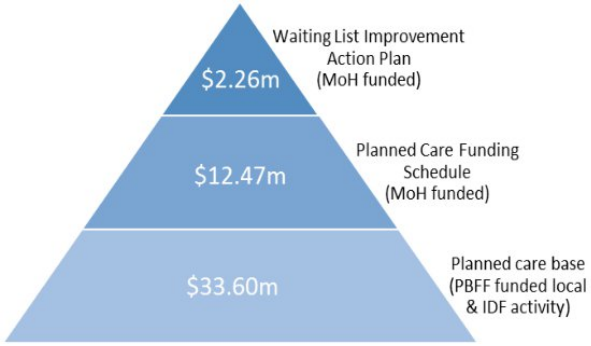
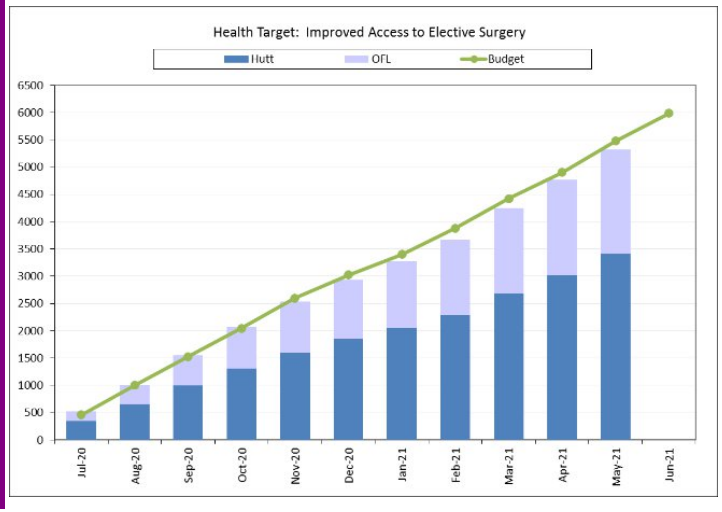
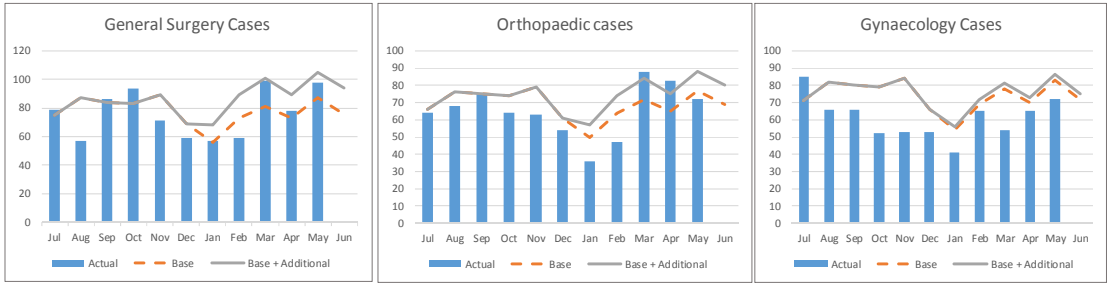


Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 99.9%

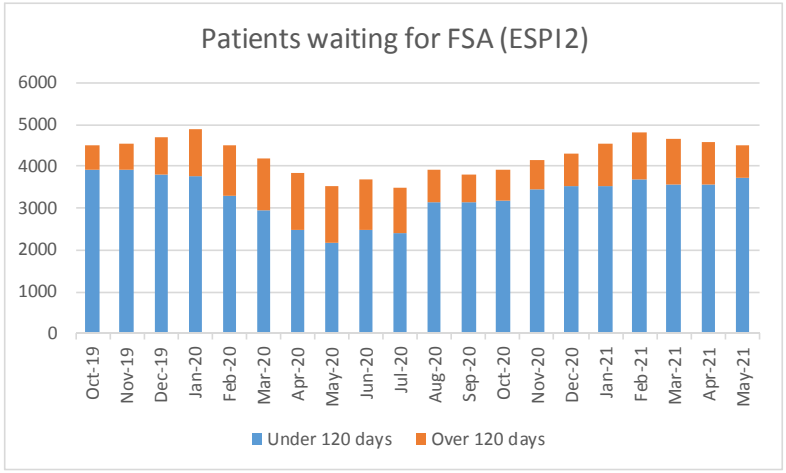


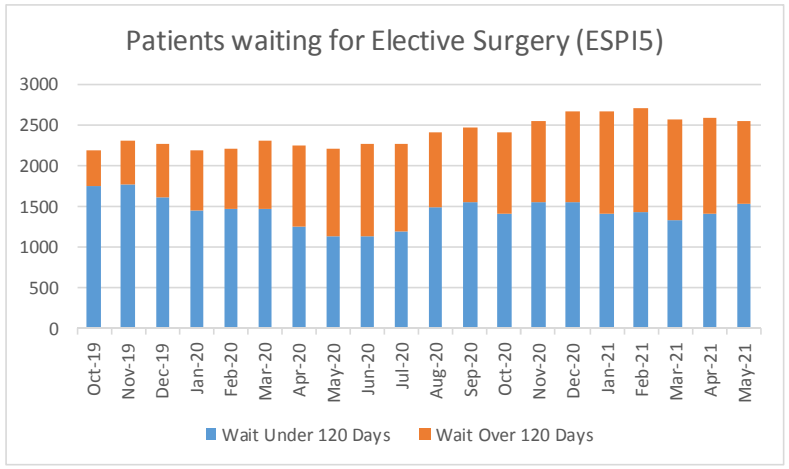
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 8 behind plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 99.9% as per figure 2.
  - May results were an improvement from April however acute demand did result in cancellations, there was a decrease in Saturday surgery and sick leave impacted.
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced examples are in General Surgery and Orthopaedics as described earlier
- **What is driving performance?**
  - General Surgery have delivered additional all day elective Saturday lists in March and operated on 18 cases. The same is planned for April, May & June, for a planned total of 7 all day elective Saturday lists to operate on 40 cases. There were less Saturday sessions in May.
  - There are 46 patients waiting for Carpal Tunnel procedure on our surgical waitlist so the service has organised weekly regular Friday PM Carpal Tunnel lists to operate on these cases by end June

Figure three: Services allocated Waiting List Improvement Action Plan funding – current delivery

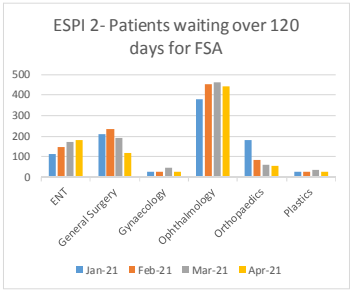


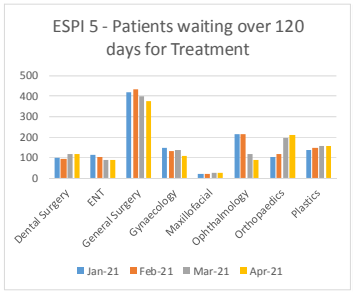
Planned Care – waiting times-

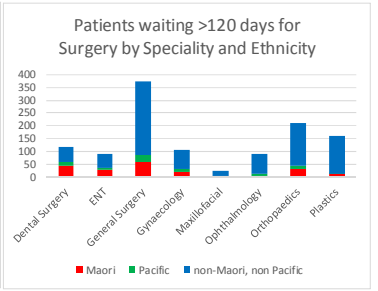




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased by 2% this month and the number waiting over 120 days by 20% (202)
  - The number waiting for elective surgery fell by 46 to 2,552 and the number waiting over 120 days fell by 157 to 1,020
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

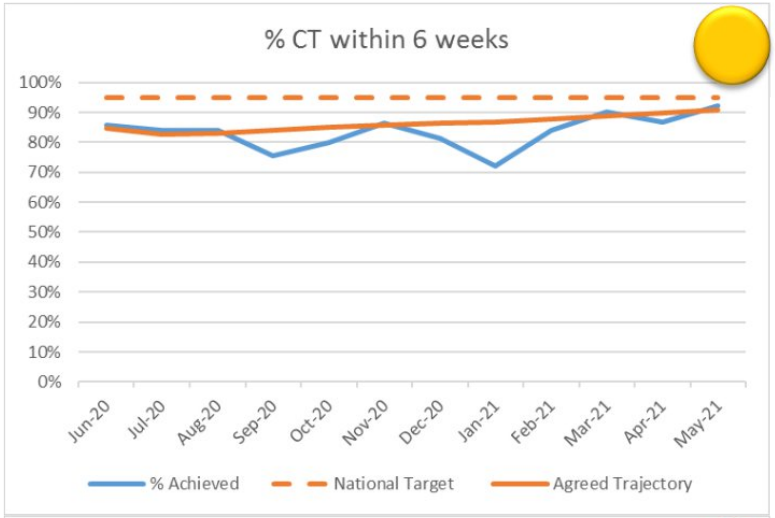


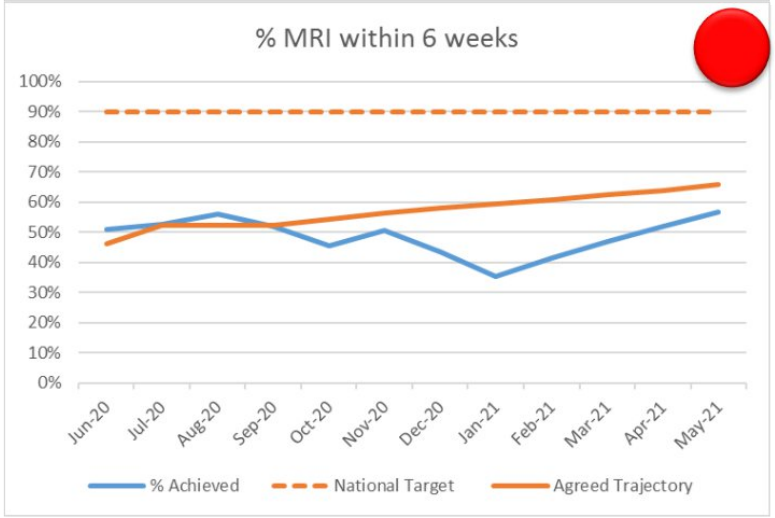




- **What is driving performance?**
  - Principally managing inflows to our waiting list and balancing against outflows is not yet robust,
  - Registered Nursing staffing in the value chain for OR production does not meet patient demand however we are moving to correct this .
  - Cancellations due to acute demand in particular General surgery
  - Wait list trajectories will take some time to correct due to acute demand and historic backlog.

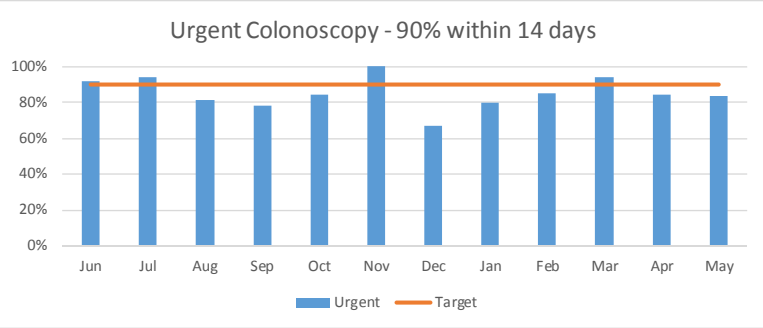
CT & MRI wait times

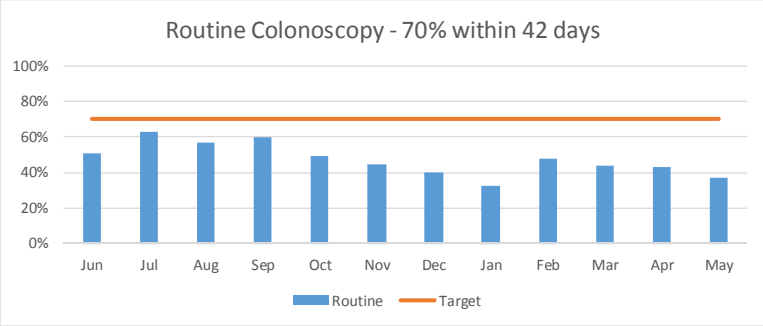


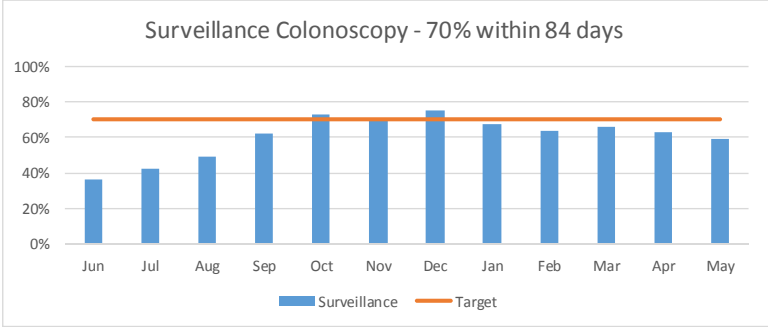


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How 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 have met Ministry targets - largely due to starting an hour earlier at 0700 weekdays and doing an additional day shift on a Sunday.
  - MRI staff are doing some voluntary overtime weekend days shifts, and the recovery trajectory has been renegotiated with the MOH (awaiting confirmation and then will be reflected in the above table).
  - Current efforts should see MRI to be in a compliant state by June 2022.
- **Management comment**
  - Actions currently underway:
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - Voluntary overtime weekend MRI day lists – approximately 4 days per month
    - Weekend CT day list - approximately 4 days per month
    - MOH Planned Care funding being used to outsource 30 MRIs per month and will increase to 70 per month for May & June (scan and reports) plus outsourcing the reporting of 100 CTs per month

Colonoscopy Wait Times







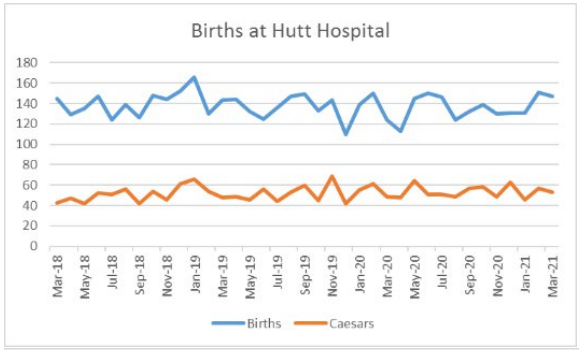
Urgent
86% YTD

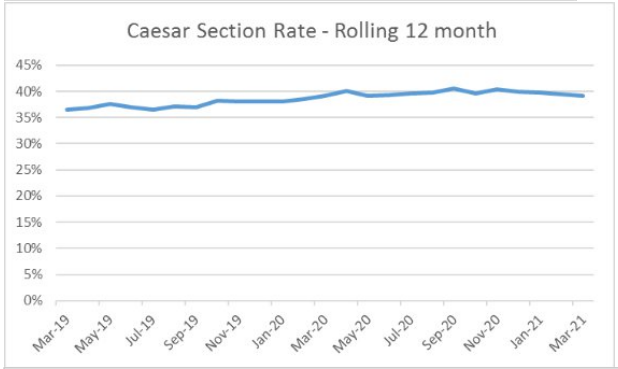
Routine
48% YTD

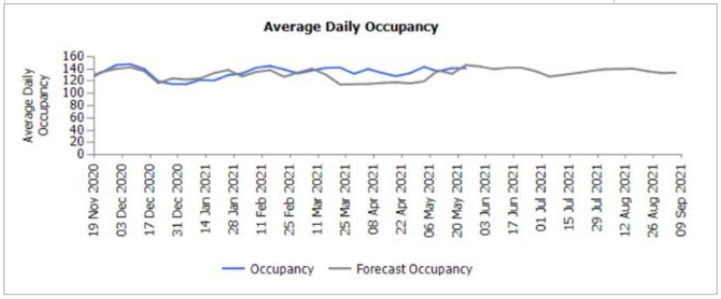
Surveil
61% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
  - One patient is outside of the target for Urgent (Maori). They were deferred as are not medically fit. Four Maori are overdue (routine category) however they are all being actively pursued to enable a booking asap although contact is proving challenging for some.
  - There are no pacific overdue for any category
- **What is driving performance?**
  - A growing surveillance waitlist with patients continuing to move onto this from the Bowel Screening Programme.
  - There is also an overall increase in referrals, with the past 6 months seeing higher numbers referred compared to the past 4 years.
  - There is concerted effort occurring to ensure that there are no Maori or Pacific patients overdue for any category and it is pleasing to note this has been achieved this month.
  - There are currently 39 patients waiting outside maximum timeframes.
- **Management comment**
  - A new performance and monitoring plan has been developed. This will enable the service to effectively plan trajectories and manage capacity to meet demand and assist in priority population booking
  - The service is projecting full recovery by February 2022 with it being in a stable position from then.

Maternity

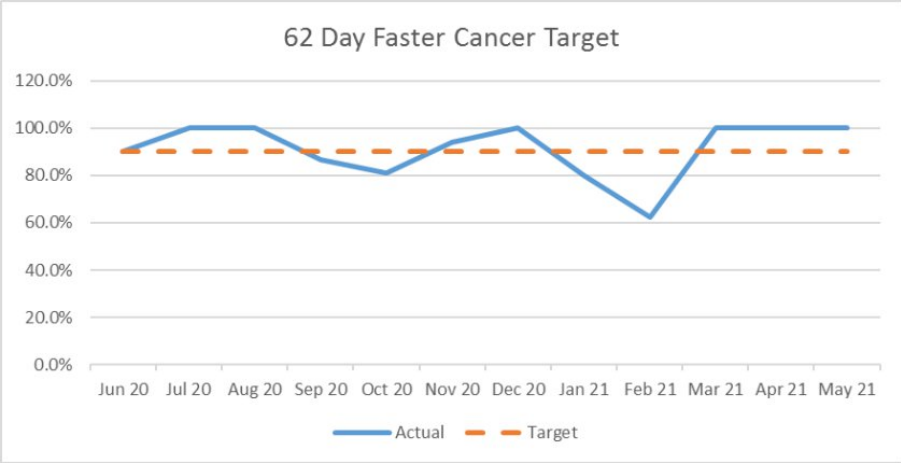


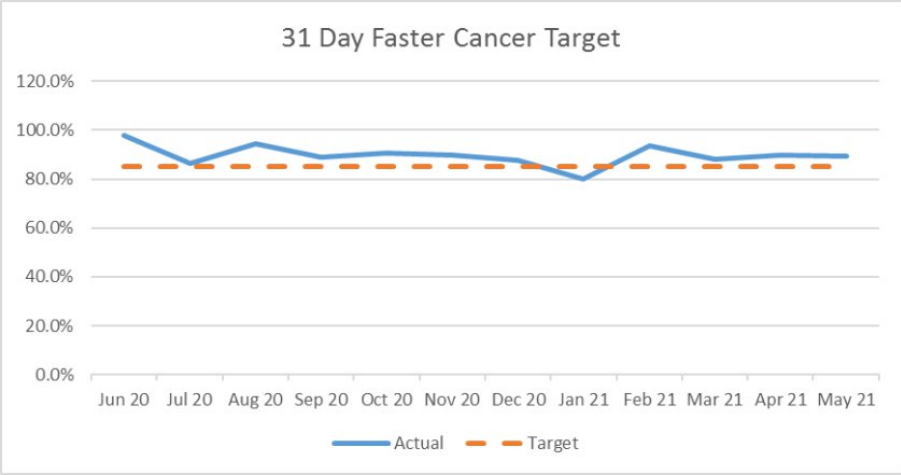




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - A presentation to the CCDHB & HVDHB Boards in March focused on the maternity quality safety programme national clinical indicators – areas HVDHB is performing well in and those where improvement is being directed. We will seek to reduce Caesarean Sections through a birthing optimisation project and prospective case audit over a 3 month period will commence in April 2021
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU).
  - The Governance Group for the facility in place and Phase One of building work (CMT space) commenced in March and is expected to complete by May.
  - Midwifery staffing was a key recognised risk in the external review; currently Hutt Valley's inpatient antenatal and post-natal ward and Delivery Suite have a combined total workforce of 35 FTE. There was a RM vacancy of around 19 FTE at the end of March and an active recruitment campaign is in place. We are employing Registered Nurses who will work in the postnatal ward.
  - We have processes to manage demand during busy periods. We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
  - We are also developing a more regional approach as both Hutt and WRH units are similarly challenged with workforce shortages.

Faster Cancer Treatment

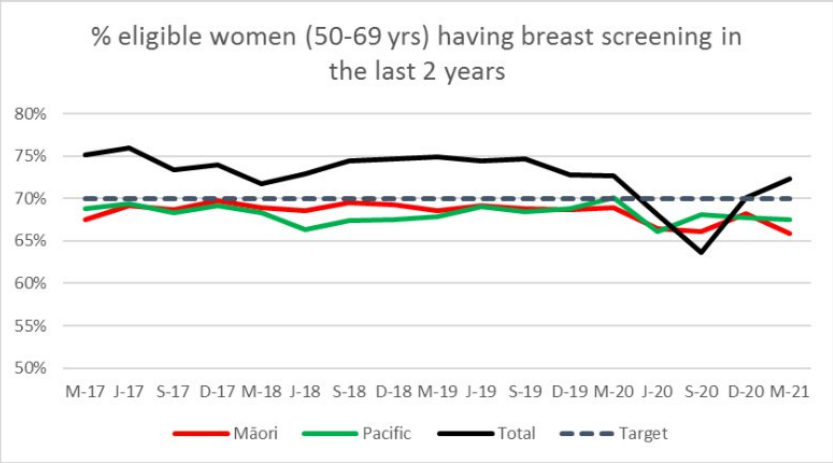


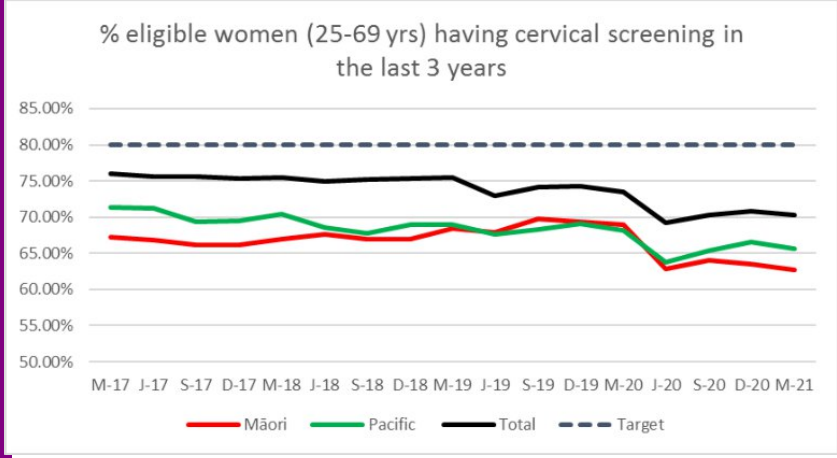


- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have 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?**
  - The decline in 62 day target pathway performance across both DHBs was due to capacity. It has now improved.
- **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 50-69 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?**
  - COVID lockdowns have resulted in a backlog of 6000 women that are overdue for BreastScreening in the 20/21 year. There has been longstanding recruitment issues for both Medical Imaging Technologists (MIT) and Radiologists.
- **What is driving performance?**
  - In May the service continues to provide Saturday sessions for the full month and screening capacity has met projected target. Saturdays continue to be run on a volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued.
  - Māori, Pacific and Asian (cervical) women continue to be prioritised for screening in both Cervical and Breast Screening
- **Management Comment**
  - MIT Recruitment continues with one MIT starting this month.
  - Extended screening weekday hours at the Hutt Valley Breast Centre as staffing allows is due to start June.
  - Saturdays have continued to be covered on a voluntary basis.
  - An admin team consultation meeting to discuss moving to a 6 day rostered and rotating service was held in May with submissions to the consultation document due back 11 June.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for May 2021

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											
40,275	40,313	(38)	39,357	918	Devolved MoH Revenue	447,354	443,438	3,917	415,974	31,381	487,390	483,750	3,639	454,822	32,568	
656	1,685	(1,029)	913	(257)	Non Devolved MoH Revenue	18,868	18,308	560	16,693	2,174	20,592	20,049	543	19,272	1,320	
766	521	246	1,484	(718)	ACC Revenue	6,501	6,587	(86)	6,817	(316)	7,134	7,219	(86)	6,457	677	
450	522	(71)	763	(313)	Other Revenue	6,824	5,787	1,037	5,839	985	7,146	6,309	837	6,074	1,072	
9,063	9,229	(166)	7,754	1,308	IDF Inflow	102,487	101,514	973	92,976	9,511	111,653	110,742	911	102,288	9,364	
1,462	303	1,159	483	980	Inter DHB Provider Revenue	12,037	3,334	8,704	4,011	8,026	12,947	3,637	9,311	4,507	8,441	
52,673	**52,572**	**100**	**50,755**	**1,918**	**Total Revenue**	**594,071**	**578,967**	**15,104**	**542,310**	**51,760**	**646,861**	**631,707**	**15,155**	**593,420**	**53,442**	1
					Expenditure											
					Employee Expenses											
4,956	5,119	163	5,117	161	Medical Employees	57,037	57,945	908	55,037	(2,000)	62,290	63,310	1,019	60,010	(2,281)	
5,798	6,167	370	6,410	612	Nursing Employees	66,786	70,306	3,520	68,814	2,028	72,977	76,767	3,789	75,339	2,361	
2,239	2,817	578	2,847	608	Allied Health Employees	26,402	31,624	5,221	29,354	2,951	28,930	34,575	5,645	32,175	3,245	
823	692	(131)	727	(96)	Support Employees	8,775	7,670	(1,106)	7,911	(864)	9,622	8,394	(1,227)	8,676	(945)	
2,155	2,483	329	2,391	236	Management and Admin Employees	24,721	28,240	3,519	25,745	1,024	27,037	30,842	3,805	28,166	1,130	
15,971	**17,279**	**1,308**	**17,492**	**1,522**	**Total Employee Expenses**	**183,722**	**195,784**	**12,062**	**186,861**	**3,139**	**200,856**	**213,888**	**13,031**	**204,366**	**3,510**	2
					Outsourced Personnel Expenses											
(878)	247	1,125	419	1,297	Medical Personnel	5,249	2,718	(2,530)	3,275	(1,974)	5,897	2,965	(2,932)	3,763	(2,135)	
21	91	70	211	190	Nursing Personnel	5,690	1,001	(4,688)	1,872	(3,818)	6,317	1,093	(5,225)	2,002	(4,315)	
7	87	81	92	85	Allied Health Personnel	4,052	962	(3,090)	508	(3,543)	4,578	1,049	(3,529)	583	(3,995)	
9	20	11	39	30	Support Personnel	436	224	(212)	467	31	456	244	(212)	522	65	
583	159	(424)	78	(505)	Management and Admin Personnel	6,068	1,601	(4,467)	1,536	(4,532)	6,741	1,765	(4,976)	1,671	(5,069)	
(258)	**605**	**863**	**839**	**1,097**	**Total Outsourced Personnel Expenses**	**21,494**	**6,506**	**(14,988)**	**7,657**	**(13,837)**	**23,990**	**7,116**	**(16,874)**	**8,541**	**(15,449)**	2
2,976	697	(2,279)	1,119	(1,857)	Outsourced Other Expenses	11,712	7,666	(4,046)	8,725	(2,987)	12,563	8,363	(4,200)	9,845	(2,718)	3
2,979	2,414	(565)	2,154	(825)	Treatment Related Costs	29,051	26,249	(2,802)	26,565	(2,486)	31,747	28,666	(3,081)	27,169	(4,578)	4
10,216	1,559	(8,657)	1,611	(8,605)	Non Treatment Related Costs	32,956	16,890	(16,066)	17,727	(15,229)	35,518	18,465	(17,053)	37,215	1,698	5
8,210	9,151	941	7,884	(326)	IDF Outflow	100,005	100,656	651	90,618	(9,386)	107,521	109,807	2,285	101,298	(6,223)	6
18,704	19,366	662	20,019	1,314	Other External Provider Costs	208,777	208,446	(331)	196,546	(12,231)	227,815	227,534	(281)	218,583	(9,232)	7
292	2,376	2,083	1,902	1,610	Interest, Depreciation & Capital Charge	21,682	26,141	4,459	22,828	1,145	23,785	28,517	4,731	25,186	1,400	8
59,090	**53,446**	**(5,644)**	**53,020**	**(6,070)**	**Total Expenditure**	**609,399**	**588,337**	**(21,062)**	**557,527**	**(51,871)**	**663,795**	**642,354**	**(21,441)**	**632,203**	**(31,592)**	
(6,417)	**(874)**	**(5,543)**	**(2,265)**	**(4,152)**	**Net Result**	**(15,328)**	**(9,370)**	**(5,958)**	**(15,217)**	**(111)**	**(16,934)**	**(10,647)**	**(6,286)**	**(38,784)**	**21,850**	
					Result by Output Class											
1,245	(471)	1,716	(1,098)	2,344	Funder	5,705	119	5,586	(1,640)	7,345	7,124	(9)	7,134	(7,889)	15,014	
175	33	142	115	60	Governance	1,044	288	755	545	499	1,031	310	720	634	397	
(7,837)	(437)	(7,401)	(1,282)	(6,556)	Provider	(22,077)	(9,777)	(12,300)	(14,122)	(7,955)	(25,088)	(10,948)	(14,140)	(31,528)	6,440	
(6,417)	**(874)**	**(5,542)**	**(2,265)**	**(4,151)**	**Net Result**	**(15,328)**	**(9,370)**	**(5,958)**	**(15,217)**	**(111)**	**(16,934)**	**(10,647)**	**(6,286)**	**(38,784)**	**21,850**	

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $15,104k
- Personnel and outsourced Personnel unfavourable ($2,930k)
  - Medical unfavourable ($1,623k); Nursing unfavourable ($1,169k); Allied Health favourable $2,132k, Support Staff unfavourable ($1,318k); Management and Admin unfavourable ($948k); Annual leave Liability cost has decreased by $433k since May 2020
- Outsourced other expenses unfavourable ($4,046k), includes reclassification of MAHIDS ($3,696k), Outsourced radiology and inpatient services
- Treatment related Costs unfavourable ($2,802k)
- Non Treatment Related Costs unfavourable ($16,066k), includes Holiday Act provision, RHIP write-off provision, charge of MHAIDS Non-clinical costs offset by revenue.
- IDF Outflow favourable $651k
- Other External Provider Costs unfavourable ($331k)
- Interest depreciation and capital charge favourable $4,459k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $100k for the month
  - Devolved MOH revenue ($38k) unfavourable, driven by a reduction in funding for capital charge offset by PHO and COVID-19 funding.
  - Non Devolved revenue ($1,029k) unfavourable driven largely deferral of revenue for current year for Breast Screening and COVID-19 funding for the Public Health Unit.
  - ACC Revenue $246k favourable.
  - Other revenue ($71k) unfavourable for the month driven by Patient Revenue, Food Sales, Donations and Bequests.
  - IDF inflows unfavourable ($166k) for the month, reflecting lower than expected volumes, and wash-up adjustments for the current year.
  - Inter DHB Revenue favourable $1,159k, reflecting the use of shared 2 & 3DHB services, including recoveries from CCDHB for Mental Health. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result -May 2021	Funder [1] (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1][3]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	4,487	157	897	5,541
Expenditure				
Employee Expenses				
Medical Employees		12	119	131
Nursing Employees		102	272	375
Allied Health Employees		20	316	336
Support Employees		50	0	50
Management and Admin Employees		63	77	140
Total Employee Expenses	**0**	**246**	**785**	**1,031**
Expenses				
Outsourced - Provider	0	0	0	0.0
External Providers - Funder [5]	5,935			5,935.0
Clinical Expenses - Provider	0	2	8	10.0
Non-clinical Expenses- Provider	0	229	104	333.1
Total Non Employee Expenses	**5,935**	**231**	**112**	**6,278.1**
Total Expenditure	**5,935**	**477**	**897**	**7,309**
Net Impact	**(1,448)**	**(320)**	**0**	**(1,768)**

(1) RPH COVID19 Funding now through MoH Contract - not Devolved Funding

(2) Includes funding via Whanganui DHB

(3) Excludes overhead charges

(4) Includes technology grant

(5) Includes Additional COVID-19 Community Pharmacy Payments

- The May year to date financial position includes $7.3m additional costs in relation to COVID-19.
- Revenue of $5.5m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $1.8m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($2,171k) for the month
  - Medical personnel incl. outsourced favourable $1,288k. Outsourced costs are $1,125k favourable due to a reclassification of MHAIDS recharge costs. Medical Staff Internal are $163k favourable, the MHAIDS restructure $255k.
  - Nursing incl. outsourced $440k favourable. Employee costs are $370k favourable, driven by the 3DHB MHAIDS Restructure $557k, offset by the recognition of penal payments related to public holidays and the uses of Bureau Nurses to cover for Annual Leave taken.
  - Allied Health incl. outsourced $659k favourable, with outsourced favourable $81k and internal employees favourable $578k. Employee costs are driven by the 3DHB MHAIDS Restructure $448k, the balance is mostly due to vacancies.
  - Support incl. outsourced unfavourable ($120k), with Outsourced $11k favourable, and employee costs ($131k) unfavourable, driven by Security ($21k), Cleaners ($20k), Sterile Supply Assistants ($25k), Orderlies ($29k) and Tradesmen & Maintenance supervisors ($44k).
  - Management & Admin incl. outsourced unfavourable ($95k) internal staff favourable $329k, outsourced unfavourable ($424k). This reflects the transition to 2DHB services for ITS and MHAIDS.
  - Sick leave for May was 3.2%, which is higher than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	May-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
280	287	7	314	34	Medical	279	287	8	293	14	287	294
760	828	68	853	93	Nursing	764	829	65	814	50	829	818
349	418	69	439	90	Allied Health	352	417	65	400	48	417	402
151	137	(14)	150	(2)	Support	147	137	(10)	143	(4)	137	143
316	388	71	387	71	Management & Administration	321	388	66	364	42	388	365
1,858	**2,058**	**201**	**2,143**	**285**	**Total FTE**	**1,864**	**2,058**	**194**	**2,014**	**150**	**2,058**	**2,023**
					$ per FTE							
17,671	17,821	150	16,297	(1,374)	Medical	204,243	201,773	(2,470)	187,630	(16,613)	216,896	215,094
7,630	7,449	(181)	7,517	(114)	Nursing	87,375	84,784	(2,590)	84,501	(2,874)	88,018	93,878
6,408	6,738	331	6,479	72	Allied Health	75,017	75,845	828	73,400	(1,617)	69,368	85,962
5,434	5,042	(391)	4,861	(572)	Support	59,723	55,906	(3,818)	55,460	(4,263)	70,136	58,552
6,810	6,402	(408)	6,177	(633)	Management & Administration	76,911	72,815	(4,096)	70,768	(6,143)	69,712	84,428
8,598	**8,395**	**(203)**	**8,163**	**(434)**	**Average Cost per FTE all Staff**	**98,567**	**95,116**	**(3,451)**	**92,779**	**(5,788)**	**97,580**	**105,731**

Medical under budget for the month by 7 FTE, driven by the MHAIDS restructure 13FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 1FTE, offset by RMO's & House Officers combined.

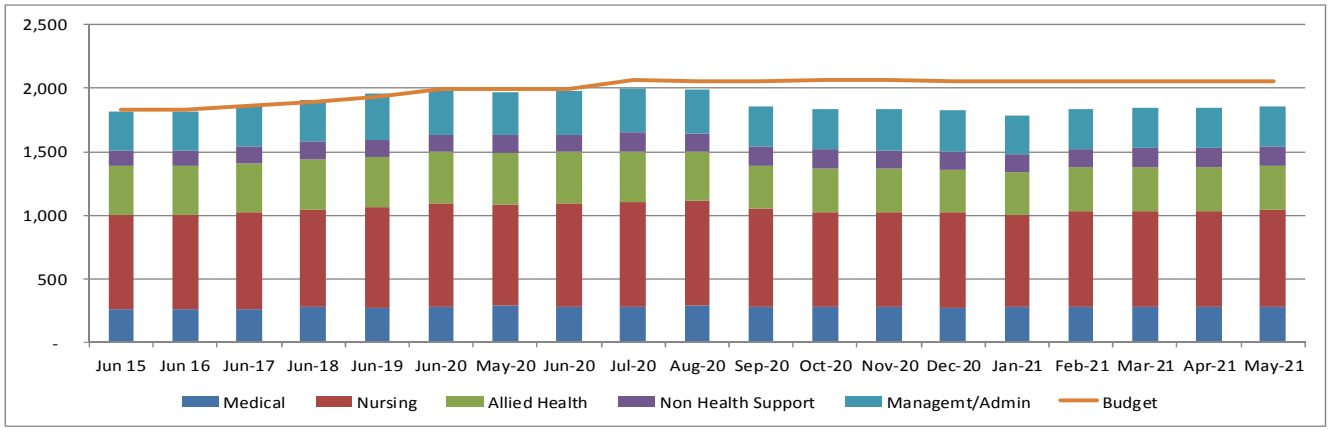
Nursing under by 68 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (22) FTE mostly driven by General Surgery (3) FTE, General Medical (6) FTE, Maternity (4), ED (3FTE) and other variances. This is offset by Midwives 24 FTE. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

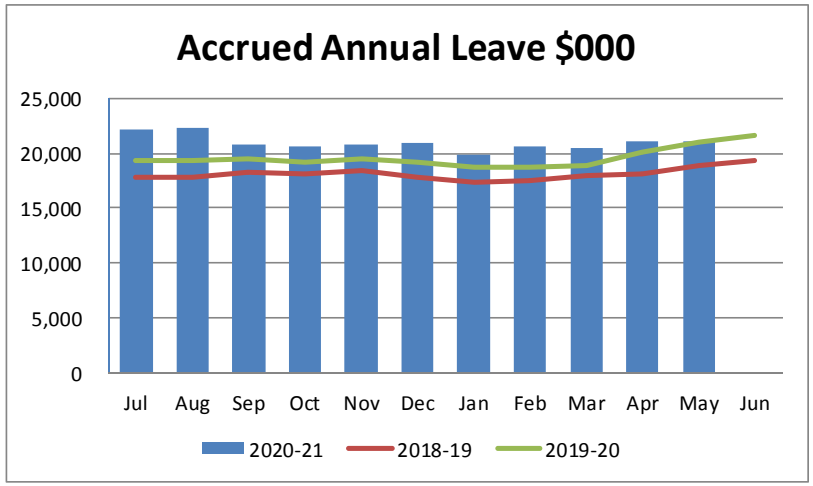
Allied FTEs are under by 69 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in community support workers 4 FTE, Health promotion 3 FTE, Other Allied Health 3 FTE.

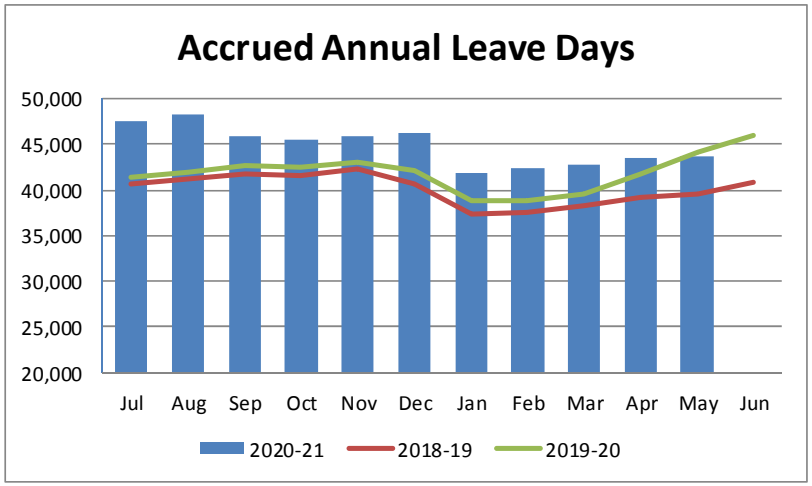
Support FTEs are (14) FTEs over budget driven by CSSD (3) FTE, Cleaning (3) FTE, Property services (2) FTE and Orderlies (7) FTE, offset by other variances.

Management & Admin are under budget by 71 FTEs driven by the MHAIDS & ITS Restructures 40 FTE.
Excluding MHAIDS and ITS changes favourable variance of 29FTE, other variances include; Executive Office 5 FTE, Project Management 3 FTE, SPO 9 FTE, Quality 3 FTE, Chief operating officer 2 FTE, Surgical Women's & Children's 3 FTE, Regional Public Health 3 FTE and Regional Screening 6 FTE.

FTE Analysis







The movement in Annual Leave Liability is driven by the MHAIDS & ITS restructures. The combined impact of this on Accrued Annual Leave 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 unfavourable ($2,279k) for the month, due to increase outsourcing of surgical and radiology ($546k) and MHAIDS ($1,819k).
  - Treatment related costs ($565k) unfavourable for the month, Pharmaceuticals ($561k) of which ($376k) reflects the update to the Hospital Rebate, Blood Supplies ($50k), Patient Appliances ($53k), Implants and Prostheses ($53k).
  - Non Treatment Related costs unfavourable ($8,605k) including Write off of RHIP ($6,520k) ($4,794k) this month for CP balance transferred from depreciation line. provision for Holidays Act Settlement ($227k) which is not budgeted as advised by MoH, Security ($46k) related mainly to COVID-19, Consultancy ($141k), non-Capital Software upgrades ($26k) , MHAIDS recoveries adjustment ($2,236k) which has an offset in Outsourced Personnel and Inter DHB income, and other minor variances. Excluding MHAIDS the movement was ($5,079k).
  - IDF Outflows $941k favourable for the month, driven by lower than expected volumes and wash-ups.
  - Other External Provider costs favourable $662k, driven largely Pharmacy and other HoP.
  - Interest, Depreciation & Capital Charge favourable $2,083k, change of classification RHIP write off now included in Non-Treatment Related Costs $1,726k and a decrease in Capital Charge for the month.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 May 2021

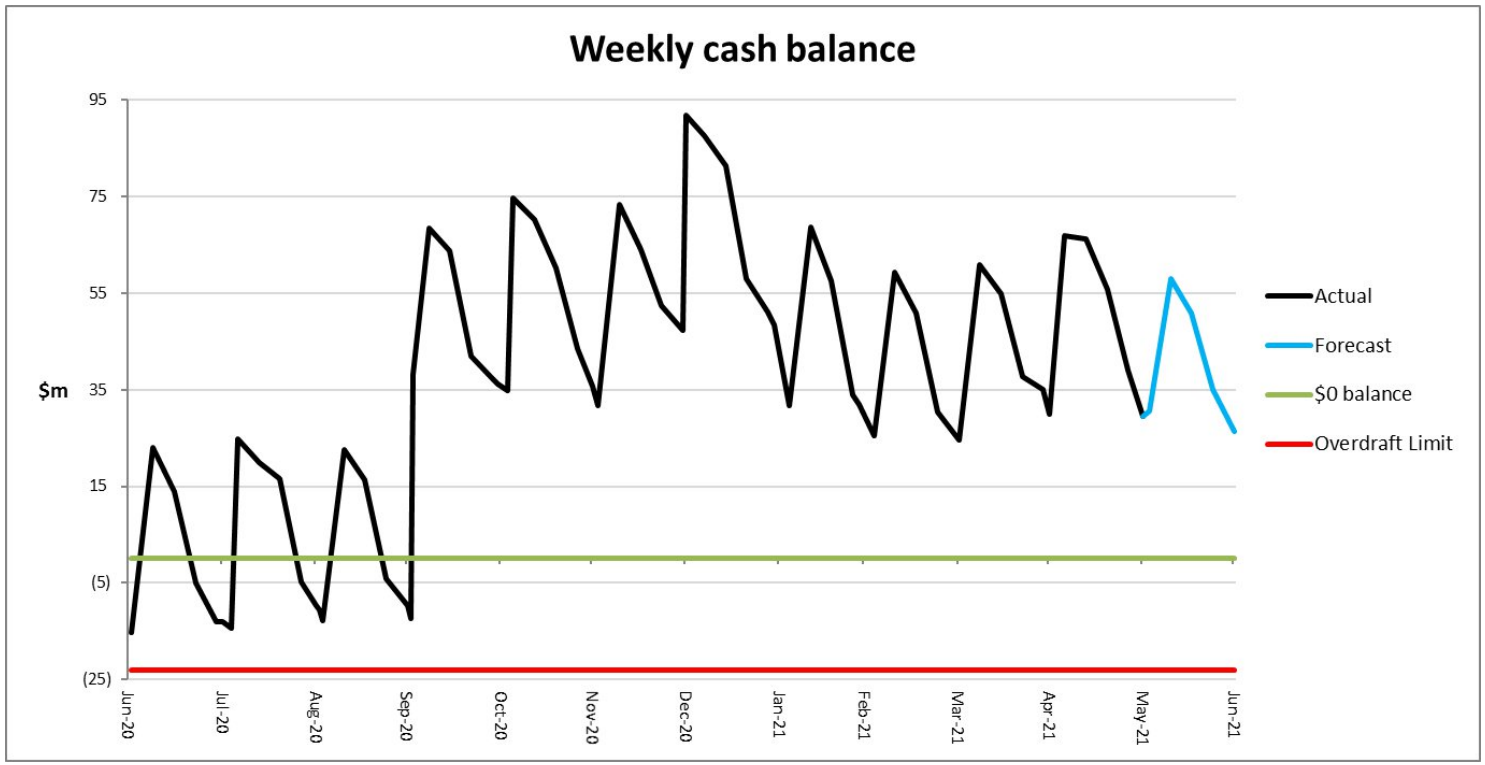
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	29,382	(5,204)	34,586	(10,986)	40,368	Average bank balance in May-21 was $51.0m ($35m equity injection received Oct-20)
Bank - Non DHB Funds *	5,831	4,927	904	4,927	904	
Accounts Receivable & Accrued Revenue	23,031	27,577	(4,546)	27,577	(4,546)	
Stock	2,614	2,200	414	2,199	415	
Prepayments	1,161	815	346	815	346	
Total Current Assets	**62,018**	**30,315**	**31,704**	**24,532**	**37,486**	
Fixed Assets						
Fixed Assets	224,840	263,595	(38,756)	229,790	(4,951)	
Work in Progress	7,905	8,201	(297)	14,001	(6,097)	
Total Fixed Assets	**232,744**	**271,797**	**(39,053)**	**243,791**	**(11,047)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,264	1,347	(82)	1,347	(82)	
Total Investments	**2,414**	**2,497**	**(82)**	**2,497**	**(82)**	
Total Assets	**297,177**	**304,608**	**(7,431)**	**270,820**	**26,357**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	73,873	60,064	(13,809)	73,615	(258)	Includes Holidays Act Provision of $30.0m
Crown Loans and Other Loans	3	42	38	42	38	
Capital Charge Payable	4,001	0	(4,001)	0	(4,001)	
Current Employee Provisions	28,199	26,018	(2,181)	26,518	(1,681)	
Total Current Liabilities	**106,076**	**86,124**	**(19,953)**	**100,175**	**(5,902)**	
Non Current Liabilities						
Other Loans	178	180	2	178	0	
Long Term Employee Provisions	8,972	8,972	0	8,972	0	
Non DHB Liabilities	5,831	4,927	(904)	4,927	(904)	
Trust Funds	1,226	1,347	121	1,347	121	
Total Non Current Liabilities	**16,207**	**15,426**	**(781)**	**15,424**	**(783)**	
Total Liabilities	**122,283**	**101,549**	**(20,734)**	**115,598**	**(6,685)**	
Net Assets	**174,894**	**203,059**	**(28,165)**	**155,222**	**19,672**	
Equity						
Crown Equity	158,916	181,123	(22,207)	123,916	35,000	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,982)	(0)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(15,328)	(9,370)	(5,958)	(38,784)	23,456	
Total Equity	**174,894**	**203,059**	**(28,165)**	**155,222**	**19,672**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 May 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	42,820	40,032	89,077	(1,303)	40,009	43,917	44,747	40,307	41,760
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	18,597	8,010	13,752	6,345	9,493	10,593	10,646	9,000	10,076
Receipts from Other Government Sources	721	778	753	770	863	669	501	579	880	608	902	750
Other Revenue	1,833	1,581	(2,392)	1,408	(60)	(202)	3,478	63	(4,494)	1,709	4,950	180
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**48,845**	**103,296**	**9,021**	**50,144**	**50,897**	**57,711**	**55,158**	**52,766**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,779)	(20,161)	(18,805)	(18,034)	(20,320)	(18,855)	(15,126)	(19,630)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(3,394)	1,140	(6,009)	(12,721)	(10,312)	(2,523)	(11,788)	(6,108)
Capital Charge Paid	0	0	0	0	0	0	0	(3,868)	0	0	0	(4,613)
GST Movement	(710)	75	230	1,030	(1,535)	1,310	2,098	(4,899)	1,241	507	(915)	3,350
Payment to Own DHB Provider	0	(0)	(0)	(0)	120	30	30	(180)	(0)	(0)	(0)	(0)
Payment to Own DHB Governance & Funding Admin	0	0	0	0	(120)	(30)	(30)	180	0	0	0	0
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(10,119)	(9,151)	(9,151)	(9,222)	(9,137)	(9,151)	(9,244)	(8,070)	(7,517)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,353)	(16,794)	(19,316)	(19,336)	(17,311)	(19,101)	(21,389)	(19,324)	(19,038)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(48,652)**	**(46,177)**	**(51,274)**	**(65,970)**	**(57,642)**	**(51,504)**	**(55,222)**	**(53,557)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**193**	**57,119**	**(42,253)**	**(15,826)**	**(6,745)**	**6,206**	**(64)**	**(791)**
Investing Activities												
Interest Receipts	0	0	0	28	35	39	44	27	26	29	32	21
Dividends	0	0	0	0	0	0	0	0	0	0	0	4
Total Receipts	**0**	**0**	**0**	**28**	**35**	**39**	**44**	**27**	**26**	**29**	**32**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(595)	(1,028)	(1,226)	(567)	(604)	(870)	(631)	(1,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	(15)	(48)	17	(8)	(11)	(38)	73	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(610)**	**(1,076)**	**(1,208)**	**(575)**	**(616)**	**(907)**	**(559)**	**(1,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(575)**	**(1,038)**	**(1,164)**	**(548)**	**(590)**	**(878)**	**(526)**	**(1,748)**
Financing Activities												
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**35,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(0)	(3)	(0)	0	(0)	0	(0)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**0**	**(0)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**0**	**(0)**	**(5)**
Total Cash In	53,100	54,861	51,678	98,624	48,880	103,335	9,065	50,171	50,923	57,740	55,191	52,791
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(49,262)	(47,256)	(52,482)	(66,544)	(58,258)	(52,412)	(55,781)	(55,335)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	35,691	91,770	48,352	31,979	24,644	29,972	29,382
Net Cash Movements	(2,150)	3,523	(60)	45,746	(382)	56,079	(43,417)	(16,374)	(7,335)	5,328	(590)	(2,544)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**35,691**	**91,770**	**48,352**	**31,979**	**24,644**	**29,972**	**29,382**	**26,837**

Weekly Cash Flow – Actual to 31 May 2021



Note

- the overdraft facility shown in red is set at $23 million as at May 2021
- the lowest bank balance for the month of May was $28.8m

Summary of Leases – as at 31 May 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses (*Lease renewal currently in negotiation)		1,149	13,787		1/11/2017	31/10/2020*	Operating
Public Trust House Lower Hutt	Community Mental Health		23,915	286,976		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		2,573	30,879		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		575	6,897		16/06/2020	16/05/2023	Operating
CBD Towers Upper Hutt	Community Mental Health		9,854	118,247		8/06/2015	7/06/2021	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			54,651	**655,796**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
			542	**6,500**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (120 Vehicles)			36,896	442,755		Ongoing	Ongoing	Operating
Custom Fleet (Nissan Leaf electrical vehicle)			579	6,948		1/10/2020	1/06/2024	Operating
			37,475	**449,703**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost R90	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90 (Room 2)	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90 (Room 1)	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Mobile Diagnost R2 (Resus)	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	28/01/2026	Operating
3 x Carestream Mobile X-ray Units	De Lage Landen (paid monthly in arrears)		9,960	119,517	597,586	27/04/2021	27/04/2026	Operating
2x Digital Diagnost C90 (Room 3 & Room 4)	De Lage Landen (paid monthly in arrears)		11,552	138,623	693,114	13/05/2021	13/05/2026	Operating
		293,188	**131,412**	**1,576,974**	**6,668,212**			
Total Leases			**224,080**	**2,688,974**				

Treasury as at 31 May 2021

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$51,028	$51,234
Lowest balance for the month	$29,361	$29,967
Average interest rate	0.74%	0.69%
Net interest earned/(charged) for the month	$32	$29

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	$16,039 NZD
Largest transaction	$12,276 NZD

	No. of transactions	Equivalent NZD
AUD	4	$16,039
GBP		
SGD		
USD		
Total	**4**	$16,039

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	$4,292	$514	$244	$252	$92	$283	$211	$2,696
Accident Compensation Corporation	$879	$672	($88)	($12)	($36)	$1	$76	$266
Wairarapa District Health Board	$476	$38	$109	$0	$132	$0	$0	$196
Ministry of Health	$385	$322	$9	$37	$8	$13	$18	($22)
ESR Limited	$122	$122	$0	$0	$0	$0	$0	$0
Auckland District Health Board	$75	$0	$68	$0	$26	$0	$7	($27)
Non Resident	$54	$0	$0	$0	$0	$0	$0	$54
Non Resident	$40	$0	$0	$0	$0	$8	$0	$33
WellNZ Limited	$29	$5	$19	$0	($0)	$0	$0	$5
Non Resident	$28	$0	$0	$0	$0	$0	$1	$27
Total Top 10 Debtors	**$6,379**	**$1,673**	**$363**	**$277**	**$221**	**$304**	**$312**	**$3,229**

Board Information - Public

4 August 2021

Capital & Coast DHB Financial and Operational Performance Report – May 2021

Action Required

The Capital & Coast DHB Board note:

(a) The DHB had a ($0.73m) deficit for the month of May 2021, being $4.3m favourable to budget before excluding COVID-19 and Holidays Act;

(b) The DHB year to date had a deficit of ($42.4m), being ($6.8m) unfavourable to budget before excluding COVID-19 and Holidays Act;

(c) In the eleven months we have incurred $5.4m additional net expenditure for COVID-19 and $7.7m against provision for Holidays Act;

(d) This means that the DHB has an overall YTD deficit of ($29.3m) from normal operations (excluding COVID-19 and Holidays Act) being $6.3m favourable to our underlying budget.

Strategic Alignment	Financial Sustainability
Authors	Rosalie Percival, Chief Financial Officer Joy Farley, Director of Provider Services Rachel Haggerty, Director Strategy Planning & Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board and FRAC in relation to the financial performance and delivery against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS, Director Strategy Planning & Performance

Executive Summary

There is ongoing significant cost due to the COVID response into the 20/21 fiscal year. Uncertainty remains around how much of the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the eleven months to 31 May 2021 is $29.3m deficit, versus a budget deficit of $35.7m.

Additional net COVID related expenditure above funding, year to date is $5.4m.

The monthly provision for increasing Holidays Act liability is $958k and year to date the impact on the result is $7.7m

For the eleven months to 31 May 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $42.4m deficit.

The DHB has submitted an Annual baseline budget of $39.8 million deficit, with a two year path to breakeven and the Annual Plan for 2020/21 has now been signed.

Capital Expenditure including equity funded capital projects was $58.4m year to date.

We had a negative cash Balance at month-end of $49.8 million offset by positive "Special Funds" of $13.6 million (net $36.2 million). It should be noted that there is a significant amount of the COVID response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than was budgeted for this point in time however the equity injection of $39.8m signalled in the 2021/22 Annual Plan will be requested for the last quarter of the year.

Activity remained high over ED attendances and both discharges and caseweights for all services. Our winter bed plan is being implemented the focus being to manage across our acute pathways and ensure continuation of planned care. We continue with two projects to increase capacity in a more sustainable way. Front of Whare and 2D Bed & Theatre Capacity are projects to identify and deliver solutions for implementation over the coming two years.

Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients; theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. Filling anaesthetist shortages will contribute to this.

Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely wisth our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. Local options include use of all maternity services and beds across the region exploring different geographical patient flows.

Our colonoscopy programme is showing improvements in all areas, achieving compliance in 2 of the 3 targets. While the results are encouraging, we will be unable to maintain the same level of performance in the next 3-4 months as a result of RN resignations. This will have a significant impact on the number of lists we can staff until we are able to recruit and train new staff. We are working with private providers to outsource some procedures, to try and maintain the gains made.

The provider arm remains within budget YTD outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave continues to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 173 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($29.3m) deficit from normal operations, against our DHB budget of ($35.7m). An additional ($5.4m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($7.7m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A	Financial outturn	Rosalie Percival, Chief Financial Officer	Currently on track but will be impacted by current events	Major (but no payment impacts)	Major (no operational impacts)

Attachment/s

3.1.1 Capital & Coast DHB Financial and Operational Performance Report – May 2021

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 May 2021

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID response into the 20/21 fiscal year. Uncertainty remains around how much of the DHB COVID response costs will be funded in 20/21. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

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Executive Summary continued

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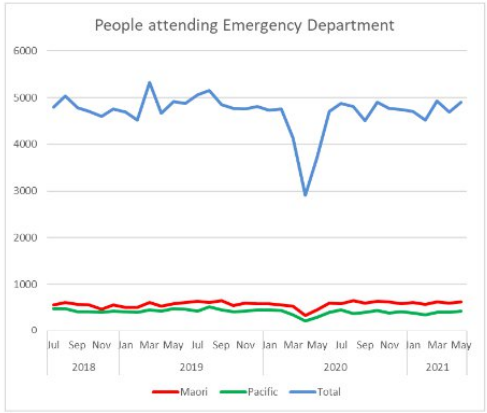
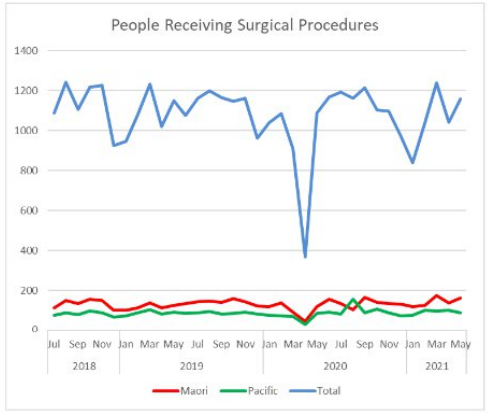
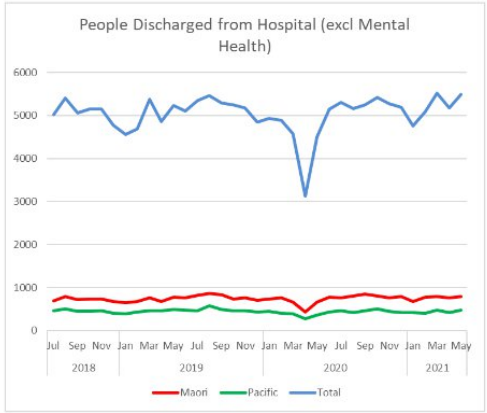
Performance Overview: Activity Context (People Served)

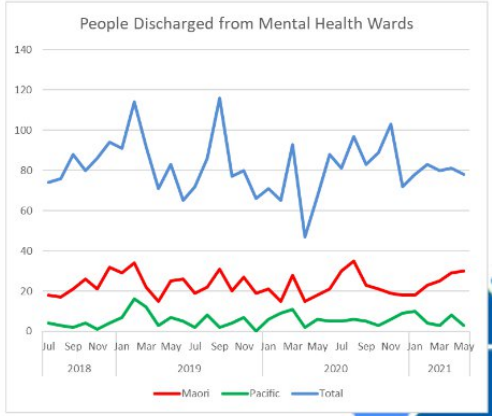
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,904**	599 Maori, 431 Pacific
People receiving Surgical Procedures (in main theatres)	**1,161**	161 Maori, 86 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,494**	791 Maori, 485 Pacific
People discharged from Mental Health Wards	**81**	29 Maori, 8 Pacific



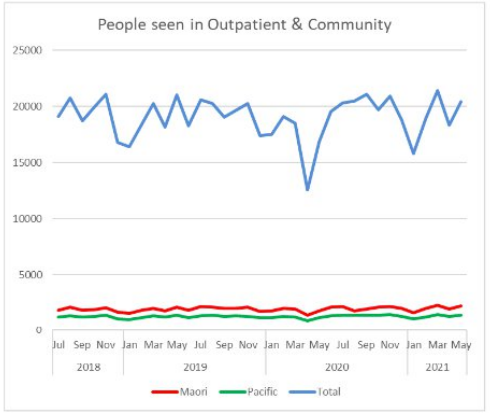


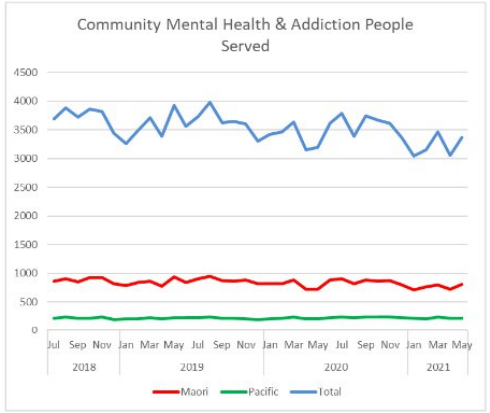


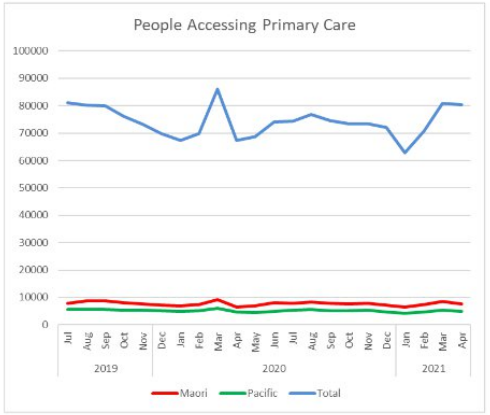


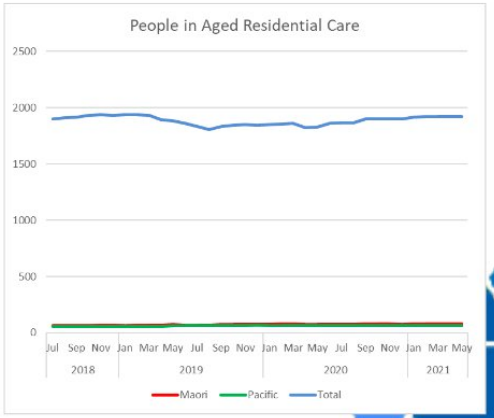
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**20,408**	2,227 Maori, 1,420 Pacific
Community Mental Health & Addiction People Served	**3,368**	712 Maori, 216 Pacific
People accessing primary care	**80,475**	7,684 Maori, 4,958 Pacific
People in Aged Residential Care	**1,921**	77 Maori, 62 Pacific









Financial Overview – May 2021

YTD Operating Position

$42.4m deficit

Incl. $5.4m COVID-19 costs
Incl. $7.7m Holidays Act

Against a budgeted YTD deficit of $35.7m. BAU Month result was $7.6m unfavourable. YTD $6.3m Favourable BAU variance.

YTD Provider Position

$52.8m deficit

Incl. $5.4m COVID-19 costs
Incl. $7.7m Holidays Act

Against a budgeted deficit of $43.8m. BAU Month result was $4.4m unfavourable. BAU YTD $4.2m favourable variance.

YTD Funder Position

$9.6m surplus

Incl. $12.6m COVID-19 costs

Against a budgeted Surplus of $8.1m. BAU Month result was $871k Favourable result. YTD $ 1.4m favourable BAU variance.

YTD Capital Exp

$58.4m spend

Incl. $33.1m strategic capex

Against a KPI of a budgeted baseline (non-strategic) spend of $60.1m.
Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)

1.64% ahead[1]

1071 CWDs ahead PVS plan (-83 IDF CWDs , but 263 Hutt ahead). Month result +321 CWDs excluding work in progress.

YTD Paid FTE

5,638[3]

YTD 173 above annual budget of 5,432 FTE (budget excludes lead DHB). There is 600 FTE vacancies at end May inclusive of lead DHB transfers.

Annual Leave Taken

($10.1m) annualised[4]

Underlying YTD annual leave taken is under by 3.7 days per FTE and Lieu leave taken for public holidays is short by 2.9 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 2349 cwd outsourced (1352 events) ~$13m 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 – May 2021

*Surgery, Hospital flow, Cancer, Specialist Medicine & community

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
28.2%	353	211**	5
33.4% below the ED target of 95% Monthly +3.5%	Against a target of zero long waits a monthly movement of -170	Against a target of zero long waits, a monthly movement of -33 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
1.64% ahead[1]	3,680[3]	$5,989*
1071 CWDs ahead PVS plan (-83 IDF CWDs , but 263 Hutt ahead). Month result +321 CWDs excluding work in progress.	YTD 30 above annual budget of 3,650 FTE. 274 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (8% above).*to Apr 2021

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 2349 cwd outsourced (1352 events) ~$13m 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

- Overall the funder has a YTD favourable variance of $1.7m. Revenue is $24.7m ahead of budget most of which is mainly due to CCDHB having additional COVID accrued and paid revenue of $25.5m. This includes additional revenue for Pharmaceuticals to offset the effect of COVID in the unstable international market. The offsetting COVID costs are ($24.8m). Recovery of all costs remains the subject of negotiations with MoH agreeing a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance continues. Vaccination rollout started in March 2021. A funding recovery model has been received from MoH and the DHBs are working with the PHOs, Pharmacies and Aged Care Facilities to rollout the programme. Revenue includes historical costs incurred to make the hospital COVID ready which the Ministry has agreed to fund.
- An revenue amount of ($2.7m) was held back and not paid to the Provider Arm due to under achievement of the IDF targets at YTD May 2021. Reduced revenue from the Ministry of ($3.6m) for capital charge costs offsets a reduced cost in the Provider Arm.
- Funding for community services are ($6.2m) unfavourable with Pharmaceuticals being ($6.8m) over budget. Of this overspend ($4.9m) is an unplanned budget saving that will not be achieved. The year end position will reflect the impact of COVID related costs. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also underspent reflecting the impact of COVID.
- There remains risk in the loss of inter-district flow revenue, planned care for the provider arm and pharmaceutical costs in a post-covid environment. All of these elements are being closely managed.
- The COVID Vaccine programme is progressing well and in line with MoH targets. There is a strong focus on equity for Māori and for our Pacific and Disability communities and coverage of these populations is improving.
- 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:
    - The number of specialist mental health and addiction interventions that are culturally specific have reduced since 2018/19.
    - Overtime, more people presenting to ED for mental health reasons are seen by a mental health nurse within an hour. This has increased to over 20% for all ethnicities since 2018/19. As part of the Acute Care Continuum project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity to contribute to achieving the 30% target.
    - We are working to improve access to mental health services so that they are responsive to the needs of our communities. CCDHB are establishing a Kaupapa Maori Forensic Step Down 6-bed service and investment in the primary mental health including Tū Ora's development of Piki Services and the Access and Choice. We are still waiting for MoH decisions on investing in kaupapa Maori and Pacific programmes. These decisions were due at the end of 2020.
    - The proportion of 10-24 year olds enrolled in primary care is relatively high for all groups; 95% for Māori, 103% for Pacific, and 91% for non-Māori, non-Pacific alongside increased use of primary care. ED presentation rates for youth has increased in 2021.
    - CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care including the YOSS in Porirua; the four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds and Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.
    - There is significant level of detail on acute flow on following slides. Reflecting the growing demand; displacement of planned care and the positive impact of the prototypes in improving early intervention in our community.

Funder Financial Statement of Performance

Month					Capital & Coast DHB Funder Result - $000 May 2021	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	801,735	801,735	749,519	0	52,216
4,294	4,665	10,220	(371)	(5,926)	Other MOH Revenue - Funder	51,565	51,314	66,933	251	(15,368)
7,723	0	0	7,723	7,723	COVID Revenue from MOH	25,498	0	0	25,498	25,498
68	45	53	22	14	Other Revenue	1,365	498	769	867	596
2,937	2,936	2,743	1	194	IDF Inflows PHOs	33,129	32,294	30,862	835	2,267
19,128	18,517	16,020	611	3,108	IDF Inflows 20/21 Wash-up Prov	200,945	203,682	185,811	(2,737)	15,135
107,035	**99,048**	**97,175**	**7,987**	**9,859**	**Total Revenue**	**1,114,238**	**1,089,524**	**1,033,893**	**24,714**	**80,344**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	9,060	9,060	10,539	0	1,479
48,000	53,684	48,943	5,684	942	DHB Provider Arm Internal Costs - HHS	564,868	576,270	527,481	11,402	(37,388)
7,767	7,752	7,423	(16)	(345)	DHB Provider Arm Internal Costs - MH	85,442	85,267	82,015	(175)	(3,427)
8,964	1,942	2,433	(7,022)	(6,531)	DHB Provider Arm Internal costs - Corp	28,205	21,648	31,909	(6,557)	3,704
6,304	0	0	(6,304)	(6,304)	DHB Provider Arm Internal costs - COVID	9,154	0	0	(9,154)	(9,154)
71,860	**64,201**	**59,756**	**(7,659)**	**(12,104)**	**Total Internal Provider**	**696,729**	**692,245**	**651,944**	**(4,484)**	**(44,785)**
					External Provider Payments:					
4,923	5,703	5,348	780	425	- Pharmaceuticals	69,530	62,731	64,881	(6,799)	(4,650)
6,737	6,645	6,498	(92)	(239)	- Capitation	73,767	73,097	70,476	(669)	(3,291)
7,077	7,354	6,868	278	(208)	- Aged Care and Health of Older Persons	79,115	80,899	76,857	1,783	(2,258)
2,283	2,862	2,637	579	354	- Mental Health	31,958	31,482	27,846	(476)	(4,112)
794	807	743	13	(51)	- Child, Youth, Families	9,324	8,878	7,827	(446)	(1,497)
1,277	958	1,051	(319)	(226)	- Demand driven Primary Services	6,957	7,511	7,483	554	526
1,710	2,356	2,165	646	455	- Other services	25,574	25,920	24,725	346	(849)
3,727	3,725	3,294	(1)	(433)	- IDF Outflows Patients to other DHBs	40,993	40,979	38,272	(15)	(2,721)
5,253	5,240	4,944	(13)	(309)	- IDF Outflows Other	58,137	57,640	54,639	(497)	(3,499)
33,779	**35,651**	**33,548**	**1,872**	**(231)**	**Total External Providers**	**395,355**	**389,137**	**373,004**	**(6,218)**	**(22,351)**
525	0	3,335	(525)	2,811	- COVID in Community PHO, Pharms, ARC	12,601	0	7,256	(12,601)	(5,345)
106,164	**99,853**	**96,640**	**(6,312)**	**(12,335)**	**Total Expenditure**	**1,104,685**	**1,081,383**	**1,032,204**	**(23,303)**	**(72,481)**
871	**(805)**	**536**	**1,676**	**335**	**Net Result**	**9,553**	**8,141**	**1,690**	**1,411**	**7,863**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 Community funding	1,333	12,954
COVID-19 Pharmaceuticals	(327)	3,139
COVID-19 HHS, MIQ and Vaccine rollout	6,717	9,406
PHOs volume change funding	(72)	1,725
Mental Health, Aged Care, Family CFAs	54	3,856
CWD IDF 2020/21 below target	611	(2,737)
Capital Charge reduced funding	(330)	(3,629)
Year to Date Revenue Variances	**7,987**	**24,714**

External Revenue Variances

- COVID-19 actual funding and accrued provision of $25.5m YTD in support of GP assessment testing, pharmaceutical costs, vaccine rollout, quarantine hotel staffing & response funding for Maori and Pacific groups. This also now includes Ministry funding for historical HHS costs for conversion to a COVID ready hospital. Cost offsets currently exceed paid funding. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for all COVID community, MIQ and Vaccine rollout costs.

- PHO additional wash-ups and volume funding of $1.7m. There are increased costs of ($1.4m) offsetting this revenue. New funding for Mental Health and Child & Youth services of $3.8m has been contracted to NGO Providers.

Internal Revenue Variances

- Provision for reduced 20/21 IDF wash up revenue is ($2.7m) due to Provider Arm not achieving the targets set. The ministry reduced the capital charge funding due to a reduction in the interest rate charged. YTD reduction is ($3.6m).

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 Community funding	(525)	(12,601)
Pharms increased volumes incl COVID	1,227	(1,884)
Pharms savings not achieved	(447)	(4,915)
COVID-19 HHS, MIQ & Vaccine rollout	(6,717)	(9,406)
PHOs volume variances offset	(154)	(1,407)
Other Community NGOs	586	545
Provider IDF below target	(611)	2,737
Capital Charge reduced funding	330	3,629
Year to Date Payment Variances	**(6,312)**	**(23,303)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs ($22m) mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by the Ministry.
- Pharmaceuticals costs have been impacted by COVID-19 with increasing costs and fees unfavourable to budget by ($1.8m). The DHB has received additional COVID funding which offsets this cost pressure. The DHB had budgeted for pharmaceutical savings in 2020/21 pre COVID. Budgeted YTD savings of ($4.9m) have not been achieved.
- PHO Capitation expenses are ($1.4m) unfavourable. Additional costs due to volume changes are offset by additional revenue. Effect is expected to be neutral at year end.
- Other Community NGO contracts have a net YTD variance of $545k. New funded NGO contracts offset lower volume trends due to COVID in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- An amount of $2.7m, was not paid to the Provider Arm due to under achievement of targets at YTD May 2021. Reduced capital charge funding of $3.6m as per the Ministry has been passed through to Provider.

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD May 2021 $000's
Inpatient CWD	(460)
Outpatient Non DRG	(381)
PCT Pharms	(1,691)
PHO Volume changes	741
Other IDF Inflows	(110)
Total per Financials	**(1,901)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($1.9m) YTD, a ($600k) decrease to last month. Breakdown of the variance commented below:

- Inpatient Case weight IDF inflows are unfavourable by ($1.4k) which is driven by lower elective IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: $659k: Cardiology ($1.6m), followed by Gen Med ($836k), Neurosurgery ($789k), Vascular Surgery (742k) and Oncology ($740k) Offset by MICU $2.1m, Cardiothoracic $1.4m (with significant outsource earlier in the year), Neurology $1.2m, Maternity $580k
  - Planned Care: ($1.1m); Vascular $1.1m, followed by Cardiology $771k & Paediatric $508k offset by Cardiothoracic ($2.6m), Orthopaedic ($561k) Neurosurgery ($550k)& General Surgery ($366k)
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PCT Pharms under target inflow is offset by a equivalent reduction in Pharmaceutical expenditure causing a nil impact on the bottom line
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry

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

Commissioning: Families & Wellbeing

What is this measure?

Youth health and wellbeing

- Percentage of youth (10-24 year olds) enrolled in a PHO
- Percentage of youth (10-24 year olds) who have used primary care services
- Youth (10-24 year olds) ED presentation rate per 1,000 population

Why is this important?

- Compared to other age groups, young people are less likely to be enrolled in a PHO and have access to core primary care services to maintain their health wellbeing. Some benefits associated with belonging to a PHO, include cheaper doctors' visits and reduced costs of prescription medicines.
- Compared to other age groups, young people are also less likely to be engaged with primary care services and more likely to present to ED for reasons that could be managed in a primary care setting.

How are we performing?

- The proportion of 10-24 year olds enrolled in primary care is relatively high for all groups; 95% for Māori, 103% for Pacific, and 91% for non-Māori, non-Pacific.
- Primary care utilisation has increased for youth in 2021. Utilisation for Māori (20%) and Pacific (14%) youth is lower than Non- Māori, non-Pacific (21%).
- ED presentation rates for youth have increased in 2021. Māori (59 per 1,000) and Pacific (48 per 1,000) youth have a higher presentation rate than Non- Māori, non-Pacific (43 per 1,000).

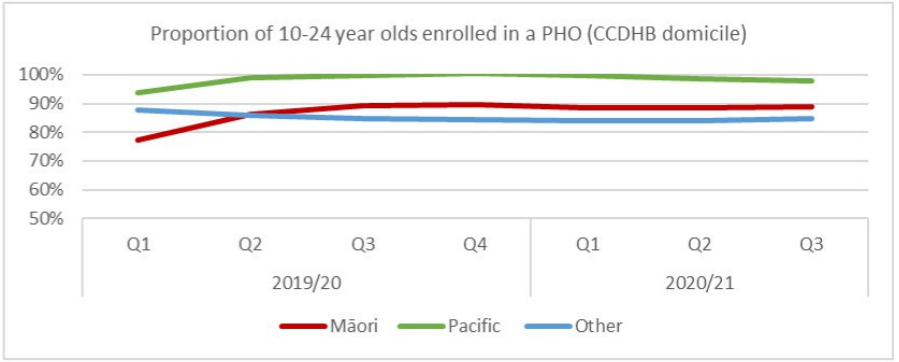
What is driving performance?

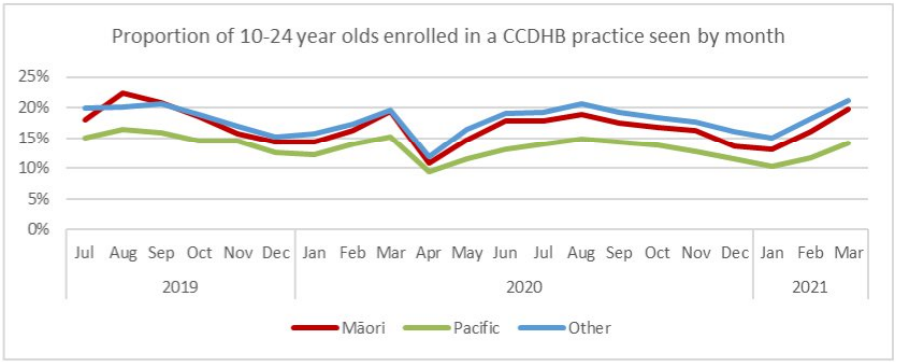
- Young people require a unique mix of social and health services which traditional and mainstream primary care services are not always best equipped to respond to.

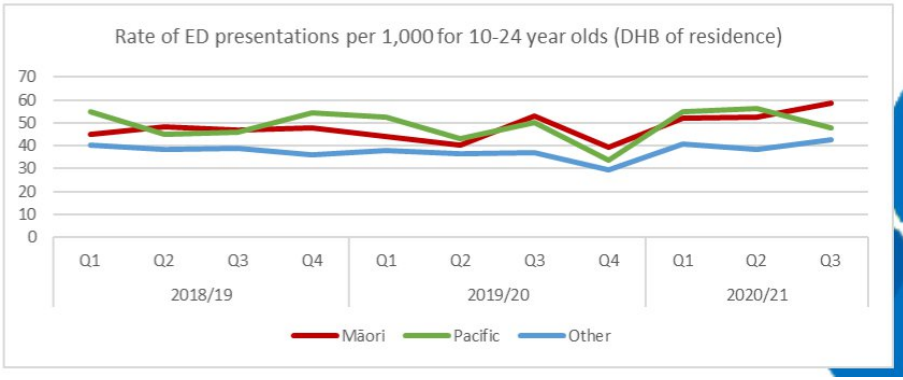
Management comment

CCDHB is progressing a range of initiatives that provide more choice and options for young people to engage in primary care. These include:

- Youth one stop shop (YOSS) for Rangatahi in Porirua with Te Runanga o Toa Rangatira.
- The four YOSS providers across the 2DHBs were successful in a Youth Mental Health RFP for 12-18 year olds.
- Tū Ora Compass Health have rolled out a new SXT app in sexual health services to enable young people to anonymously contact their sexual partners when diagnosed with an STI.







Primary care presentations are stable:

- There has been no change in primary care capacity in CCDHB. Between January and March 2021, there were almost 360,000 visits to a primary care doctor or nurse.

The total number of people visiting Wellington ED is decreasing over time:

- Presentations to Wellington ED are decreasing for all ethnicities except Māori presenting (driven by adults).
- The decrease is driven by decreasing presentations for the 0-15 years age group.
- Presentations to ED for all other age groups are stable or increasing over time.
- Increasing presentations by adults is accompanied by an increase in the average time spent in ED.
- The increase in waiting time in Wellington ED has coincided with an more people not waiting for treatment.

People who are presenting to ED are higher acuity.

- There are more triage 1, 2 and 3 presentations and fewer triage 4 and 5 presentations.
- Triage 1 and 2 presentations now comprise 15% of presentations.
- With increasing acuity in ED, there are more adults being acutely admitted for medical and surgical events.
- The proportion of people admitted acutely to Wellington Hospital is significantly increasing.
- Acute admissions are increasing for all ethnicities and specialties.

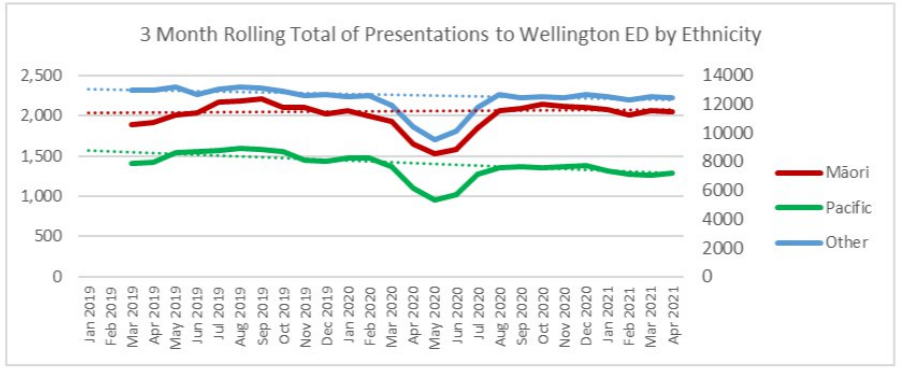
Note: Graphs for the commentary below are on the next page

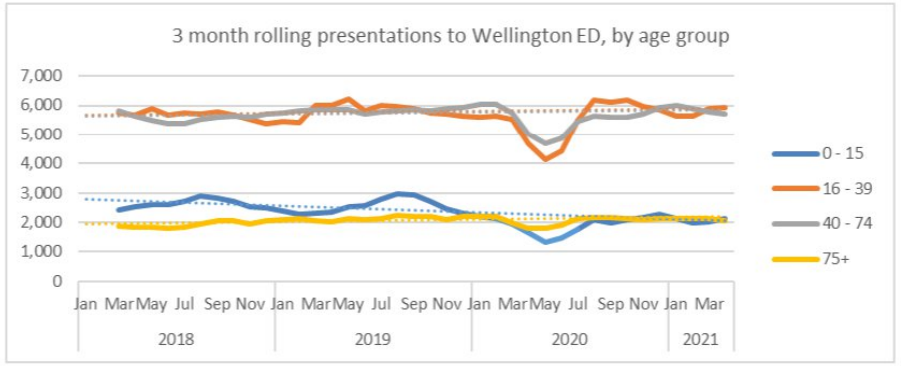
Surgical admissions from Emergency Departments are increasing for Wellington ED:

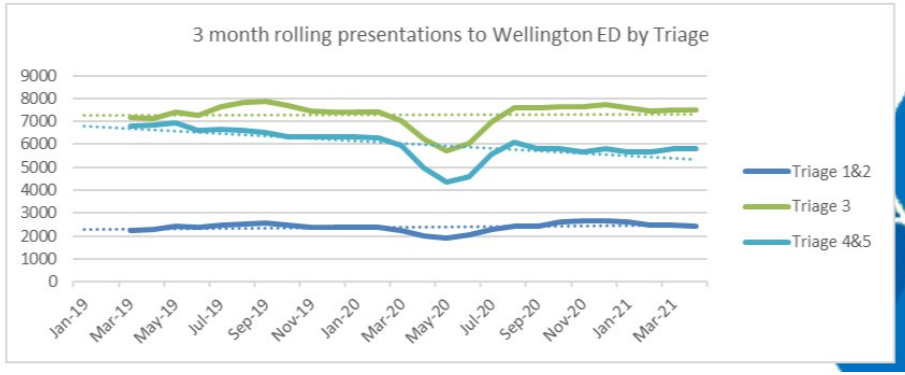
- More people are being admitted to ED under surgical specialities.
- Increasing acute surgical admissions increases requirements for ward beds as the average length of stay (ALOS) is highest for acute surgical patients (~3.5 days) compared to planned surgical patients (~2.0 days).
- The increase in acute surgical presentations also displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced specialties are in General Surgery and Orthopaedics The example provided is for General Surgery.

The increased acute surgical activity is impacting planned surgery provision:

- More people are waiting longer than four months for surgical treatment than in March-April 2020.
- In Budget 2020 the Government made available investment for DHBs to recover waiting lists impacted by the COVID-19 Level 4 lockdown. CCDHB requested to focus our $4.2million service delivery investment in areas of greatest need, increasing demand, inequities and historical performance.
- The 2DHBs are focused on addressing our bed and theatre capacity to ensure access to planned care and surgical treatment is maintained in 2021 and beyond.







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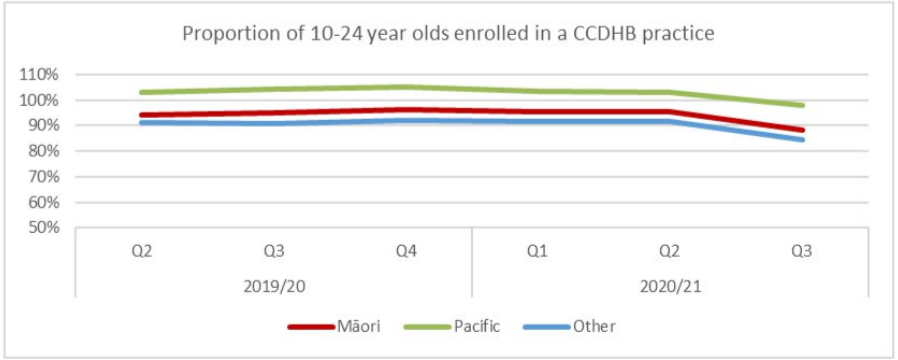
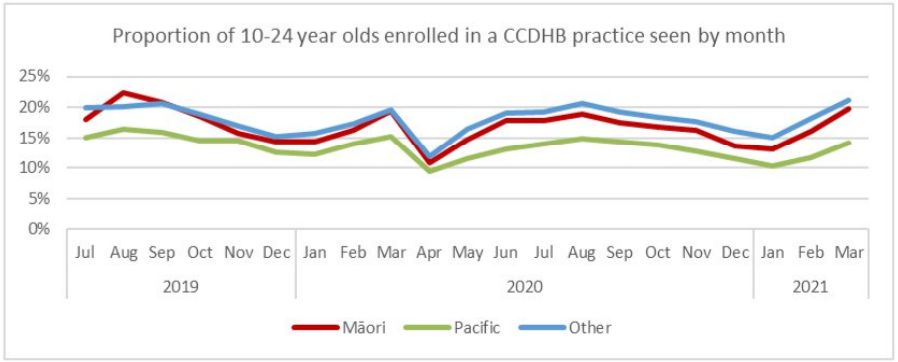
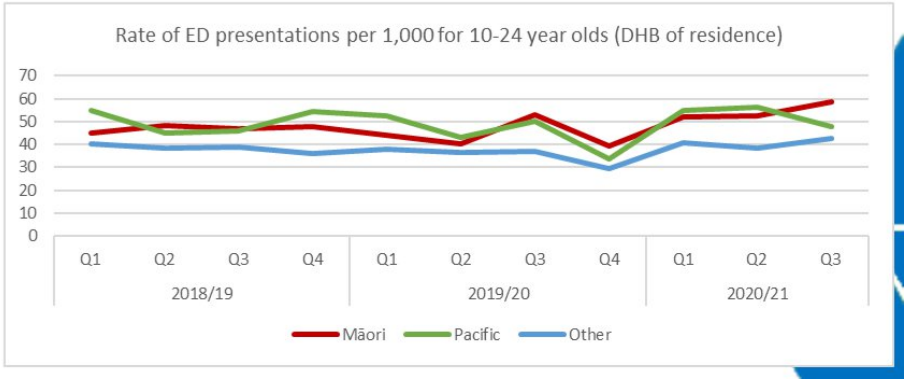






Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

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

Why is this important?

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

How are we performing?

- The proportion of the HVDHB 75+ year old population who live at home is relatively stable and over 90% for all ethnicities.
- The current acute bed day rate for 75+ year olds is highest for Pacific (2,031) and Māori (1,999) compared to Non- Māori, non-Pacific (1,608). Acute bed day rates have been decreasing since 2018/19.
- The 28 day readmission rate for 75+ year olds accessing care at CCDHB facilities is highest for Pacific (11.5%) and Māori (11.2%), compared to non-Māori, non-Pacific (10.2%).

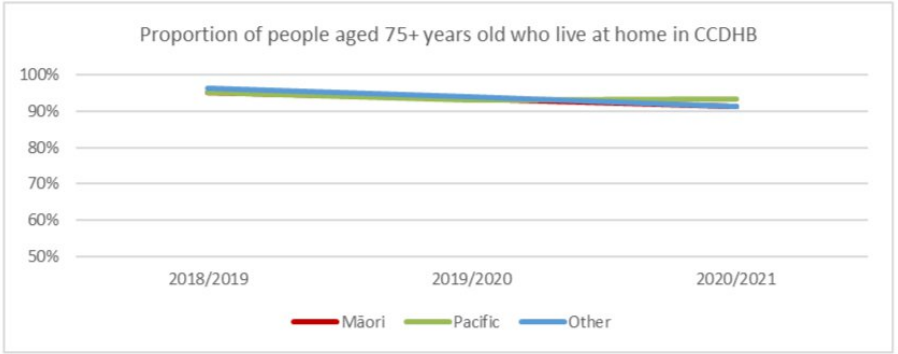
What is driving performance?

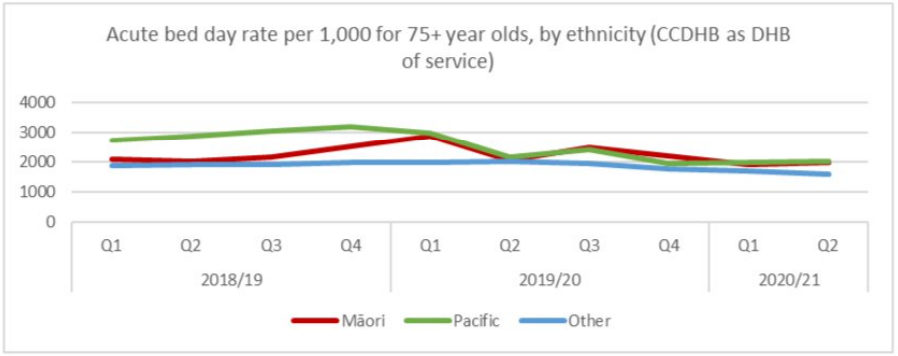
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

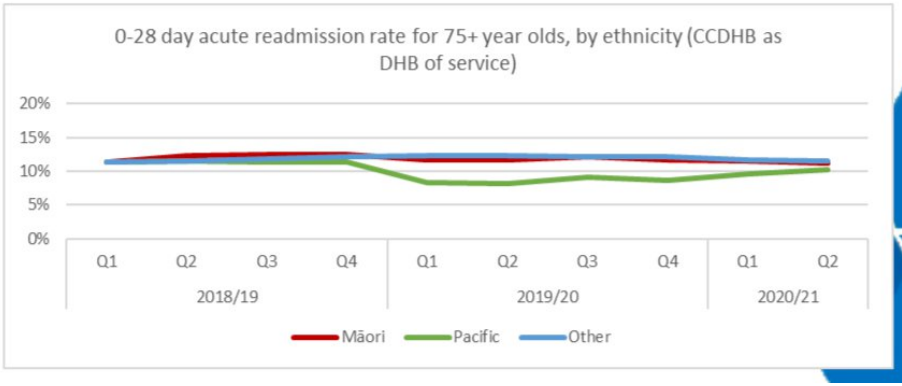
Management Comment

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

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







Commissioning: Hospital & Speciality Services

What is this measure?
- Acute flow at Wellington Regional Hospital

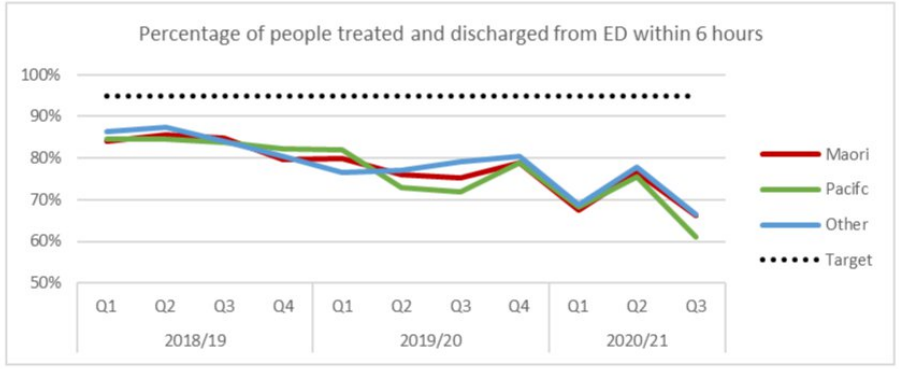
Why is this important?
- Recently, there has been increased attention and discussion about acute demand and presentations to hospital Emergency Departments across New Zealand. Addressing capacity constraints and mitigating rising acute demand is important for making sure that people receive appropriate and timely access to acute care with equitable health outcomes.
- At the request of the Ministers of Health and Director General Health, the Ministry of Health is developing a programme of work around acute demand. This work takes a whole sector perspective and includes community, primary care and hospital services. CCDHB and HVDHB are supporting the Ministry of Health deliver this programme and providing analytics and insights.

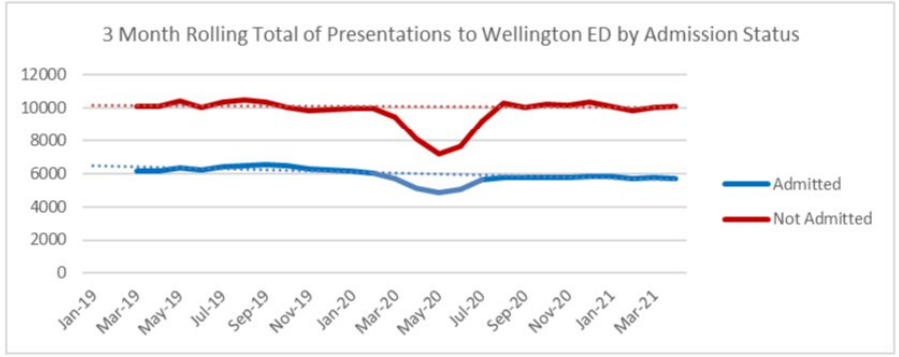
What do we mean by acute flow?
- **Acute care** is urgent or unplanned health care that a person receives for an illness or injury. It is usually time-sensitive, and can result in death or long-term disability if the person does not receive the care they need in a timely manner.
- **Acute flow** at an individual level describes the journey a person takes through our health system to receive care for their urgent or unplanned event. **Acute flow** at a system level describes the flow of all acute patients through our health system.
- **Acute demand** measures how many people require acute care in a particular period of time.

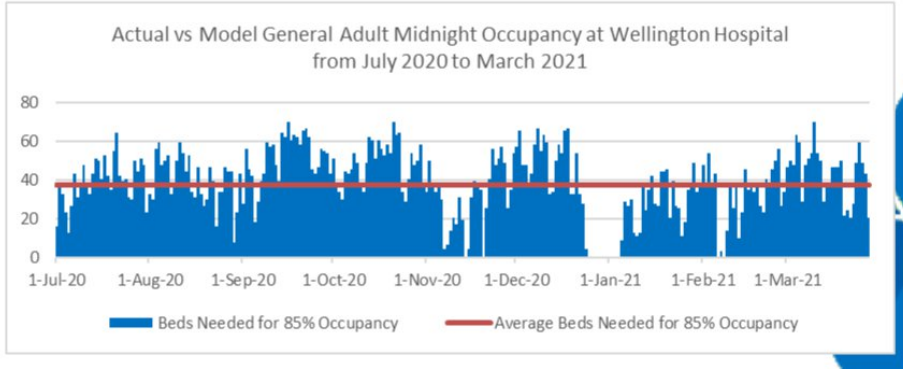
How are we performing?
- Our performance against the Shorter Stays in Emergency Departments measure is decreasing. The target is 95% of people are seen, treated and discharged from ED within 6 hours. Our performance was 80% in Q4 of 2019/20 and is currently 66% as at Q3 2021. This means people are waiting longer in ED to be admitted to hospital. A consequence of this is people who do not require admission to hospital are also waiting longer. Overall, more people are waiting in ED for longer

What is driving performance?

Overall, our performance is driven by the current capacity constraints across our 2DHB Hospital Network:
- The average general adult bed deficit is 37 at Wellington Regional Hospital in 2020/21.
- We have analysed our data across our 2DHB Hospital Network and have identified a number of demographic and clinical drivers that are impacting acute flow and acute demand across our health system.







Primary care presentations are stable:

- There has been no change in primary care capacity in CCDHB. Between January and March 2021, there were almost 360,000 visits to a primary care doctor or nurse.

The total number of people visiting Wellington ED is decreasing over time:

- Presentations to Wellington ED are decreasing for all ethnicities except Māori presenting.
- The decrease is driven by decreasing presentations for the 0-15 years age group.
- Presentations to ED for all other age groups are stable or increasing over time.
- Increasing presentations by adults is accompanied by an increase in the average time spent in ED.
- The increase in waiting time in Wellington ED has coincided with an more people not waiting for treatment.

People who are presenting to ED are higher acuity.

- There are more triage 1, 2 and 3 presentations and fewer triage 4 and 5 presentations.
- Triage 1 and 2 presentations now comprise 15% of presentations.
- With increasing acuity in ED, there are more adults being acutely admitted for medical and surgical events.
- The proportion of people admitted acutely to Wellington Hospital is significantly increasing.
- Acute admissions are increasing for all ethnicities and specialties.

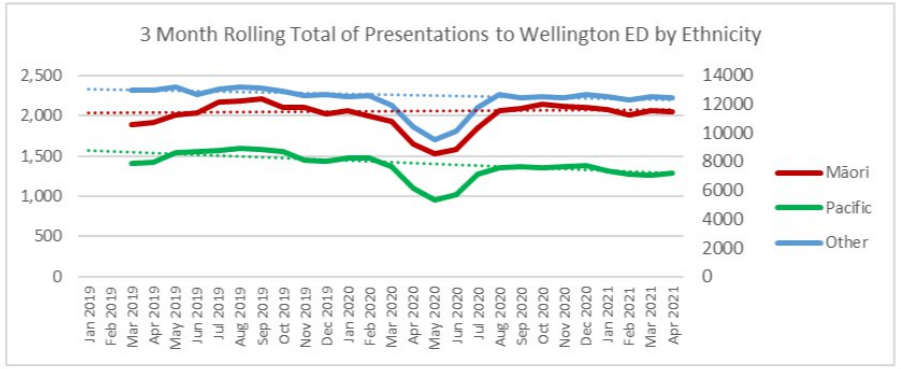
Note: Graphs for the commentary below are on the next page

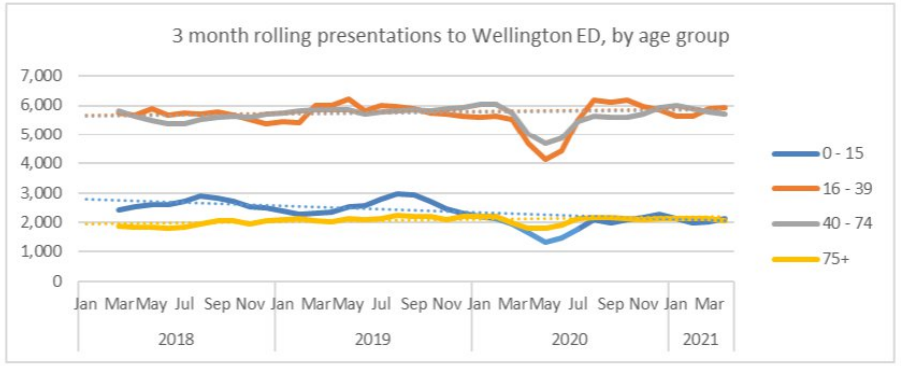
Surgical admissions from Emergency Departments are increasing for Wellington ED:

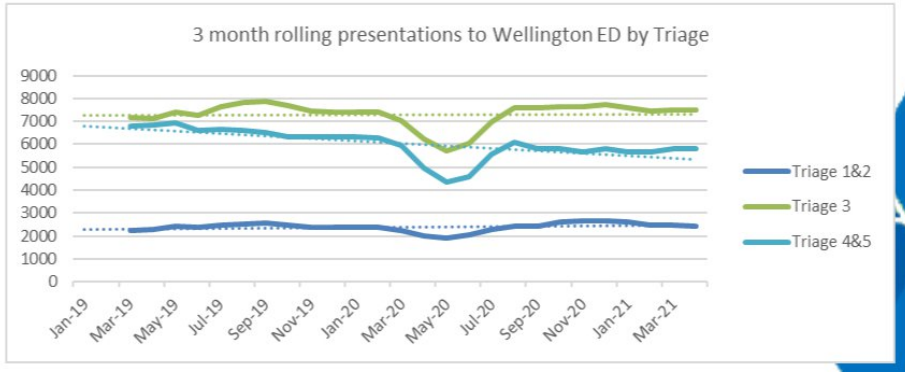
- More people are being admitted to ED under surgical specialities.
- Increasing acute surgical admissions increases the requirements for ward beds as the average length of stay (ALOS) is highest for acute surgical patients.
- The increase in acute surgical presentations also displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced specialties are in General Surgery and Orthopaedics The example provided is for General Surgery.

The increased acute surgical activity is impacting planned surgery provision:

- More people are waiting longer than four months for surgical treatment than in March-April 2020.
- In Budget 2020 the Government made available investment for DHBs to recover waiting lists impacted by the COVID-19 Level 4 lockdown. CCDHB requested to focus our $4.2million service delivery investment in areas of greatest need, increasing demand, inequities and historical performance.
- The 2DHBs are focused on addressing our bed and theatre capacity to ensure access to planned care and surgical treatment is maintained in 2021 and beyond.







Note: Commentary for the graphs on this page are on the prior page

We have invested across our health system to reduce acute demand:

- **Kāpiti CARS** aims to reduce travel to Wellington ED and reduce the potential for hospital admission for Kāpiti residents. In the two years since it has been operating, Kāpiti CARS has diverted 402 people from Wellington ED to primary care with an 88% success rate.
- **CHOPI** uses the skills of nurse practitioners and pharmacists along with speciality advice from geriatricians in partnership with general practice to work with frail older people in community settings and avoid hospital admissions. It is currently piloted in two Wellington practices.
- **AHOP** is effective at moving older people with frailty through ED faster. Although AHOP patients have a slightly longer average length of stay in hospital, they are less likely to be readmitted.
- **AWHI** works to reduce the functional decline of patients. It optimises the use of our allied health workforce, demonstrates material improvements in outcomes for patients and is showing savings.

These investments have reduced acute demand, however our acute flow is still under pressure

We are investing to address capacity constraints across our 2DHB Hospital Network in 2020/21:

Destravis has been engaged to provide options on the best use of facilities across HVDHB and CCDHB in the 2DHB Hospital Network in the medium to long term.

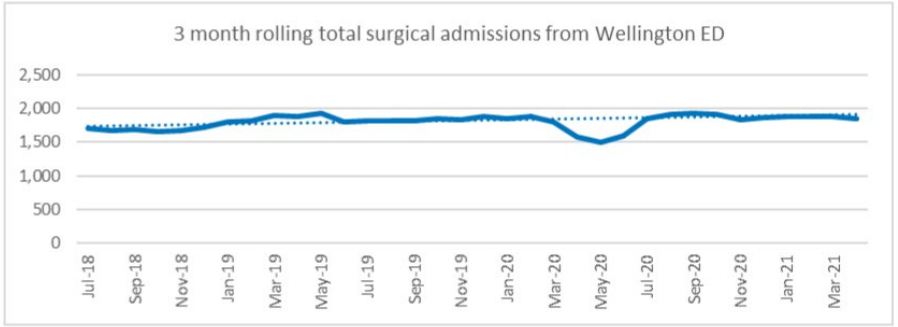
We are investing in redesigning the front doors of our hospitals to ensure smoother flow of people receiving care through the system, and making most effective use of resources by delivering the appropriate level of care in the lowest cost setting (cost being time & travel for patients and cost of delivering care).

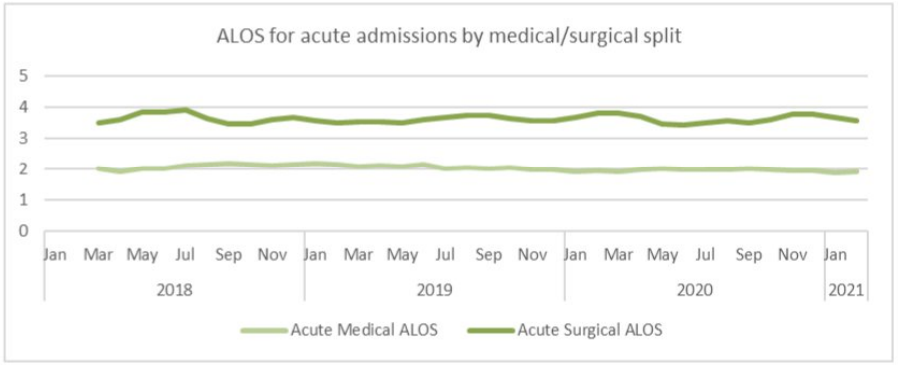
In response to capacity constraints we are undertaking the following projects:

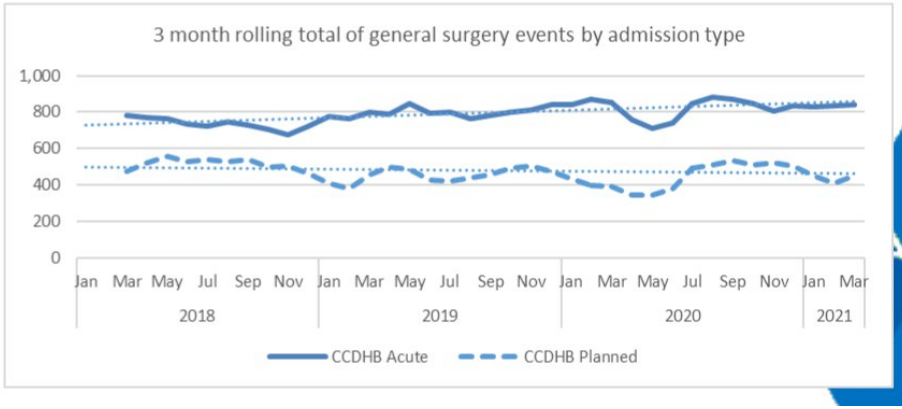
- **Bed & Theatre capacity** – identifying options for increasing theatre and bed capacity across our three hospitals within the next two years while optimising use of current capacity
- **Front of Whare** – identifying options for increasing capacity and flow through Wellington ED and acute assessment areas

A range of strategies underway to manage acute demand in both community and hospital settings:

- **Winter Planning:** During winter there is normally an increase in acute medical demand. CCDHB is planning to fund inpatient capacity with the provision of additional beds and physical spaces, and fund improved patient flow.
- **Community Investments:** Subject to finalising budget 2021/22, we are Investing in our communities to deliver more care closer to home







Commissioning: Mental Health & Addictions

What is this measure?

- Number of specialist NGO and MHAIDS cultural interventions for Māori and Pacific
- Number of primary mental health and addiction interventions for Māori and Pacific
- ≥30% of mental health presentations to ED seen by an ED mental health nurse within an hour

Why is this important?

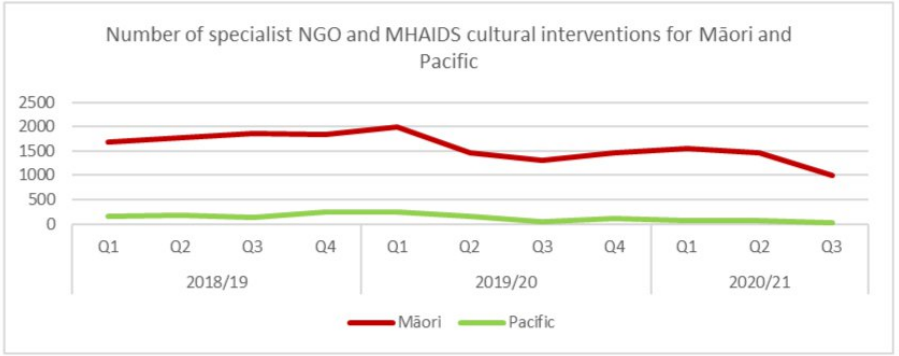
- In order to provide a pro-equity system of care, providers need to deliver solutions that are designed with people in mind. One such service is culturally specific interventions which are found throughout MHAIDS and NGO specialist services.
- Primary mental health and addiction services aim to provide timely care for people closer to home. Investment in this area will address people with lower levels of acuity earlier on.
- Emergency departments are under-equipped to resolve mental health presentations in a timely manner. The extensive wait times for mental health consultations often results in increasing distress and readmissions.

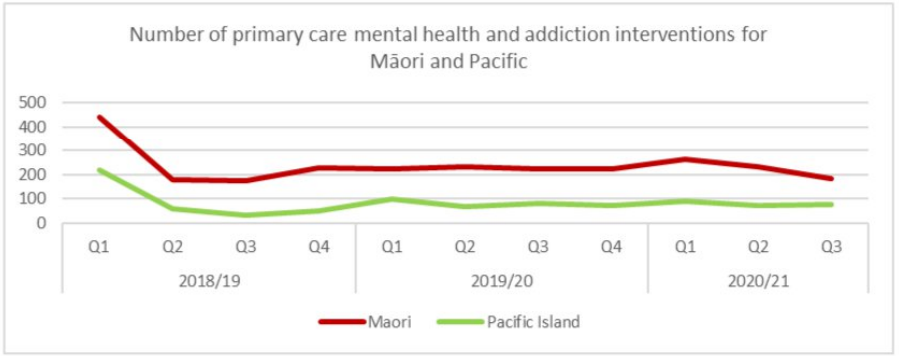
How are we performing?

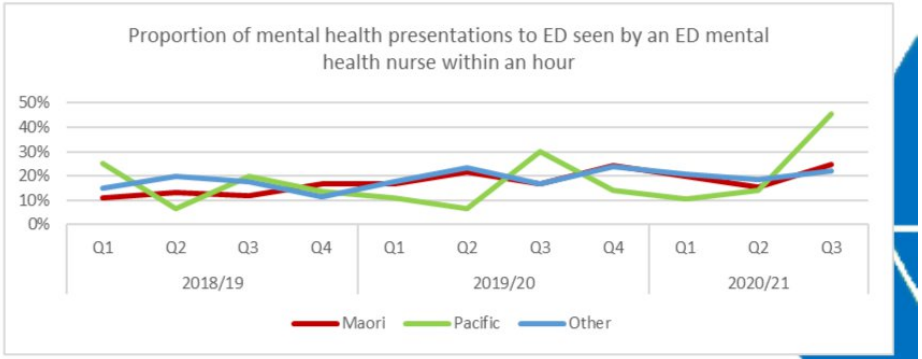
- The number of specialist mental health and addiction interventions that are culturally specific have reduced since 2018/19.
- The number of primary mental health and addiction interventions has been relatively stable since 2018/19.
- Overtime, more people presenting to ED for mental health reasons are seen by a mental health nurse within an hour. This has increased to over 20% for all ethnicities since 2018/19. Our target is ≥30% of presentations seen by an ED MH Nurse within 1 hour

Management comment

- We are working to improve access to mental health services so that they are responsive to the needs of our communities. In CCDHB, we are establishing a **Kaupapa Maori Forensic Step Down** 6-bed service.
- Investment in the primary care space is an integral part of our system development plan. Investments like Tū Ora's development of **Piki Services** and the **Access and Choice** service aim to equip primary care services with the tools they need to address mental health and addiction needs earlier on.
- As part of the **Acute Care Continuum** project, there will be an increase in mental health nurse FTE in Emergency Departments and an increase in Crisis Respite capacity. The intent of this is to reduce wait times for those requiring mental health assessment by offering earlier access through improved capability in ED and alternative locations for known clients (ACC CR).
- We are still waiting for MoH decisions on investing in kaupapa Maori and Pacific programmes. These decisions were due at the end of 2020.







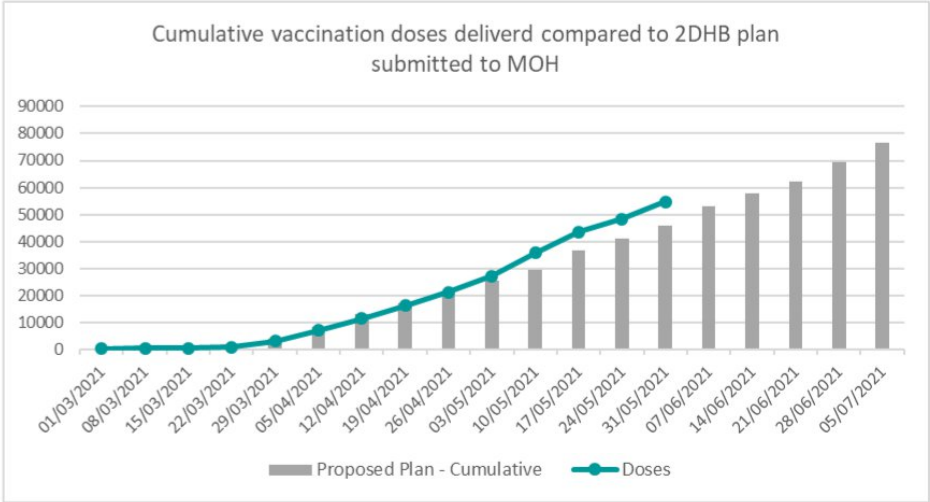
2DHB COVID-19 Response

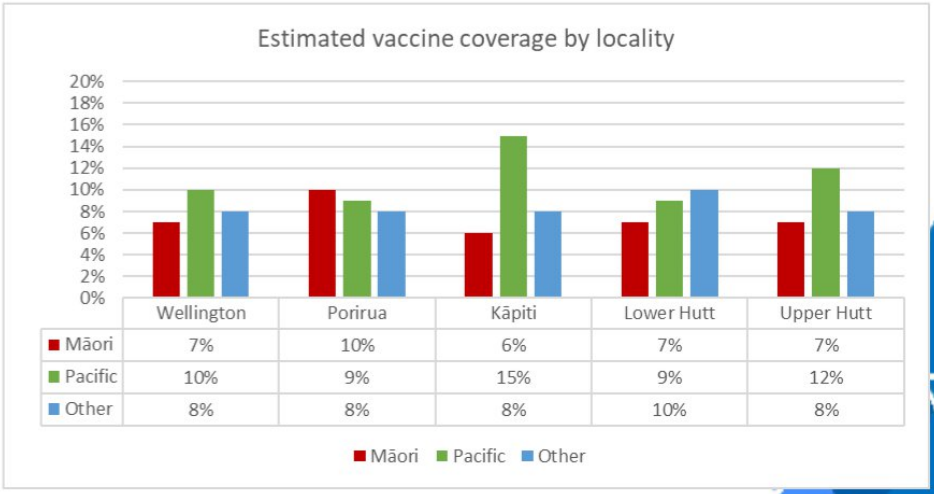
What is this measure?
- Vaccination roll-out

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

How are we performing?
- **Group 1:** Border, MIFQ workers and people they live with
- **Group 2:** Frontline health workforce interacting with patients and supporting in high-risk places, residential care workers, emergency response services
- **Group 3:** people with elevated risk, including people who are 65 years or older, people with underlying conditions, disabled people, people in custodial settings
- **Group 4:** general rollout (including early vaccine access)

2DHB group	Dose 1	Dose 2
Group 1	3,729	2,821
Group 2	21,998	15,978
Group 3	3,653	508
Group 4	3,887	2,037
CCDHB total	21,701	14,800
HVDHB total	11,681	6,594





Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 30/05/2021
Data current at: 31/05/2021 @11:00am

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- Activity remained high over ED attendances and both discharges and caseweights for all services. Our winter bed plan is being implemented the focus being to manage across our acute pathways and ensure continuation of planned care. We continue with two projects to increase capacity in a more sustainable way. Front of Whare and 2D Bed & Theatre Capacity are projects to identify and deliver solutions for implementation over the coming two years.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients; theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. Filling anaesthetist shortages will contribute to this.
- We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- Our Maternity Units across the region continue to struggle with midwifery vacancies and high occupancies - 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. Local options include use of all maternity services and beds across the region exploring different geographical patient flows.
- Our colonoscopy programme is showing improvements in all areas, achieving compliance in 2 of the 3 targets. While the results are encouraging, we will be unable to maintain the same level of performance in the next 3-4 months as a result of RN resignations. This will have a significant impact on the number of lists we can staff until we are able to recruit and train new staff. We are working with private providers to outsource some procedures, to try and maintain the gains made.
- The provider arm remains within budget YTD outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave continues to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

CCDHB Contract Activity Performance

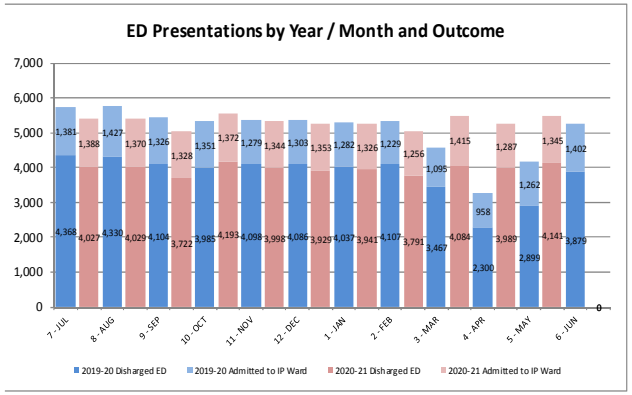
Capital and Coast DHB: May 2021

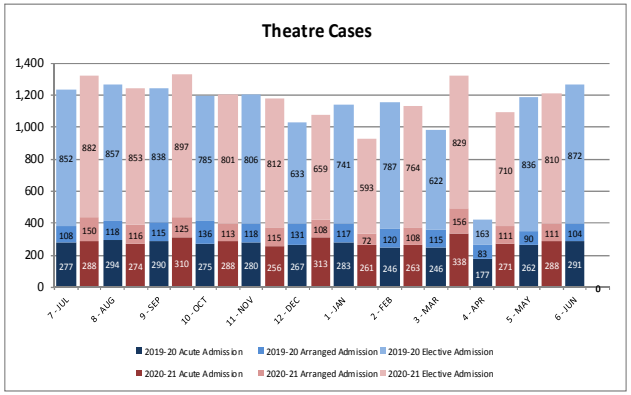
ED Presentations

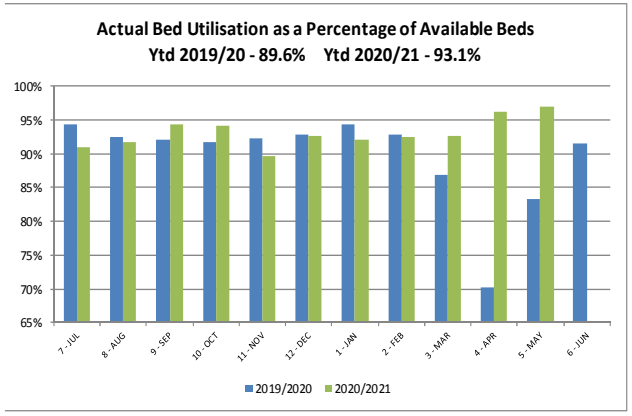
	2019/20	2020/21
YTD Totals	55,674	58,628
Change		2,954
% Change		5%

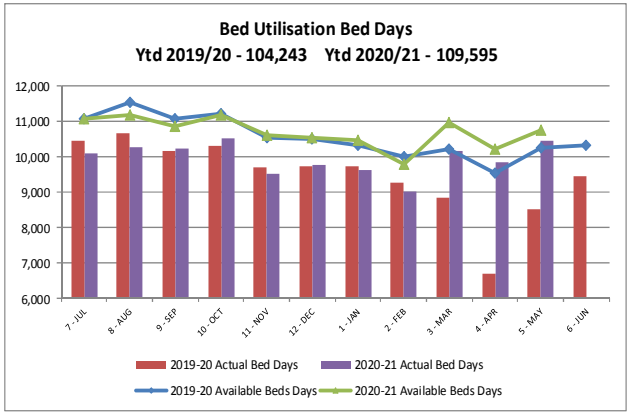
Theatre Cases

	2019/20	2020/21
YTD Totals	12,068	13,045
Change		977
% Change		8%









ED

- The total number of presentations to ED in May 2021 was 5,481 (this includes 407 DNWs)
- The volumes in 2020 were massively impacted by COVID-19 lockdown so comparison between the two periods is of limited value but the numbers for May 2019 are similar to May 2021.
- The average number of daily presentations May 2021 was 176.8, this is slightly lower than May 2019 178.1.

Bed Utilisation

- The utilisation of available of adult beds in core wards in May 2021 was 97.0% making it one of the busiest month this year. For comparison the utilisation in May 2019 was 93.1%.
- This continues to exacerbate patient flow for the ED
- The number of Elective theatre cases has decreased for the month of May 2021 by 6.1% (53 cases) when compared to May 2019. The decreases are spread across a number of specialties in particular Gynaecology (-40) and ENT (-38) but countered by increases in Urology (31).

CCDHB Activity Performance

Capital and Coast DHB: May 2021

HSS Inpatient Caseweight Activity

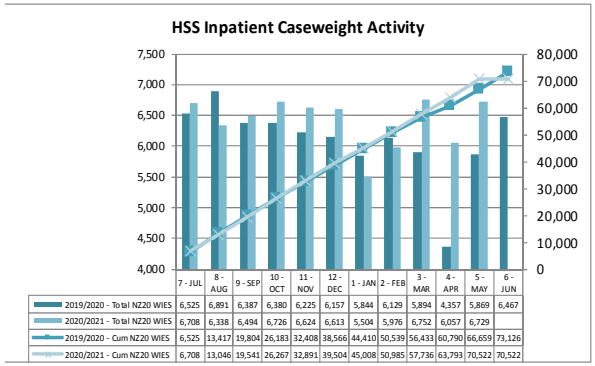
	2019/20	2020/21
YTD Totals	66,659	70,522
Change		3,863
% Change		5.8%

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

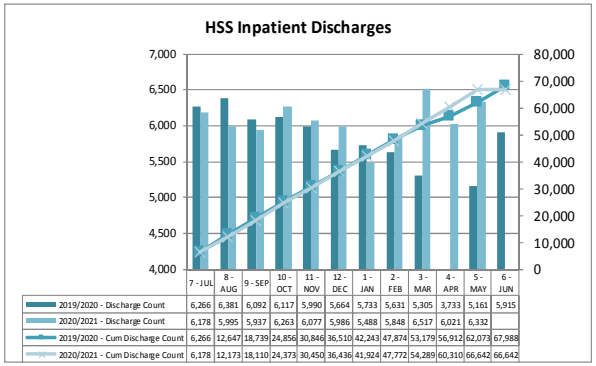
HSS Inpatient Discharges

	2019/20	2020/21
YTD Totals	62,073	66,642
Change		4,569
% Change		7.4%

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



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020 - Total NZ20 WIES	6,525	6,891	6,387	6,380	6,225	6,157	5,844	6,129	5,894	4,357	5,869	6,467
2020/2021 - Total NZ20 WIES	6,708	6,338	6,494	6,726	6,624	6,613	5,504	5,976	6,752	6,057	6,729	
2019/2020 - Cum NZ20 WIES	6,525	13,417	19,804	26,183	32,408	38,566	44,410	50,539	56,433	60,790	66,659	73,126
2020/2021 - Cum NZ20 WIES	6,708	13,046	19,541	26,267	32,891	39,504	45,008	50,985	57,736	63,793	70,522	70,522



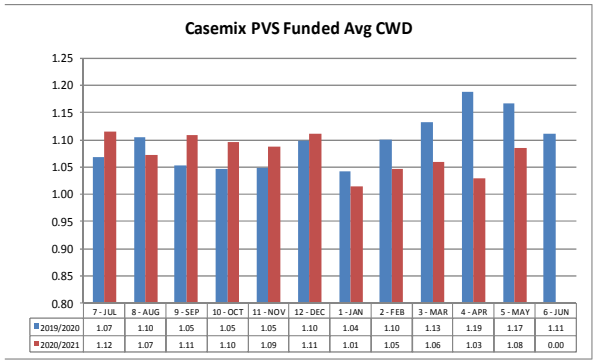
	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020 - Discharge Count	6,266	6,381	6,092	6,117	5,990	5,664	5,733	5,631	5,305	3,733	5,161	5,915
2020/2021 - Discharge Count	6,178	5,995	5,937	6,263	6,077	5,986	5,488	5,848	6,517	6,021	6,332	
2019/2020 - Cum Discharge Count	6,266	12,647	18,739	24,856	30,846	36,510	42,243	47,874	53,179	56,912	62,073	67,988
2020/2021 - Cum Discharge Count	6,178	12,173	18,110	24,373	30,450	36,436	41,924	47,772	54,289	60,310	66,642	66,642

Casemix PVS Funded Avg CWD

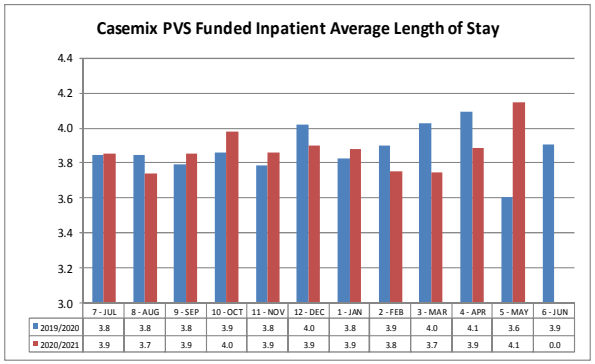
	2019/20	2020/21
YTD Totals	1.09	1.08
Change		-0.02
% Change		-2%

Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.87
Change		0.00
% Change		0.1%



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020	1.07	1.10	1.05	1.05	1.05	1.10	1.04	1.10	1.13	1.19	1.17	1.11
2020/2021	1.12	1.07	1.11	1.10	1.09	1.11	1.01	1.05	1.06	1.03	1.08	0.00



	7 - JUL	8 - AUG	9 - SEP	10 - OCT	11 - NOV	12 - DEC	1 - JAN	2 - FEB	3 - MAR	4 - APR	5 - MAY	6 - JUN
2019/2020	3.8	3.8	3.8	3.9	3.8	4.0	3.8	3.9	4.0	4.1	3.6	3.9
2020/2021	3.9	3.7	3.9	4.0	3.9	3.9	3.9	3.8	3.7	3.9	4.1	0.0

Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (1,330, CWDs) with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine and Orthopaedics. The CWD increase is driven primarily by Emergency Medicine, General Surgery and Neurology.
- Local Elective CWDs are higher than the previous financial year (764 CWDs) with an increase in discharges; a lower ALOS and a similar average CWD. The discharge increase is driven primarily by General Surgery, Cardiology and Vascular Surgery. The CWD increase is driven primarily by General Surgery, Cardiology, and Urology.
- IDF acute CWDs are higher (1,001 CWDs) than the previous financial year also with an increase in discharges; a lower ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine, Urology and Haematology. The CWD increase is driven primarily by Neonatal, Haematology and Neurology.
- IDF Elective CWDs are higher than the previous financial year (653 CWDs) with more discharges; a lower ALOS and average CWD. The discharge increase is driven primarily by Ophthalmology, Vascular Surgery and Neurosurgery. The CWD increase is driven primarily by Neurosurgery, Cardiology and Paediatric Surgery.
- In combination these four admission groups equate to an increase of 3,748 CWDs compared to the previous year. The services that most significantly impact this shift are Emergency Medicine (757), General Surgery (394), Haematology (335), Cardiothoracic (306), Orthopaedics (302) and Neurology (299), but countered by deceases in Paediatric Medicine (-149) and Respiratory Medicine (-130).
- General Medicine is currently 30 CWDs year to date higher when compared to last the last financial year but the gap would have been higher if not for the WRH AHOP counting change (388 CWDs now counted as bed days) and Paediatric Medicine (-149 CWDs) will be heavily impacted by the reduction in the number of presentations for under 16 to the Emergency department (293 Ytd).

Discharges:

- The impact of lockdown can be seen in the number of publicly funded casemix discharges for the month of May 2021 which have increased by 1,173 (24.8%) in comparison to the number of discharges recorded in May 2020.
- The number of outsourced discharges recorded in May 2021 was 158 which higher than previous months. This increase is attributable to Vascular Surgery (18 x Veins) outsourcing for the first time this calendar year and increase activity by both Gynaecology and Ophthalmology. CCDHB now utilising Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period May 20 to May 21

Domain	Indicator	2020/21 Target	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May
Care	Serious Safety Events	TBD	10	5	15	9	11	5	19	6	12	12	3	7	5
	Total Reportable Events	TBD	907	1,086	1,168	1,269	1,370	1,359	1,417	1,511	1,423	1,482	1,448	1,396	1,504
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	93.5%	90.6%	86.4%	94.3%	93.9%	94.9%	92.0%	83.3%	93.1%	95.5%	91.4%	94.2%	96.1%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		4,161	5,281	5,415	5,399	5,050	5,565	5,342	5,282	5,267	5,047	5,499	5,276	5,486
	Emergency Presentations Per Day		134	176	175	174	168	180	178	170	170	180	177	176	177
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	82.8%	74.6%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%
	ELOS % within 6hrs - non admitted	TBD	90.4%	82.6%	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%	75.6%	71.7%	76.1%
	ELOS % within 6hrs - admitted	TBD	66.3%	54.6%	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%	42.6%	40.6%	41.1%
	Total Elective Surgery Long Waits	Zero Long Waits	433	350	247	107	99	184	208	307	490	539	526	523	353
	Additions to Elective Surgery Wait List		1,091	1,505	1,520	1,376	1,542	1,397	1,391	1,286	921	1,238	1,439	1,189	1,199
	% Elective Surgery treated in time	TBD	76.3%	71.3%	73.0%	84.2%	90.3%	89.0%	86.3%	88.5%	75.4%	75.6%	72.1%	72.1%	75.0%
	No. surgeries rescheduled due to specialty bed availability	TBD	1	12	5	9	13	14	1	6	2	6	11	7	13
	Total Elective and Emergency Operations in Main Theatres	TBD	1,103	1,202	1,237	1,192	1,254	1,130	1,118	1,002	878	1,076	1,270	1,063	1,190
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	92.0%	91.0%	93.0%	85.0%	87.0%	82.0%	85.0%	87.0%	82.0%	90.0%	88.0%	85.0%	80.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	77.0%	85.0%	94.0%	83.0%	88.0%	88.0%	83.0%	89.0%	87.0%	83.0%	95.0%	80.0%	88.0%
	Specialist Outpatient Long Waits	Zero Long Waits	1,286	1,450	1,076	571	314	185	225	314	353	355	302	244	211
	% Specialist Outpatients seen in time	Zero Long Waits	81.0%	74.2%	74.1%	84.9%	90.0%	88.7%	92.1%	92.9%	89.1%	88.2%	85.6%	80.1%	90.7%
	Outpatient Failure to Attend %	TBD	7.2%	6.6%	7.1%	6.7%	7.0%	7.6%	7.7%	7.9%	7.3%	7.5%	7.1%	7.1%	7.1%
	Maori Outpatient Failure to Attend %	TBD	14.0%	13.5%	14.7%	13.9%	15.2%	15.3%	16.0%	16.6%	16.2%	16.1%	15.6%	15.7%	14.6%
	Pacific Outpatient Failure to Attend %	TBD	16.5%	16.2%	16.9%	14.4%	14.6%	16.3%	16.3%	18.8%	19.7%	17.8%	16.9%	15.5%	15.8%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)
	Contracted FTE (Internal labour)		4,930	4,976	4,976	5,035	5,237	5,267	5,263	5,257	5,256	5,344	5,346	5,365	5,363
	Paid FTE (Internal labour)		5,199	5,317	5,317	5,368	5,607	5,607	5,650	5,692	5,694	5,812	5,726	5,789	5,760
	% Main Theatre utilisation (Elective Sessions only)	85.0%	82.0%	81.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	20.4%	21.9%	24.0%	22.8%	24.8%	22.2%	25.1%	22.6%	22.3%	21.9%	23.2%	25.4%	23.6%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	24	29	30	35	51	33	34	37	37	38	41	37	35
	Adult Overnight Beds - Average Occupied WLG	TBD	323	357	362	363	382	378	363	360	355	373	381	381	386
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	16	17	19	19	18	23	18	17	16	14	19	19	23
	Adult Overnight Beds - Average Occupied KEN	TBD	55	63	71	72	74	76	67	64	67	71	69	72	73
	Child Overnight Beds - Average Occupied	TBD	18	23	24	23	22	23	24	22	17	19	22	22	22
	NICU Beds - ave. beds occupied	36	30	29	28	31	38	36	33	35	38	39	44	39	42
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.61	3.91	3.85	3.74	3.85	3.98	3.86	3.90	3.88	3.75	3.75	3.89	4.12
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.3%	3.8%	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%
	Presentations to ED within 48 hours of discharge	TBD	139	203	199	201	215	254	171	170	218	202	194	247	253
Staff Experience	Staff Reportable Events	TBD	109	161	140	156	138	179	173	175	147	184	161	152	145
	% sick Leave v standard	TBD	2.5%	3.5%	4.0%	4.0%	3.6%	3.4%	3.4%	3.1%	2.0%	2.7%	3.1%	2.8%	Tbc
	Nursing vacancy	TBD	171.0	157.6	248.1	265.3	251.1	247.4	267.5	268.5	267.8	223.4	234.4	235.0	Tbc
	% overtime v standard (medical)	TBD	1.4%	1.6%	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%	1.8%	Tbc

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

- Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the emergency department therefore improves the health services DHBs are able to provide.
- Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services.
- Increasing performance on this measure will also result in a more unified health system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay.

How are we performing?

- In May 2021, CCDHB SSIED performance for this measure was 67%. This result is an increase on the 63.2% recorded last month in April 2021 and a decrease on the 82% recorded in May 2019. The performance measure of patients who were seen, treated and discharged by ED for May 2021 was 78%. The performance measure relating to patients who were seen and admitted to hospital for May 2021 was 46%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for May 2021 was 97%. The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in May 2021 was 347.

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work, as well as increased acuity of acutely admitted patients. There has also been the usual seasonal increase in admissions. We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our inpatient wards to manage COVID case definition vs. non-COVID patients. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day, to enable patients being admitted from ED to move to the ward in a timelier manner and thus improves our SSiED performance. Unfortunately, this continues to be a major challenge with only negligible improvement for patient waiting times and patient flow from ED.

Performance	MAR	APR	MAY
2018-19	81%	82%	82%
2019-20	79%	84%	83%
2020-21	66%	63%	67%

Breaches	MAR	APR	MAY
2018-19	1,032	887	886
2019-20	919	498	680
2020-21	1,686	1,766	1,673

ED Volumes	MAR	APR	MAY
2018-19	5,456	4,939	5,204
2019-20	4,285	3,211	4,005
2020-21	5,010	4,797	5,074

Management Comment

CCDHB is facing a significant capacity issue as demonstrated by the consistently high occupancy rate and the bed blockage experienced across hospital flow as a consequence. The very small footprint of the Emergency Department cannot readily tolerate delays in moving patients from ED to the ward and this, combined with the high hospital occupancy, contributes significantly to the unsafe level of overcrowding in the ED.

The following work streams continue to be progressed and implemented including:

The Advancing Wellness at Home Initiative (AWHI) project facilitates early supported discharge for people whose level of function has declined on admission and has involved making changes to the Patient Care Coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine and reducing need for in-hospital stay.

A project group to review patients who have been in hospital more than 10 days, continues to identify barriers to discharge and address these with our teams.

Activities continue across the organisation to improve discharge processes.

A working group has been established to identify space to create additional acute assessment beds. This is the biggest challenge facing CCDHB at present as there is little further opportunity to create additional space on the current physical footprint.

Work is underway to relocate the Kenepuru Day Ward creating additional surgical and rehabilitation beds on the Kenepuru Hospital site. This requires building work and will not be completed and provide additional beds this winter.

It is important to note that while these initiatives are all very important and will continue, it is unlikely to make a significant impact on the very poor SSiED performance at CCDHB, without a complete revamp of the way in which acute patients present and are processed from the front door (including transition to assessment and observation units). We are embarking on a Front of Whare project that will identify the barriers and likely confirm the need for improved resources (facilities and personnel). This work is inextricably linked to other ongoing work to assess and address overall hospital capacity.

During the month of May 2021 there were nil presentations where the patient(s) was suspected of having COVID-19

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Total planned care results year to date is unfavourable 672 to our planned target of 9,857.
- May month end result is favourable 80 to a plan of 881. We performed well in-house achieving 58 over the planned 528. Our outsourcing volume was just 26 adverse to the planned 163, this is a good result considering we are still experiencing contractual restraints.
- Our IDF outflow position is positive for May resulting in 21 ahead of the planned 86, our elective surgical discharges were 40 over the planned 64 for May, which has offset under delivery in arranged and non-surgical measures.
- We are in the process of evaluating the impact of planned care programme overall between the planned care initiative and the waiting list improvement action plan – at this point underperformance in the former will be offset by the latter.

What is driving performance?

- High volumes of cancellations due to acute demand is the main reason we did not meet our planned care targets, coupled with inability to outsource the planned volumes each month.
- Theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. Filling anaesthetist shortages will contribute to this.

Management Comment

- Our focus remains on scheduling our longest-waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. At Kenepuru the installation of theatre lights has been extended to mid-July therefore planning continues with operating lists rescheduled to Wellington where capacity allows. However we do not have sufficient spare capacity in Wellington to cover off all lost lists.
- Outsource contracts are still being drafted but will not be finalised before this financial year as planned. We have interim agreements on some procedures but will not manage the required volume to meet our planned care target this year.
- We are making slow progress against our long wait patients for both outpatient and surgery, we continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow. SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

MRI and CT Waiting Times

What is this measure?

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

Why is this important?

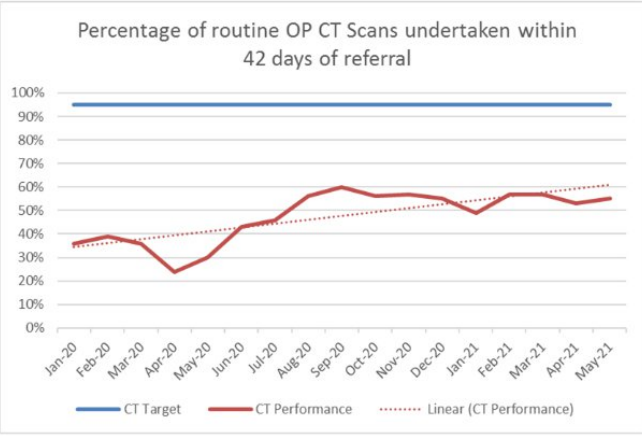
- Delayed diagnosis can lead to poorer health outcomes as a patient's condition may deteriorate while waiting. The period of 6 weeks (i.e. 42 days) is generally accepted as the reasonable clinical timeframe to receive imaging results for non-acute outpatient referrals.

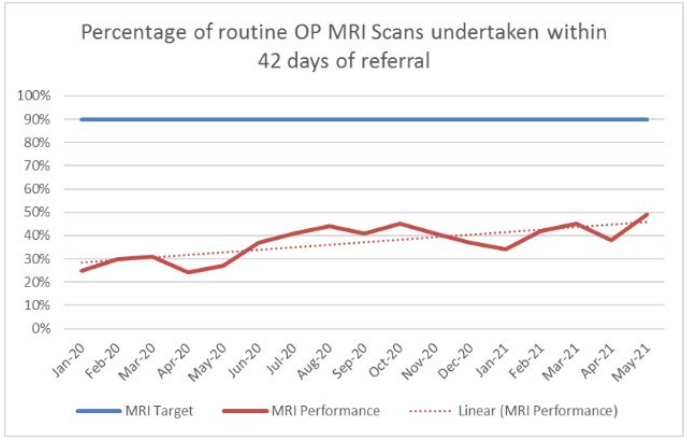
How are we performing?

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time but are slowly trending up (see linear trend line for CT performance in Figure Two below).

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 still risk of patient harm including disease progression while waiting for imaging appointments. The service continues to prioritise based on clinical urgency and processes images for inpatient and ED patients within expected timeframes in order to maximise inpatient flow.
- It was predicted that significant outsourcing would improve MOH performance much more than we have seen during the first 5 months of 2021. Investigating this more closely we can see this is a result of:
  - Demand during this period was much higher than forecast
  - CT demand was up 18% compared to 2019 (expected 10%)
  - MRI demand was up 29% compared to 2019 (expected 5 – 8%)
  - The largest portion of demand growth for both CT and MRI was Inpatient and ED referrals which was much higher than forecast
  - CT Inpatient/ED demand was up 26% compared to 2019
  - MRI Inpatient/ED demand was up 45% compared to 2019
- As Inpatient/ED are acutely unwell, this increased demand must be met with internal capacity. In turn, this significantly reduces planned care appointment slots which therefore increases waiting times.
- The next six months will be extremely challenging as the service has received 9 full-time technologist resignations since Easter. The majority of these staff are leaving for regional centres where they receive identical pay conditions but have purchased homes.
- Recruitment has begun but in the current international environment it is extremely challenging and lengthy to recruit internationally. While recruitment progresses there will likely be a reduction in productivity. Outsourcing continues at the maximum capacity across service providers available within the region.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography has decreased to 96.9% this month.

What is driving performance?

- Target has been met this month. Less SMO annual leave over this time. Administration/booking have been focusing more on ensuring timeframes are met

Management Comment

- We currently have two consultants on parental leave, with their return in June. This will help maintenance of the target in future

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

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

National Performance	69.4% (518/746)
Central Region	72.7% (109/150)
CCDHB	81.6% (31/38)
Hawkes Bay	51.9% (14/27)
Hutt Valley	66.7% (8/12)
Mid Central	74.1% (20/27)

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

What is driving performance?

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

Management Comment

Staffing continues to be a limiting factor due to two SMO's on parental leave, however with the return of the SMO's in June this will improve capacity. The underlying issue remains access to beds. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. Additional overnight beds have opened in the transit lounge which will mitigate some of this issue, allowing better patient flow. Trans-oesophageal Echocardiograms and CTCA patients have been moved out of the IRW space to free up bed space in IRW and Ward 6 South to help mitigate this issue and this is working well currently. The recruitment of an interventional radiology service manager to implement the recommendations of the recent review aims to improve efficiencies and performance within the IRU/Cath lab environment.

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 May at 88% compared to 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 May at 80% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.
- Patient numbers for both measures are less than expected and may reflect the public holiday impacting upon reporting timeframes in early June. High acute demand has also displaced some elective surgeries.

What is driving performance?

- The two patients who breached the 62 day target experienced delays in accessing FSA appointments. . The breaches occurred in the lung and skin tumour stream. The patient with lung cancer experienced delays in medical oncology FSA and subsequently received palliative care as first treatment. The patient with melanoma experienced delays to see Plastics and a further delay for a decision to have a wider excision. Neither patients were Māori or Pacifica. 62 day compliance was 100% Pacifica (3/3 patients) and no Māori were covered by 62 day target as acute presentations are excluded.
- Nine of the thirteen breaches in the 31 day indicator was due to capacity reasons – access to surgery for urological (4), breast, lung, skin, lower GI and radiation for brain/CNS. Two breaches were due to clinical reasons – other health events, triaged treat within 3- 4 months. A further two breaches were for patient reasons – religious and family commitments.
- 31 day compliance was 67% for Māori, 100% Pacifica and 80% for other ethnicities.

Management Comment

- Acute demand and staffing vacancies is having a negative effect upon access to FSA and surgical services. Some surgeries have been cancelled and rescheduled due to acutes or staffing/bed shortages. Some surgical work is being outsourced.
- The largely manual process for prospectively tracking patients can make it difficult to intervene in a timely manner to enable outsourcing within FCT timeframes.

Figure Eight: FCT 62 day target

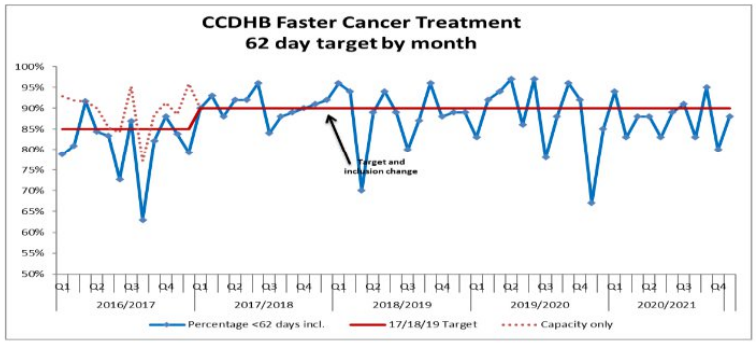
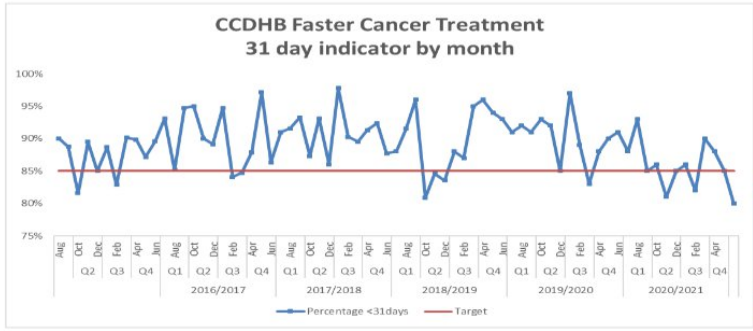


Figure Nine: FCT 31 day target



Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing? Refer two graphs

CCDHB achieved the Ministry of Health target for urgent colonoscopies with a performance of 92.3% (target 90%). For diagnostic waits, we achieved 60.2% in May, which was an improvement on the 58.4% in April, but we did not meet the MOH target of 70%.

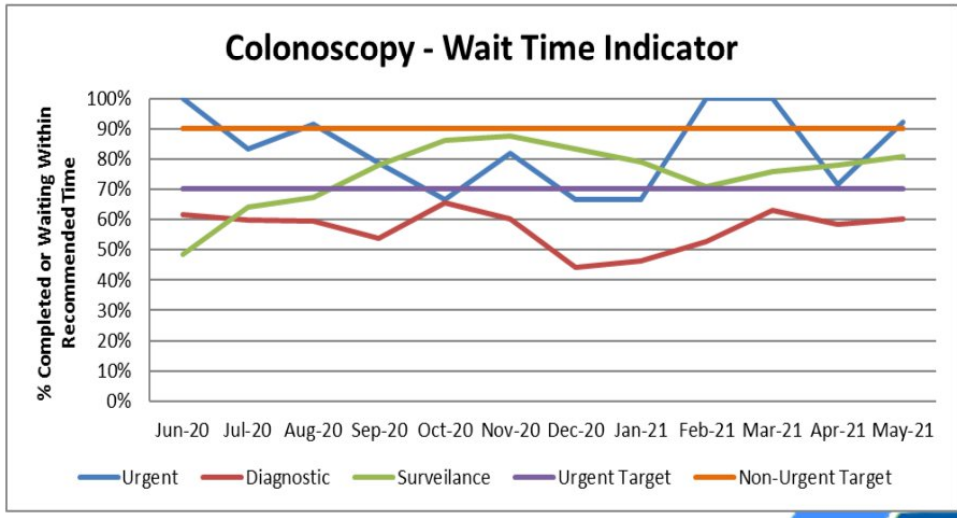
We exceeded the Ministry of Health target for surveillance achieving 80.7%, (target 70%). This is an improvement on the April return of 78%.

What is driving performance?

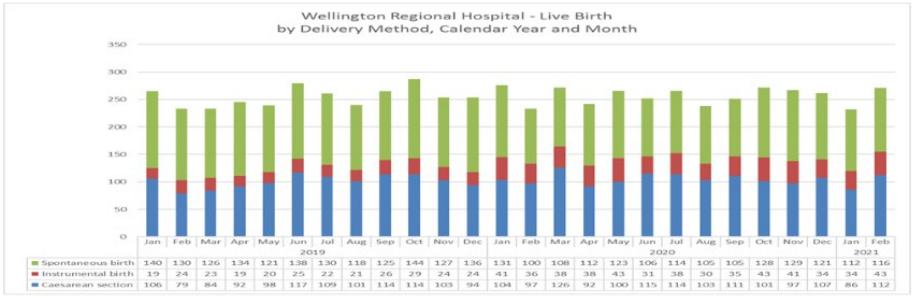
This month showed an improvement in all areas, achieving compliance in 2 of the 3 targets. This is partly due to fewer lists being lost as a result of Public Holidays, and being able to access any space capacity from the bowel screening lists in Kenepuru.

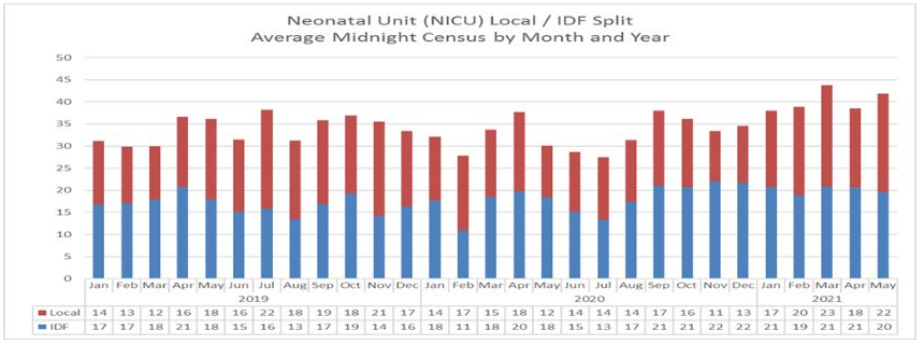
Management Comment

- As anticipated our performance improved in May, with fewer cancellations are a result of Public Holidays.
- While the results are encouraging, we will be unable to maintain the same level of performance in the next 3-4 months as a result of RN resignations. This will have a significant impact on the number of lists we can staff until we are able to recruit and train new staff.
- We are working with private providers to outsource some procedures, but there will be limits to the amount of patients they can see also.
- At this stage we do not anticipate an impact on the Bowel Screening lists in Kenepuru.



Maternity and Neonatal Intensive Care services





What is the issue?

- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal Intensive Care service.
- The Wellington Regional Hospital (WRH) and Kenepuru maternity unit, have increasing and significant Registered Midwifery vacancies (circa 48 %) this includes 11 FTE new roles that have been created by CCDM FTE calculations but not yet filled. The NICU had an increase of 27FTEs from CCDM calculation last year but continue to struggle with over occupancies – NB resourced beds are 36.
- An international recruitment drive is being relaunched with a focus on Australia, and the UK.
- Escalation plans are in place and are followed but are being challenged with continued presentations, high acuity, and continued shortages.
- We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
- Local options include use of all maternity services and beds across the region exploring different geographical patient flows.

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit YTD was $6.3m favourable against budget.
- Two extraordinary items exist which are not included within the budget, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($5.3m); COVID-19: additional costs during COVID-19
  - ($7.7m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position, $29.7 million relates to our YTD from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m some of which are still due to start within the year.
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of May Bank Balance was in overdraft ($36.4m) with $13.3m in special fund balances.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD May 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(8,317)		Devolved MoH Revenue	(2,266)	(23,574)		(34,157)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	693			2,730	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue			(44)	0	(44)
2,037	**(8,317)**	**0**	**Total Revenue**	**(1,573)**	**(23,574)**	**(44)**	**(31,426)**	**(44)**
			Personnel					
(1,610)		(2,049)	Medical	(5,764)		(2,175)	(7,374)	(26,313)
(1,620)		(9,145)	Nursing	(3,474)		(3,566)	(5,094)	(43,132)
		(1,370)	Allied Health			(594)	0	(7,179)
		32	Support			(159)	0	(1,926)
		168	Management & Administration			(679)	0	(8,147)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(9,238)**	**0**	**(7,173)**	**(12,468)**	**(86,698)**
			Outsourced Personnel					
(51)			Medical	(131)		(16)	(182)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(131)**	**0**	**(16)**	**(182)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(2,338)			496	0
(1,952)			Treatment related costs - Outsourced	(564)			(2,516)	0
(1,921)			Non Treatment Related Costs	(1,979)		(564)	(3,899)	(564)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(16,256)		(26,173)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(4,881)**	**(16,256)**	**(564)**	**(32,093)**	**(564)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(14,250)**	**(16,256)**	**(7,752)**	**(44,743)**	**(87,278)**
6,357	**1,600**	**12,365**	**Net result**	**12,678**	**(7,318)**	**7,709**	**13,317**	**87,234**

- The year to date financial position includes $50.5m additional costs in relation to COVID-19.
- Revenue of $23.6m has been received to fund additional costs for community providers however this has not been sufficient for these costs
- Additional personnel costs of $7.7m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – May 2021

Month - May 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD May 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
84,902	77,550	78,358	7,352	6,544	7,387		77,515	(35)	Devolved MoH Revenue	878,799	853,050	816,452	25,749	62,347	25,840		852,959	(91)
3,708	3,559	3,532	149	176			3,708	149	Non-Devolved MoH Revenue	40,547	39,134	38,800	1,413	1,747			40,547	1,413
3,104	2,909	2,525	195	579	(0)		3,104	195	Other Revenue	49,568	31,740	33,656	17,829	15,912	(693)		50,261	18,522
22,065	21,452	18,764	613	3,301			22,065	613	IDF Inflow	234,074	235,976	216,672	(1,902)	17,402			234,074	(1,902)
4,063	780	587	3,284	3,477		0	4,063	3,284	Inter DHB Provider Revenue	38,253	8,484	7,619	29,769	30,634		44	38,253	29,769
117,842	**106,251**	**103,765**	**11,592**	**14,077**	**7,387**	**0**	**110,455**	**4,205**	**Total Revenue**	**1,241,241**	**1,168,383**	**1,113,200**	**72,858**	**128,042**	**25,147**	**44**	**1,216,095**	**47,711**
									Personnel									
16,793	16,077	15,164	(716)	(1,629)	(60)	191	16,662	(585)	Medical	174,470	170,030	159,336	(4,440)	(15,134)	5,764	2,175	166,531	3,499
22,396	20,050	18,694	(2,346)	(3,702)	(1)	313	22,084	(2,034)	Nursing	235,064	214,912	205,187	(20,152)	(29,876)	3,474	3,566	228,023	(13,112)
6,633	5,690	5,334	(944)	(1,299)		52	6,581	(891)	Allied Health	69,101	63,219	56,718	(5,882)	(12,383)		594	68,507	(5,288)
985	900	919	(85)	(67)		14	971	(72)	Support	9,895	10,056	8,950	160	(945)		159	9,736	320
8,580	6,007	5,624	(2,573)	(2,957)		59	8,521	(2,514)	Management & Administration	77,871	70,997	66,303	(6,874)	(11,568)		679	77,192	(6,195)
55,388	**48,723**	**45,734**	**(6,665)**	**(9,654)**	**(61)**	**630**	**54,819**	**(6,096)**	**Total Employee Cost**	**566,400**	**529,214**	**496,494**	**(37,187)**	**(69,907)**	**9,238**	**7,173**	**549,990**	**(20,776)**
									Outsourced Personnel									
(346)	445	593	790	939	0	0	(346)	790	Medical	7,212	4,841	6,203	(2,371)	(1,009)	131	16	7,065	(2,224)
(7)	25	12	32	19			(7)	32	Nursing	514	273	227	(240)	(287)			514	(240)
168	114	95	(54)	(73)			168	(54)	Allied Health	1,518	1,250	1,360	(267)	(157)			1,518	(267)
34	22	18	(12)	(15)			34	(12)	Support	376	240	273	(136)	(104)			376	(136)
407	79	438	(328)	31			407	(328)	Management & Administration	3,921	888	2,273	(3,032)	(1,648)			3,921	(3,032)
256	**684**	**1,155**	**428**	**899**	**0**	**0**	**256**	**428**	**Total Outsourced Personnel Cost**	**13,541**	**7,493**	**10,336**	**(6,047)**	**(3,205)**	**131**	**16**	**13,393**	**(5,900)**
11,930	11,617	9,913	(313)	(2,017)	345		11,585	32	Treatment related costs - Clinical Supp	122,590	122,195	113,229	(395)	(9,360)	2,338		120,252	1,943
2,355	2,591	2,549	236	195	0		2,355	236	Treatment related costs - Outsourced	23,935	26,490	21,642	2,554	(2,293)	564		23,371	3,118
9,736	7,166	6,530	(2,570)	(3,206)	(409)	308	9,837	(2,671)	Non Treatment Related Costs	98,033	76,354	70,890	(21,680)	(27,144)	1,979	564	95,491	(19,137)
8,979	8,965	8,241	(14)	(738)			8,979	(14)	IDF Outflow	99,131	98,619	92,960	(512)	(6,170)			99,131	(512)
25,325	26,686	28,662	1,361	3,338	(269)		25,594	1,092	Other External Provider Costs (SIP)	308,826	290,519	287,432	(18,307)	(21,394)	16,256		292,569	(2,051)
4,604	4,817	4,886	213	281			4,604	213	Interest Depreciation & Capital Charge	51,225	53,157	53,866	1,931	2,641			51,225	1,931
62,929	**61,843**	**60,781**	**(1,086)**	**(2,148)**	**(333)**	**308**	**62,954**	**(1,111)**	**Total Other Expenditure**	**703,740**	**667,332**	**640,019**	**(36,408)**	**(63,720)**	**21,137**	**564**	**682,039**	**(14,707)**
118,574	**111,251**	**107,670**	**(7,322)**	**(10,903)**	**(394)**	**938**	**118,030**	**(6,778)**	**Total Expenditure**	**1,283,681**	**1,204,039**	**1,146,849**	**(79,642)**	**(136,832)**	**30,507**	**7,752**	**1,245,421**	**(41,382)**
(731)	**(5,001)**	**(3,905)**	**4,269**	**3,174**	**7,781**	**(938)**	**(7,574)**	**(2,574)**	**Net result**	**(42,439)**	**(35,656)**	**(33,649)**	**(6,784)**	**(8,790)**	**(5,360)**	**(7,709)**	**(29,327)**	**6,329**

Note two adjustments are made for

1. COVID-19 and
2. Holidays Act.

These two items form part of the DHB deficit; as revenue from MoH/Government has not been received to offset these costs, 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 ($42.4m). The variance to the YTD Budget is ($6.8m)
- Included within this result is recognition of the adjustment to the holiday act provision ($7.7m) and an estimated impact of COVID-19 of ($5.4m).
- Excluding the two items above brings the deficit for the year into deficit of ($29.3m) being $6.4m favourable to budget.
- Revenue is favourable by $72.9m YTD, after excluding COVID-19, lead DHB changes this is on budget. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($1.9m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($37m) YTD, excluding the Holidays Act provision ($6.5m) and the COVID-19 related costs of ($9.3m) incurred the net unfavourable variance is ($21.2m). This ($21.2m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($18.1m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $866k is unfavourable with increased costs associated with Bloods, prostheses and grafts offset by a favourable movement in drugs and outreach clinics.
- Outsourced clinical services is favourable YTD by $2.4m; favourable movement due to outsourced surgical service delayed compared to budget plan, however this is offset by the increase in MRI, CT Scans and other radiology services.
- Non treatment related costs ($18.9m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and provision to reduce investment in TAS IT systems Non Treatment related costs were breakeven.
- The funder arm is favourable YTD due to additional revenue from spend requirements for our community COVID-19 response which may not all be funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $1.5m favourable YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($1.9m)
- The variance is due to revenue for special funds/research of $733k, Interest due to overdraft situations ($411k), Donations ($933k) MHAIDS non-lead DHB revenue of $1.5m Favourable. The funder arm is also unfavourable by $24.7m revenue however with offsetting community cost and COVID related costs in the Provider.

Personnel (including outsourced)

- Medical Personnel is $724k favourable for the month, YTD unfavourable by ($6.8m). The favourable position for the month is due to the transfer of costs to CCDHB for MHAIDs services ~$681k, Holidays Act provisions ($191k) and the year to date exc MHAIDS, Holidays Act was an unfavourable variance of $600k is driven by vacancies across other services, most notably surgery and Women's and Children's services offset by COVID expenditure.
- Nursing Personnel is ($2.3m) unfavourable to budget for the month, YTD ($20.4m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is ($998k) unfavourable to budget for the month, YTD ($6.2m) unfavourable to budget. $4.8m of the YTD variance results from the transfer of staff from other DHBs to CCDHB.
- Support Personnel labour month position is unfavourable by $97k, YTD favourable by $24k.
- Management/Admin Personnel is unfavourable in the month by ($2.9m), YTD unfavourable by ($10.3m). $5.3m YTD of this variance has corresponding offsetting revenue within ICT, the remainder is spread across the organisation and driven largely by the use of outsourced contractors.

Section 4

Financial Position

Cash Management – May 2021

Month : May 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD May 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
111,914	**111,708**	**110,155**	**206**	**1,759**	**Receipts**	**1,272,675**	**1,228,790**	**1,181,800**	**43,885**	**90,874**
					Payments					
47,536	45,974	41,407	(1,562)	(6,129)	Payments to employees	537,643	505,714	488,988	(31,929)	(48,655)
62,115	66,384	71,014	4,269	8,899	Payments to suppliers	686,689	705,938	661,681	19,248	(25,008)
0	0	0	0	0	Capital Charge paid	21,845	23,465	12,297	1,619	(9,549)
7,370	(137)	(5,944)	(7,507)	(13,314)	GST (net)	(1,950)	1,504	2,249	3,454	4,199
117,022	**112,222**	**106,478**	**(4,800)**	**(10,544)**	**Payments - total**	**1,244,228**	**1,236,620**	**1,165,214**	**(7,608)**	**(79,014)**
(5,107)	**(513)**	**3,678**	**(4,594)**	**(8,785)**	**Net cash flow from operating Activities**	**28,447**	**(7,830)**	**16,586**	**36,277**	**11,861**
					Investing Activities					
8	**75**	**10**	**67**	**2**	**Receipts**	**180**	**825**	**1,368**	**645**	**1,189**
					Payments					
7,551	42,734	4,902	35,183	(2,649)	Purchase of fixed assets	58,365	131,781	37,138	73,416	(21,227)
7,551	**42,734**	**4,902**	**35,183**	**(2,649)**	**Payments - total**	**58,365**	**131,781**	**37,138**	**73,416**	**(21,227)**
(7,543)	**(42,659)**	**(4,892)**	**35,250**	**(2,647)**	**Net cash flow from investing Activities**	**(58,186)**	**(130,956)**	**(35,769)**	**74,061**	**(20,038)**
					Financing Activities					
0	**37,223**	**52**	**(37,223)**	**(52)**	**Receipts**	**23,705**	**71,162**	**27,804**	**(47,457)**	**(4,099)**
					Payments					
0	**0**	**0**	**0**	**0**	Interest payments	**8**	**0**	**0**	**(8)**	**(8)**
0	**0**	**0**	**0**	**0**	**Payments - total**	**8**	**0**	**0**	**(8)**	**(8)**
0	**37,223**	**52**	**(37,223)**	**(52)**	**Net cash flow from financing Activities**	**23,697**	**71,162**	**27,804**	**(47,465)**	**(4,107)**
(12,650)	**(5,949)**	**(1,162)**	**(6,567)**	**(11,484)**	**Net inflow/(outflow) of CCDHB funds**	**(6,042)**	**(67,625)**	**8,621**	**62,874**	**(12,285)**
24,845	(43,439)	17,867	(68,284)	(6,978)	**Opening cash**	18,236	18,236	8,083	0	(10,153)
111,922	149,006	110,217	(36,950)	1,709	Net inflow funds	1,296,559	1,300,777	1,210,973	(2,927)	87,964
124,573	154,956	111,380	30,383	(13,193)	Net (outflow) funds	1,302,601	1,368,401	1,202,352	65,800	(100,249)
(12,650)	**(5,949)**	**(1,162)**	**(6,567)**	**(11,484)**	**Net inflow/(outflow) of CCDHB funds**	**(6,042)**	**(67,625)**	**8,621**	**62,874**	**(12,285)**
12,194	**(49,389)**	**16,704**	**61,583**	**(4,510)**	**Closing cash**	**12,194**	**(49,389)**	**16,704**	**61,583**	**(4,510)**

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD May 2021		
	Actual $000	**Budget $000**	**Variance $000**
Net Cashflow from Operating	28,447	(7,830)	36,277
Non operating financial asset items	(153)	-	(153)
Non operating non financial asset items	(3,329)	(2,805)	(524)
Non cash PPE movements	(29,848)	(29,485)	(363)
Working Capital Movement			
Inventory	471	-	471
Receipts and Prepayments	31,685	12,100	19,585
Payables and Accruals	(69,709)	(7,636)	(62,073)
Total Working Capital movement	**(37,554)**	**4,464**	**(42,018)**
Operating balance	**(42,437)**	**(35,656)**	(6,781)

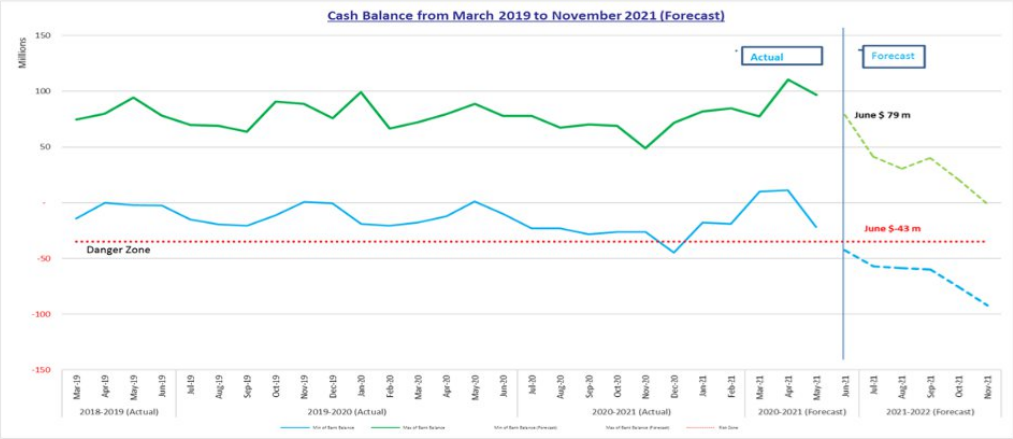
Net inflow cash: May $12.65m (Unfavourable)

Net cash flow from operating activities un-favourable this month due to an additional GST payment and payroll payment.

Investment activities are frequently behind as compared to the budgeted amount due to delay of a number of projects.

Debt Management / Cash Forecast – May 2021

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	9,623	7,381	373	154	25	1,690	7,625
Other DHB's	6,717	2,016	895	125	478	3,203	6,622
Kenepuru A&M	227	26	24	22	155	0	223
ACC	183	163	(115)	(4)	(24)	163	442
Misc Other	2,915	943	147	10	213	1,602	3,392
Total Debtors	**19,665**	**10,529**	**1,324**	**307**	**847**	**6,658**	**18,304**
less : Provision for Doubtful Debts	(3,668)						(3,623)
Net Debtors	15,997						14,681



Debt Management

- MOH – The $1,690K overdue was caused by i)contracts not signed by the Ministry causing invoices on hold, ii) reports not yet provided by CCDHB or iii) disputed invoices.
- 'Other DHB's' - HVDHB is the single largest debtor of the $3,203K debt.
- Kenepuru A&M – The $155K debts include a huge number of low value patient transactions.
- 'Misc Other' debtors includes just below $1.9m non-resident debt. Approx. 85% of the non-resident debts have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash Management

The DHB will require further equity injection in July 2021.

Cash forecast June21: High:+$79m, Low:-$43m, improved by cash management process.

Balance Sheet / Cashflow – as at 31 May 2021

Apr-21	Month : May 2021						Capital & Coast DHB Balance Sheet
					Variance		
ADtual	Actual	Budget	At May 2020	At Jun 2020	Actual vs Budget	Actual vs May 2020	YTD May 2021
31	31	31	31	31	0	0	Bank
11,540	928	(0)	3,415	6,523	928	(2,487)	Bank NZHP
13,275	13,561	11,683	13,259	11,683	1,879	302	Trust funds
52,168	63,930	49,375	46,127	46,342	14,555	17,803	Accounts receivable
9,953	9,466	8,995	9,264	8,995	471	202	Inventory/Stock
7,694	7,902	6,257	8,084	6,257	1,645	(181)	Prepayments
94,661	**95,818**	**76,341**	**80,179**	**79,831**	**19,477**	**15,639**	**Total current assets**
512,001	509,015	626,470	516,027	522,978	(117,454)	(7,011)	Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988	Work in Progress - CRISP
86,311	94,034	50,096	61,848	57,317	43,938	32,186	Work in progress
613,159	**617,896**	**691,413**	**587,734**	**591,921**	**(73,516)**	**30,162**	**Total fixed assets**
1,150	1,150	1,150	1,150	1,150	0	0	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**0**	**0**	**Total investments**
708,970	**714,864**	**768,903**	**669,063**	**672,901**	**(54,039)**	**45,801**	**Total Assets**
0	2,325	61,101	0	0	58,776	(2,325)	Bank overdraft HBL
101,935	96,762	64,504	62,267	76,604	(32,259)	(34,495)	Accounts payable, Accruals and provisions
6,222	7,840	8,209	9,839	(252)	368	1,999	Capital Charge payable
593	593	593	593	593	0	0	Insurance liability
11,511	11,441	36,144	23,225	36,144	24,703	11,784	Current Employee Provisions
171,086	180,467	140,857	125,763	140,857	(39,609)	(54,704)	Accrued Employee Leave
23,971	22,515	7,299	18,488	7,299	(15,216)	(4,028)	Accrued Employee salary & Wages
315,317	**321,944**	**318,708**	**240,175**	**261,245**	**(3,236)**	**(81,769)**	**Total current liabilities**
94	92	95	102	95	3	10	Restricted special funds
605	605	605	605	605	0	0	Insurance liability
6,564	6,564	6,564	6,296	6,564	0	(269)	Long-term employee provisions
7,263	**7,262**	**7,264**	**7,003**	**7,264**	**3**	**(259)**	**Total non-current liabilities**
322,580	**329,206**	**325,972**	**247,178**	**268,510**	**(3,234)**	**(82,027)**	**Total Liabilities**
386,390	385,659	442,931	421,885	404,391	(57,272)	(36,227)	Net Assets
833,446	833,446	846,712	816,205	813,224	(13,266)	17,240	Crown Equity
0	0	0	0	(3,484)	0	0	Capital repaid
0	0	0	0	0	0	0	Capital Injection
130,659	130,659	130,660	131,110	130,659	(1)	(451)	Reserves
(577,715)	(578,447)	(571,664)	(525,483)	(536,008)	(6,784)	(52,964)	Retained earnings
386,389	**385,658**	**442,931**	**421,884**	**404,392**	**(57,274)**	**(36,226)**	**Total Equity**

Balance Sheet

1. DHB's cash balance at the end of May is $61m favourable.
2. Accounts receivable is higher than the budgeted by $14.5m, increase funding from MoH.
3. A $4.7m radiotherapy system has been capitalised.
4. Accounts payable, accruals and provisions is higher than budget primarily due to a timing differences
5. Employee liabilities are higher than the budgeted. This is due to an unbudgeted employee costs (MHAIDs) approx. $3m per month;

Cash flow

1. The net cash flow from operating activities is unfavourable to the budget. An additional of payroll payment and GST payment;
2. The net cash flow from investment activities is unfavourable to the budget due to delay of projects;

Financial ratios

1. Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities. DHB's current ratio is maintained at 0.30, which is the same as last month.

2. Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 0.85 : 1 (April - 0.83 : 1).

Capital Expenditure Summary May 2021

			Actual spend on live projects							Forecast spend on approved projects		
Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	September Quarter actual spend	December Quarter actual spend	March Quarter actual spend	April actual spend	May actual spend	Actual YTD Spend	Actual LTD Spend	To spend	Jun-21	Forecast cash spend to June 21*
Buildings	17,979,996	-	225,088	820,879	479,840	219,788	1,094,332	2,839,927	2,839,927	15,140,069	1,150,106	3,990,032
Clinical Equipment	11,684,569	-	643,250	1,506,284	1,113,275	739,550	263,287	4,265,646	4,265,646	7,418,922	1,137,277	5,402,923
ICT	2,407,504	-	41,960	142,786	373,375	135,239	82,561	775,921	775,921	1,631,583	368,637	1,144,558
2020-21 projects	**32,072,069**	-	**910,298**	**2,469,950**	**1,966,490**	**1,094,577**	**1,440,180**	**7,881,495**	**7,881,495**	**24,190,574**	**2,656,019**	**10,537,513**
Buildings	17,941,282	8,814,096	1,395,429	934,819	806,729	443,162	678,977	4,259,114	13,073,210	4,868,072	215,831	4,474,945
Clinical Equipment	44,232,069	21,222,465	7,018,217	5,846,681	1,209,371	277,576	496,400	14,848,245	36,070,709	8,161,360	765,725	15,613,970
ICT	9,172,562	6,711,200	1,266,724	348,068	263,844	(23,251)	43,315	1,898,699	8,609,899	562,663	91,875	1,990,574
Prior Year projects	**71,345,913**	**36,747,760**	**9,680,370**	**7,129,568**	**2,279,943**	**697,486**	**1,218,692**	**21,006,059**	**57,753,818**	**13,592,094**	**1,073,431**	**22,079,489**
Total	**103,417,982**	**36,747,760**	**10,590,667**	**9,599,517**	**4,246,434**	**1,792,063**	**2,658,872**	**28,887,554**	**65,635,313**	**37,782,668**	**3,729,450**	**32,617,003**

** does not take into account unapproved business cases in the 2020/21 Capital Plan*

Key highlights to May 2021 (excludes New Children's Hospital, Water Remediation Project & ISU for MHAIDS and MOH donated assets for Covid-19):

- The development of business cases from the 2020/21 Capital Plan are at various stages. It was anticipated that $3m-$4m be presented for approval each month. $32m in projects have been approved to May 2021
- Total spend to the end of May 2021 was $28.9m which mostly related to prior year approved projects
- The forecast cash spend for the year is $30m-$32m. This excludes $3.03m from the CCDHB towards its $5.2m total funding contribution towards the New Children's Hospital project
- The FY21/22 capital plan is currently being finalised for ELT endorsement and board approval. This plan will be carefully considered what strategic investments to undertake and what to hold off given the direction of the sector

Board Information – Public

4 August 2021

Update on Implementation of 2DHB Strategic Priorities

Action Required

The Boards note:

(a) Progress towards implementing the agreed strategic priorities to be delivered in the 2021/22 financial year as we transition to the new health and disability system. Including:

i. Governance

ii. Programme and Project Development

iii. Performance Monitoring

iv. Communications and Engagement

(b) Programme milestones are currently being developed within the programme and will be authorised by the Governance Forums and will inform future reports to the Board.

Strategic Alignment	We are focussed on achieving equity, clinical excellence, and financial sustainability to ensure the needs of our populations are met during a period of change. Our priorities are aligned to the Government's planning priorities for health and the Minister's Letters of Expectations. Our work on the priorities over the next 12 months is consistent with the transition to the new health and disability system.
Author	Rachel Haggerty, Director, Strategy, Planning & Performance, CCDHB and HVDHB
Endorsed by	Fionnagh Dougan, Chief Executive, CCDHB and HVDHB
Presented by	Rachel Haggerty, Director, Strategy, Planning & Performance, CCDHB and HVDHB
Purpose	This paper updates the Boards on progress towards implementing the agreed strategic priorities to be delivered in the 2021/22 financial year as we transition to the new health and disability system.
Contributors	N/A
Consultation	N/A

Executive Summary

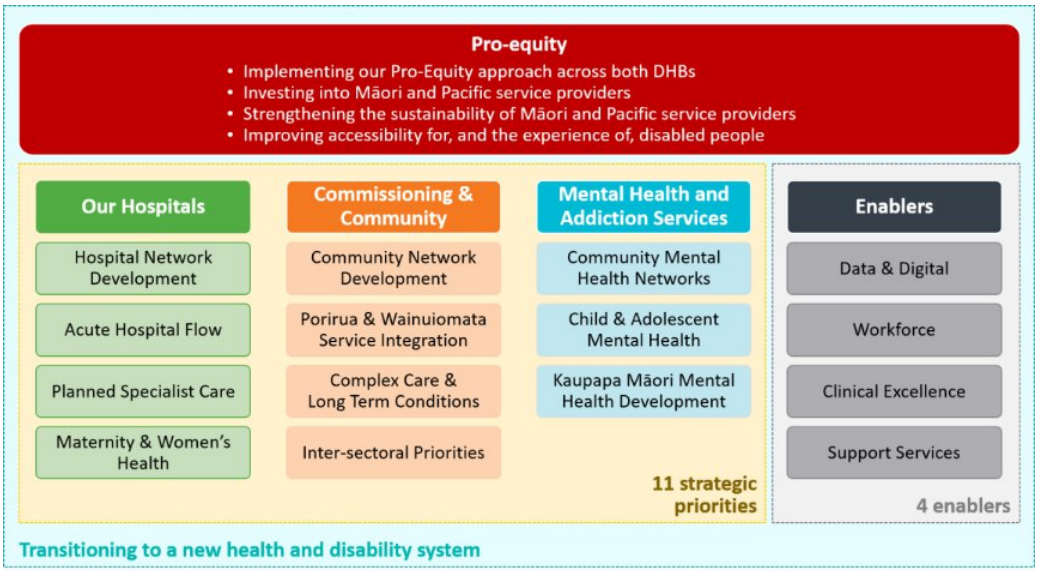
Our DHBs are well positioned to support the planned changes to New Zealand's health and disability system. We have already embarked on a transformational journey that broadly aligns with the direction and future of the wider health and disability system.

For the past 18 months we have been working together to deliver improved health outcomes for the communities we serve. Our health system vision and focus areas puts people, place, and partnership at the heart of what we do. We are—and will remain—focused on delivering services in the community, working collaboratively across our campuses, and creating a sustainable hospital network across our regions to make the best use of the resources we have. This will enable us to continue to bring health care closer to people through more service provision in the community, and developing our hospitals to ensure we can continue to deliver the emergency, acute, and planned care services we currently offer.

Our focus will strongly remain on delivering equitable health outcomes and intensifying support for Māori, Pacific people and those living with disability, mental illness and addiction.
We will:

- *continue to commission, fund, and deliver health outcomes for our local and regional population*
- *accelerate work in focus areas that will support Health NZ and the Māori Health Authority*
- *stop/pause some work that may duplicate efforts by other DHBs or national health organisations.*

To support this transition over the next twelve months the Boards have agreed on the following strategic priorities and enablers to be delivered in the 2021/22 financial year as we transition to the new health and disability system:



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 over-arching 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 new investment prioritisation process is focussed on implementation of the strategic priorities, and the enablers needed to support them.
Governance	A governance structure to support implementation of the strategic priorities has been established.

Engagement/Consultation

Patient/Family	ELT has agreed the communications and engagement approach aligned to the strategic priorities.
Clinician/Staff	
Community	

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A	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 recent appointment of the Director Transformation is designed to ensure there is executive level focus and alignment across the programme	Low Risk	Low Risk

Implementing our strategic priorities

Governance

A governance structure has been established to oversee the delivery of the work programmes that will implement our strategic priorities which comprises three Executive Leadership Team (ELT) led Forums:

- Our Hospitals Forum – co-chaired by Joy Farley and John Tait
- Commissioning and Community Forum – chaired by Rachel Haggerty
- Mental Health and Addiction Commissioning – chaired by Fionnagh Dougan

Programme and Project Development

The Boards have previously signed off on the high-level work streams and work programmes. The executive has since worked to identify the key projects required to deliver against the direction set by the Board. The detailed work programmes and project plans will be considered by the Governance Forums scheduled for August.

Performance Monitoring

Improvements in health system performance as a result of implementing our strategic priorities will be captured via an outcomes framework specific to each Forum. We have a common structure to capture the expected improvements in health system performance as a result of implementing the strategic priorities. These are built around:

- Impact measures – how many people are better off?

- Process measures – how well are we doing it?
- Structural Measures – what are we doing?

Improvements in health outcomes and equity are likely to be seen in the medium to long-term.

A visualisation of this performance management framework can be found in Attachment 1. This example reflects the Hospital Network Outcomes framework previously approved by the Boards. Management and operational management of the work programmes and projects is being managed in accordance with the systems and processes overseen by the 2DHB Enterprise Management Office.

Communications and Engagement

ELT has agreed the communications and engagement approach aligned to the strategic priorities. The objectives of which are:

- inform and engage our partners, stakeholders, providers, stakeholders, staff, and the public on our focus areas and how we are preparing to transition into the new Health and Disability System
- engage with communities, groups, and leaders in designing and implementing solutions to shared problems and opportunities.

Mental health and addiction Services

Governance

The Mental Health and Addiction Commissioning Forum will provide governance for our DHBs' delivery on the mental health and addiction focus area and strategic priorities; driving system transformation as we transition to a new health and disability system. The Forum will steer the design and implementation a whole of population, equitable, mental health and addiction system of care to support the wellbeing of the people in our sub-region.

Membership of the Mental Health and Addiction Commissioning Forum includes: Māori clinical and system leadership; DHB system leaders; people with lived experience; and clinical/expert leaders. The Mental Health and Addiction Commissioning Forum will provide advice and recommendations to the Chief Executive, Hutt Valley and Capital & Coast DHBs.

The Disability Support Advisory Committee considered and noted the establishment of a Mental Health and Addiction Commissioning Forum at its meeting on 21 July 2021 (refer DSAC agenda item 3.5, page 126 on Diligent).

Programmes of work

There are three key areas of focus: the development of community mental health networks including child and adolescent mental health, responding to inpatient demand and Kaupapa Māori mental health service development.

The scoping of the **community mental health network development** is being led by a senior leadership team. The programme of work is identifying how we will redesign the model of care and service delivery model for community mental health. This includes community mental health services provided by MHAIDS, NGOS and primary care. The programme of work is being scoped with a focus on partnership with Maori.

The scoping is considering how **we partner effectively with Maori to create kaupapa Maori models of care that reflect Mātauranga Maori** (Maori experience and knowledge), the lived experience of our

communities, the relationships amongst primary care, NGOs and specialist services and the building of a shared purpose for outcomes with our communities. Particular focus is on the management of change and re-commissioning processes that will be required to de-commission and re-commission (and re-establish) the required service delivery model for the model of care.

We are working closely with the Ministry of Health mental health team to finalise the **business case for inpatient mental health beds**. This work is informed by bed modelling that will inform future capacity requirements.

Our Hospitals

There are 4 strategic priorities in this focus area. This report focuses on the 2DHB Hospital Network as there is significant progress to report.

2DHB hospital network

There has been considerable progress made in the development of the 2DHB hospital network. There is the performance of the current system including the delivery of planned specialist care targets

Clinical configuration

In early July the clinical directors, management, and senior leaders from across Hutt Valley and Capital & Coast DHBs met with the Executive Leadership Team for their first combined workshop to determine the clinical configuration of the 2DHB Hospital Network. Clinical configuration describes how our services are arranged and delivered across sites. This work needs to be informed by the views and expertise of our senior clinical and non-clinical staff to ensure that any such configuration is fit for purpose.

The first workshop generated a lot of discussion in and out of the room which is informing planning for the second workshop in August 2021.

Infrastructure options

The DHB infrastructure teams and Destravis have been touring our sites virtually and in person over July. These visits are informing the development of master site planning envelopes for each hospital campus. This is the next stage in detailed master site planning – which will be informed by the clinical configuration recommendation developed in our workshops with senior leaders.

Hospital Network is future-focused but informs our options to address the capacity constraints here and now through the Front of Whare and 2DHB Bed and Theatre projects.

Front of Whare

The “Front of Whare” project will deliver options to improve the design and layout of the “Front of Whare” services (Emergency Department and Acute Assessment Areas) at Wellington Regional Hospital for patients, whānau and clinicians. The project has three work streams: consumers, clinical, and facilities & infrastructure including Destravis that are working together on service design. Destravis have identified an area that could be used to expand ED capacity and this option is being tested with the Executive Leadership Team.

2DHB Bed and Theatre

The Bed & Theatre capacity project will identify options to increase capacity across our hospital sites to ensure we have safe hospital occupancy and can deliver both planned and acute care to our communities. There are a range of work streams looking at internal and external solutions: wet lease of capacity from private hospitals, extending hours of operating, and working with Destravis to identify infrastructure options for increasing physical space for beds, theatres and associated services.

The groups have identified options across each work stream and further discussions are underway for wet lease and extended operating hours. Destravis have signalled options for increasing capacity with

infrastructure investment to yield additional on-site capacity in beds, theatres and associated services. These options are currently being tested with the Executive Leadership Team.

Commissioning and Community

There are 4 strategic priorities in this focus area.

As reported to the Health System Committee at its meeting on 28 July 2021 (refer HSC agenda items 2.2 and 3.2) the localities work has progressed through developing relationships, trust, understanding, skill and capability to integrate health service delivery to improve outcomes in our communities. The work includes:

- *Locality Planning*
- *Locality integration partnering with Ngati Toa o Rangatira in the Porirua community;*
- *Developing a prototype Community Health Network within the Kāpiti community;*
- *Developing mental health and addiction networks with our community providers.*

Building an iwi relationship with Ngāti Toa o Rangatira and Te Ati Awa ki te Upoko o Te Ika a Maui

We've partnered to understand investment into Ngāti Toa, agree on shared outcomes for the Porirua community and an intervention logic and measurement framework to support service and system performance under the new integrated contract. This capability building is a key foundation for a future network in this area. The new integrated contract will transition over 24 contracts to a single integrated contract from 1 October 2021.

This approach is now being developed with Te Ati Awa ki te Upoko o Te Ika a Maui as mana whenua relationship. Strengthening this relationship with mana whenua is partnered with the building of relationships with our Maori providers, including our urban and community Marae.

Community Network development

Community Health Networks (CHNs or Networks) are described as the central organising point for delivering effective and efficient health care. CHNs build on a comprehensive roll out of Health Care Homes across both districts.

The Kāpiti CHN is leading a work programme focused on local priorities and builds on and supports existing initiatives and system changes. Over time as the network develops there will be focus on other population health priority areas (such as youth).

Kāpiti Community Health Network

The Kāpiti Community Health Network (Kāpiti CHN) establishment began in July 2020. Kāpiti CHN is a network of health providers who are supported to coordinate and organise health service delivery to better meet the needs of and achieve equitable care for the Kāpiti population.

The Kāpiti CHN is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongatai), CCDHB and Tū Ora Compass Health (the local PHO) in the first instance. These three organisation are joined by representation from the Kāpiti Health Advisory Group in the Kāpiti CHN Establishment Governance Group.

This has involved defining and building the foundations for successful integration, system (re)design and developing strong network relationships. Much of the foundational work is underway in Kāpiti and includes the development of:

- *Network Charter, which defines shared values and principles which guide and underpin providers when working together*

- *Network Operating Model, which details how the Network Operations Team will work to develop and deliver on a shared work programme*
- *Network Outcome Framework, which guides the work underway in the Network to ensure the wider impacts on health outcomes are measured and achieved*
- *Network Data management Framework, which will support and guide providers when information is shared within a Network*

Extending to other Communities

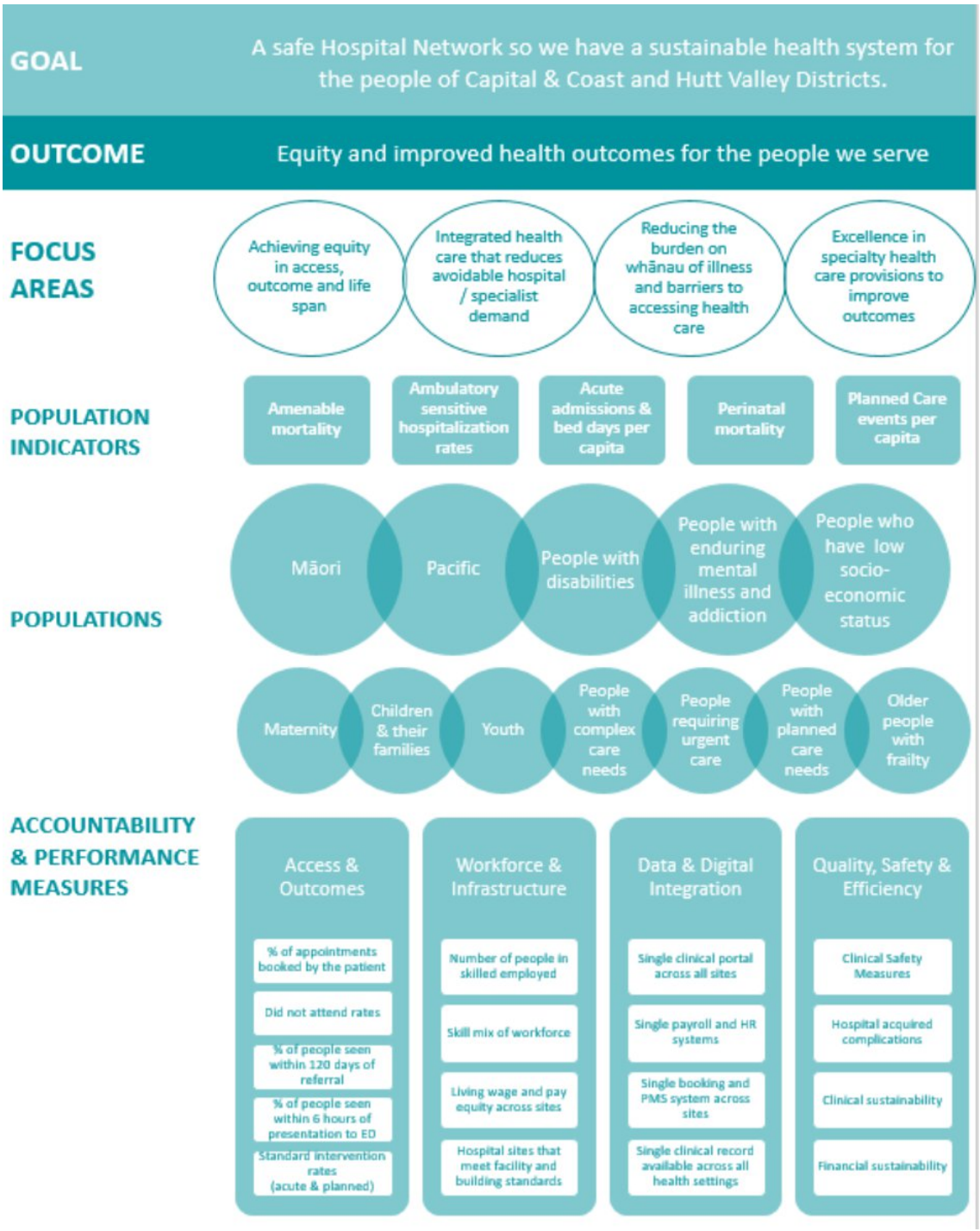
Ground work has commenced to identify how we will work with a wider range of communities. The priority is the development of Hutt Valley networks with a focus on Wainuiomata. The next milestone is agreement on priority areas and the leadership and establishment models that will work best for these networks.

Complex Care

Support for Māori and Pacific families

Our Maori and Pacific teams are working to extend the support available to Maori and Pacific communities with long term and complex conditions. This includes extending our navigation services and community nursing support for those with long term conditions.

Attachment 1: Performance management framework applied to the Hospital Network (example of an Impact Framework for Workstream).



Board Information – Public

4 August 2021

Māori Health Update – Quarter Four

Action Required

The Boards note:

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

(b) work continues on the implementation of Te Pae Amorangi

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

(d) the developments in the Whānau Services team and our commissioned services, Whare to Whare Kaiarahi, progresses

(e) the updates in the Maternal, Child and Youth area.

Strategic Alignment	Ministry of Health, Whakamaua: the Māori Health Action Plan 2020-2025 CCDHB Health System Plan 2030 (the 2030 Plan) CCDHB, Taurite Ora Māori Health Strategy 2019-2030 HVDHB, Te Pae Amorangi, Māori Health Strategy 2018-2027
Author	Arawhetu Gray, Director Māori Health Services
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Director Māori Health Services
Purpose	Provide an update on the progress and performance of the two DHBs against the two Māori Health strategies.
Contributors	Māori Health Services across the two DHBs
Consultation	Not applicable

Executive Summary

1. The 2DHB Māori Directorate change programme is completed and the decisions were communicated on Monday 24 May 2021. The new structure establishes strong leadership and aligns with the two DHBs strategies. Focus is now on supporting staff through the changes and recruitment into the newly established roles. The final structure will be in effect from 1 August 2021.
2. Te Ūpoko o te Ika Maui Council (TUIMC) met in May, and will be presenting their Protocol to the DHB Boards.
3. Tāngata Whaikaha Community Engagement is a new research project to identify gaps and barriers in disability support for tāngata whaikaha Māori and their whānau.
4. Whānau Care services continues its positive collaboration on the Whare ki te Whare Kaiarahi – Whānau Ora Navigation service. However, with the start of the COVID-19 vaccination clinic at Maraeroa, progress is likely to slow, as is necessary.
5. A new Project Manager has started in the Surgical, Women's and Children's Health area, mandated to deliver against Taurite Ora Service Focus Area 1, Maternal, Child and Youth. Focus is on assessing the work programme's current state and completing work that had been in progress. This includes the Transition into Care (formerly uplift) guidelines, Children's Health – Health Literacy training for staff and ongoing support for the Maternity Quality and Safety Programmes.

Strategic Considerations

Service	Continued delivery of the tailored programmes of work highlighted in Te Pae Amorangi and Taurite Ora to address the impact of inequity on Māori health outcomes.
People	The ongoing change programme for the 2DHB Māori Health Directorate is underway.
Financial	Baseline funding remains, Taurite Ora - $500k and Te Pae Amorangi $350k.
Governance	Te Ūpoko o te Ika a Maui Māori Council

Engagement/Consultation

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

Identified Risks

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

Attachment/s

1. 2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report – Quarter 4 (2021/2022).

2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report (2020/2021 Quarter 4)

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

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

Contents

1. Changes to the Māori Health Directorate

Staff in the Māori Health Directorate have been expecting a change proposal for some time. However with the previous leadership changes, the requirement to develop a Māori health strategy first, the move towards a 2DHB structure and then COVID-19, the change programme was not started until March 2021.

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

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

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

It is my intention to recruit to new roles and establish the new 2DHB structure, ready to commence operating on 1 August 2021.

Within Whānau Care Services specifically we have evolved our services to align with Taurite Ora, this has meant a disinvestment in one of the two cardiology roles. This has enable us to reallocate funding to appoint a Māori child health nurse to be appointed. This role is working within the child health team supporting the delivery of high quality care to Māori. To provide consultation, support, advice, education for ward staff to improve the care experience for whānau Māori. Our other nurse is still committed to supporting Māori patients with long term conditions and those receiving cardio-vascular treatment.

1.1 Key components and rationale driving proposed changes

1.1.1 Redefine core functions

While there is strong alignment between the two Māori Health strategies there is a need to align key deliverables into a combined HVDHB and CCDHB action plan, so effort and resources can be focused more deliberately. Despite the strategies being engaged and our intent to achieve better health outcomes for Māori, “business as usual” has continued across parts of the directorate. The change proposal sought to address this issue by resetting the respective work programmes to align with the new deliverables.

In line with the other 2DHB directorate changes, a review of our current functions was undertaken and as a result, recognised that core functions needed to be redefined to leverage expertise and avoid duplication. Firstly, within our team and secondly, across other directorates that we work closely with. This is critical given that other directorates are responsible for a number of actions in both strategies.

1.1.2 Measurable contribution to Māori health outcomes

Another key finding from the review has shown that there is no robust tracking system in place, making it difficult to track progress on the various deliverables in each plan. It is important that the directorate can measure contributions to improved Māori health outcomes and make robust decisions that are evidence based. The recruited Senior Insights Analyst has been a significant step in progressing this work. A key objective in this role is to establish baseline data for key deliverables in the strategies and establish robust data capture systems to monitor progress, both ours and other directorates.

1.1.3 Strengthening senior leadership capability and capacity

The creation of a 2DHB Director Māori role has revealed a senior management gap within the Māori Health directorate. Two new management roles have been created to strengthen cultural, strategic and operational capability and capacity. This robust management structure will enable the Director of Māori Health to maintain strategic oversight across Māori Health and relevant directorates. Having senior managers in place will also provide staff with clear direction on a daily basis and will help to embed a new, collaborative way of working with other directorates.

1.1.4 Supporting the organisations commitment to pro equity

The Māori Health Directorate continues to work closely with Strategy, Planning and Performance to support the establishment of a pro equity agenda across the organisation, specifically taking a leadership role regarding what this means for Māori. While an equity lens is an integral component of all roles within the proposed structure, three roles in the new directorate are dedicated to working in the areas of workforce, commissioning and equity. Te Upoko ki te Ika a Maui Māori Council, has provide invaluable feedback on changes that need to be incorporated into the draft.

1.1.5 Strengthened relationships with key directorates

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

1.1.6 Impact of the Health and Disability System Review

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

2. Te Pae Amorangi

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

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

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

Work continues on prioritising Māori workforce and how to increase it. Toi Ora have worked with hauora Māori students and have been part of an expo day to promote health as a career for Māori.

3. Taurite Ora

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

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

The critical task for the Māori Health Development Group and the ELT, is to determine how to best build a work programme that embeds these issues.

3.1 Tāngata Whaikaha Community Engagement Programme

One of our early responses to improve Maori health outcomes was to contract with the Foundation for Equity and Research (FERNZ) to undertake research with the tāngata whaikaha community to identify the gaps and barriers in disability supports for tāngata whaikaha Māori and their whānau. The research will help 2DHB planning for service for tāngata whaikaha so that we focus on achieving equitable outcomes. As this the Directorate has taken a strong Kaupapa Māori approach to this mahi, the community stretches into Wairarapa, so 3 DHB, rather than 2 DHB alone.

4. Strengthening our commissioned services

4.1 Whare ki te Whare Kaiarahi – Navigation service

MHDG continues to work alongside Maraeroa in the development of the Whare ki te Whare Kaiarahi – Navigation service to provide a community based service to support Māori:

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

The service supports Māori to be healthy at home, with a strong focus on prevention, improving access to existing health services, providing linkages to services, providing holistic community based care. It works with primary care and hospital based teams to keep people stay well in their homes. The service team works with individuals and the whole whānau.

We are in discussions with Maraeroa Marae on how we can strengthen the service in the 2021/22 financial year. Currently, Maraeroa is heavily involved in setting up its Covid-19 vaccination clinic and all its resources are focussed on providing this service to its community. We will pick up discussions at a later date and when they are ready.

5. Maternal, Child & Youth

In April 2021, a new Project Manager started in this area, this position is one of the four mentioned earlier that has a dotted reporting line to the Director Maori. Previous work is being re-assessed for continuation and completion, this has meant a delay in project timelines.

5.1 Maternity Quality and Safety Programmes (MQSP)

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

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

Survey work is a work in progress. There are iPads available to survey consumers utilising Maternity services, it is offered in both Te Reo Māori and English. The most recent data received for May had 18 respondents, two of whom were Māori. Of the 18, 15 said they were well cared for by staff "Yes,

always" and the remaining three chose "Yes, sometimes". All 18 respondents said they felt culturally safe during their stay with only one choosing "Yes, sometimes". Overall, the feedback was positive regarding care and there were suggestions for limiting visiting (external and internal visitors), restricted quiet times and private space. This work has been realigned and is reported to the Maternal Quality and Safety Programs Governance group. The summary of survey responses for May is in Appendix Three.

5.3 Maternal Wellbeing and Child Protection

The Newborn Transition into Care (formerly uplifts) and Care of the Vulnerable Pregnant Person guidelines are nearing a completed first draft. Some clinical feedback is still being sought from Children's Health services and an assessment of the consumer engagement and feedback on the policies is underway.

5.4 Children Clinics Service Improvement and Health Literacy

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

5.5 Commissioning Updates for Maternal, Child and Youth

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

6. 2DHB Māori Health Dashboard: Measures of Equity

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

Given the parallel nature of the aims and objectives of the two Māori health strategies, these five overall measures of equity are adopted as a framework for identifying indicators of progress toward Māori health equity in both the Capital and Coast and Hutt Valley regions. What we are conscious of is that significant change in improvements to Māori outcomes, takes time to reveal itself, therefore, we are looking at how we do report such slow progress in a more meaningful way.

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

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

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

7. Appendix One: 2DHB Māori Health Dashboard

Systemic changes enable equitable health outcomes for Māori

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

Areas of focus

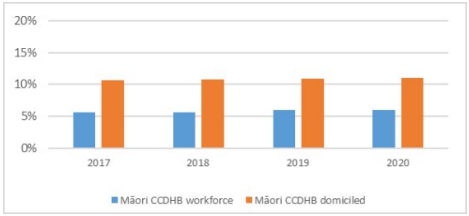
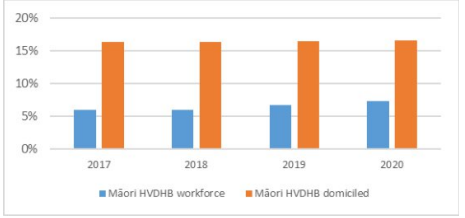
- DHBs as pro-equity health organisations
- Growing and empowering our workforce to have a strong Māori health workforce, and a workforce equipped to improve Māori health
- Strengthening commissioned services
- Accessible appointments

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: Māori workforce is proportional to the regional working population	An increase in Māori workforce is expected to improve cultural safety in the by both Māori and non-Māori staff, for both Māori staff and patients. This is expected to have a positive impact on accessibility of appointments and cultural safety for Māori patients.	Māori workforce across all professions of the DHBs and their partners / commissioned services 2DHB: ≥13.0% *CCDHB: ≥11.1%* *HVDHB: ≥17.1%*			Targets are based on working population age (15-64) from 2018 Census, which is 11.1% for CCDHB and 17.1% for HVDHB. CCDHB: Baseline of workforce declaring Māori ethnicity is 6.9% as of November 2020. Note that 15% of staff have 'Other' or 'Unknown' ethnicity, and this number may decline with as data collection improves (one of the programmes of work).
Indicator 2: All current and future staff provide culturally safe and competent services to Māori	Ensuring all our commissioned services prioritise Māori health is the primary outcomes sought.				In the next quarter we will be developing a cultural competency workforce plan to set core competencies for all staff to achieve health equity and improve Māori health outcomes. The first phase will be to establish the current status (baseline data) of cultural competence within our workforce

Māori live longer lives

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

Areas of focus

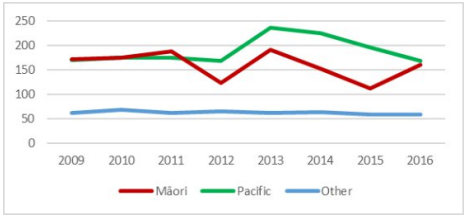
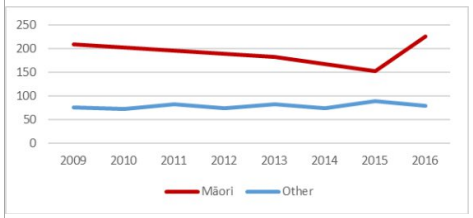
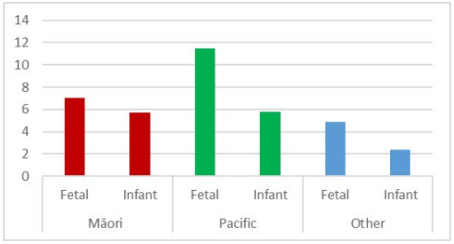
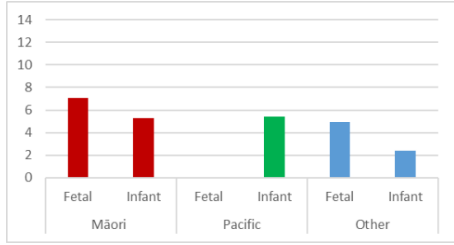
- Amenable mortality
- Maternal, child and youth
- Mental Health and Addictions

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: Amenable mortality	Amenable mortality measures deaths that are potentially preventable given the appropriate effective health care and is an indicator of the performance of a health system.	Māori amenable mortality rates are equal to or lower than non-Māori rates		 Pacific Rates suppressed as they are >30 deaths	The potential positive impacts of the parallel Māori Health Strategies on this measure of equity will not be available for at least five years if amenable mortality is calculated by the Ministry of Health.
Indicator 2: Increase in life expectancy for Māori	A healthcare system that provides equitable outcomes should not show differences in life expectancy for different ethnicities.	Māori life expectancy rates are equal to or greater than non-Māori rates	❖ Baseline and future life expectancy as calculated by the Ministry of Health can be found here or here		Life expectancy has not been calculated in New Zealand on a DHB level, but rather for the whole Wellington region (including Wairarapa, Hutt Valley and all of the Kāpiti Coast).
Indicator 3: Lower rates of Māori infant and foetal mortality	A healthcare system that provides equitable outcomes should not show differences in foetal/infant mortality rates for different ethnicities.	Māori infant and foetal mortality rates are equal to or lower than non-Māori rates per 1,000 (2017)			This is connected to initiatives on breastfeeding, immunisations, smoke-free homes, and safe sleep devices.

Māori have fewer avoidable hospital admissions

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

Areas of focus

- ASH
- Long-term conditions
- Maternal, Child and Youth
- Mental Health and Addictions

Links to Whakamaua: Māori Health Action Plan 2020-2025

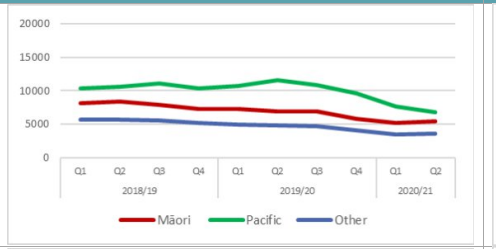
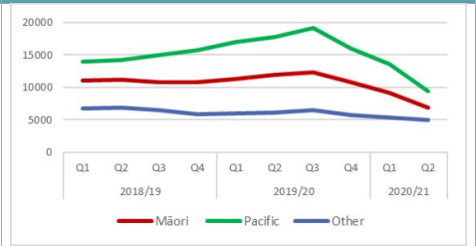
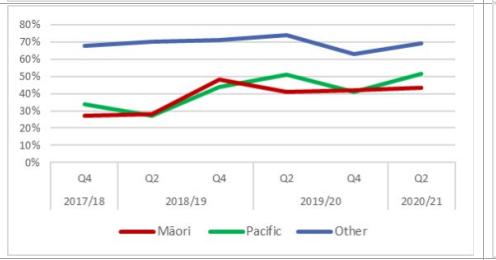
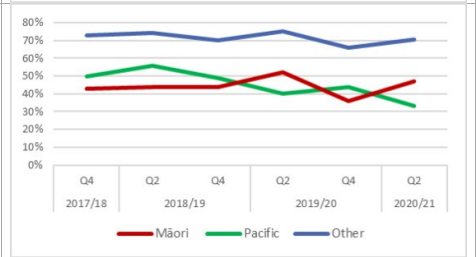
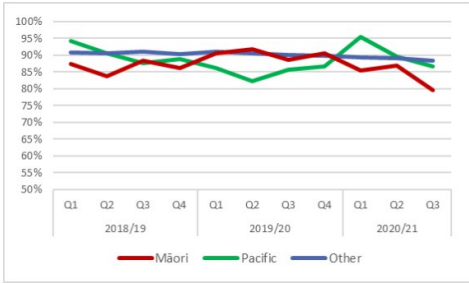
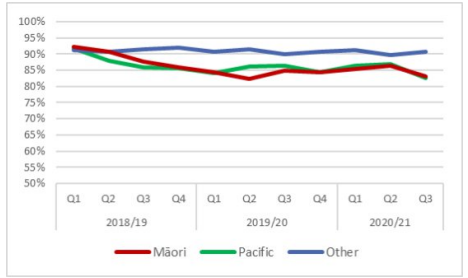
- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 3: Reduce health inequities and health loss for Māori

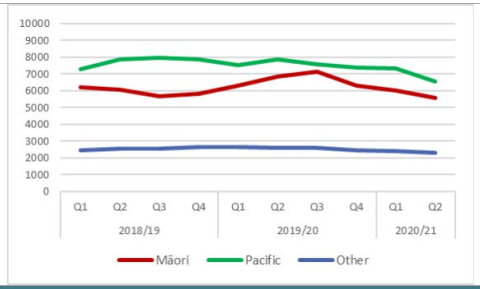
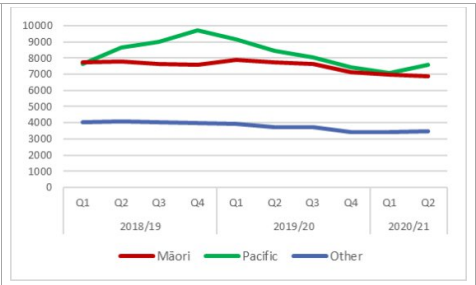
Sub-regional initiatives (2DHB)

- MHA Services Review
- Long-term conditions initiatives
- Programmes with focused messages around safe sleep, immunisation, breastfeeding, and smoking cessation
- Programmes with a focus on encouraging use of primary care

Local initiatives

- CCDHB: SLMs for youth
- CCDHB: Zero Seclusion Project
- HVDHB: Shift MHA services and care closer to home

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: ASH rates (ages 0-4)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care intervention and Māori have been found to have higher rates than non-Māori, pointing to inequitable healthcare outcomes.	Reduction in Māori child ASH rates by 6%			Other measures of avoidable hospitalisation are being explored and developed, but not yet available to use as a baselines, such as housing-related hospitalisations in children.
Indicator 2: Māori babies live in smoke-free homes	Babies living in smoke-free homes are expected to have greater health outcomes and reduced rates of hospitalisation.	At least 70% of Māori babies live in smoke-free homes			Māori observed increased percentages in the recent data point however overall trends appear to be pleateuing. This suggests achieving target may require some disruptive intervention.
Indicator 3: Māori babies are immunised	Children who receive immunisations can be protected from some illnesses that might result in hospitalisation. Māori tamariki are currently less likely to be fully immunised by age 5 than non-Māori children.	95% of Māori tamariki are immunised by age 5			WellChild data also includes data on breastfeeding and smoke-free homes and a range of other indicators by DHB.

Indicator 4: ASH rates (ages 45-64)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care intervention and Māori have been found to have higher rates than non-Māori, pointing to inequitable healthcare outcomes.	Reduction in Māori ASH rates by 6%			ASH data is not available for ages 5 to 44. While ASH rates may reduce comparatively for ages 5-44, we do not know how Māori are impacted in this age range. Acute hospital bed days data can be found here. Average inpatient length of stay data available here.

Māori have greater access to appointments

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

Areas of focus

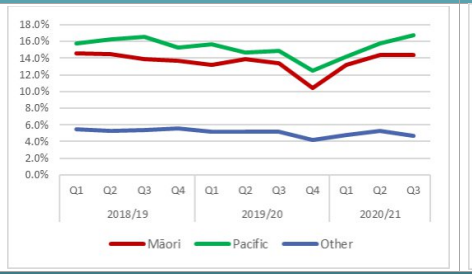
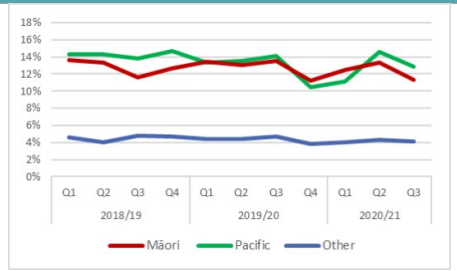
- Accessible appointments
- Did Not Attend (DNA) rates

Links to Whakamaua: Māori Health Action Plan 2020-2025

- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 2: Shift cultural and social norms
- Objective 3: Reduce health inequities and health loss for Māori

Sub-regional initiatives (2DHB)

- Cultural competency workforce plan and associated resources
- Project analysing DNA rates and how these can be addressed

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: DNA rates	'Did Not Attend' rates can be an indication of accessible appointments. Reasons for people not attending have previously been categorised as 'patient' and 'clinic' factors, thus attributing much of the blame to the patient. Most of the reasons attributed to the patient can be overcome by reframing the idea that the fault lies with the patient, and instead focusing on increasing accessibility to clinics for all patients.	Reduced DNA rates for 2DHB Māori			There are a number of DNA projects underway at CCDHB, Māori Service Team are involved and working to ensure a Māori voice is represented.

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

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

Areas of focus

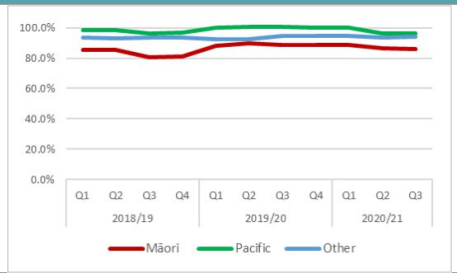
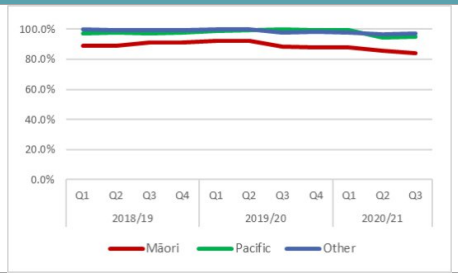
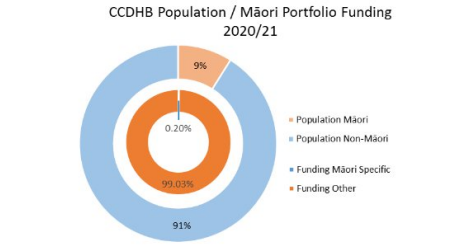
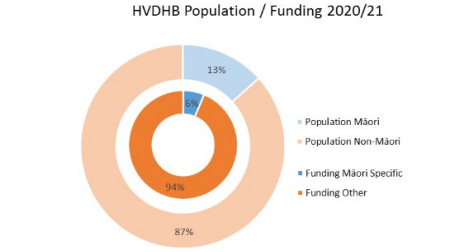
- Primary care and Māori health providers
- Community health services
- Co-design and partnership-based approaches

Links to Whakamaua: Māori Health Action Plan 2020-2025

- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 4: Strengthen system accountability settings

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: PHO enrolment rates	Enrolment in and utilisation of primary care is an important factor in reducing avoidable hospital admissions, managing long-term conditions, and improving health outcomes overall.	All Māori are enrolled in PHOs			Māori observe very gradual decreasing trends since mid-2019.
Indicator 2: Māori Health portfolio funding Increased funding to Māori health providers as a proportion of total funding	Māori health providers facilitate culturally safe access to community-based services and primary care, providing options outside of secondary care.	Increased Māori Health portfolio funding proportion			The CCDHB Maori portfolio funding is managed by MHS and includes $755,924 of Well Child funding via the MoH Crown funding agreement. The HVDHB Maori provider funding includes $301,677 COVID support funding

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

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

Board Information – Public

4 August 2021

Pacific Health & Wellbeing Strategic Plan 2020-2025 Update: A Focus on the 2DHB Pacific Health Workforce	
Action Required **The Boards note:** (a) the Pacific Directorate are focussed on addressing the six priority areas defined in the Pacific Health & Wellbeing Strategic Plan 2020 – 2025. This paper provides an update on the approach to developing the 2DHB Pacific Health Workforce. (b) development of a Pacific workforce is linked to the ability of the DHB's to address Pacific health disparities. (c) there are a number of initiatives that need to be implemented to recruit, retain, and develop the Pacific Health Workforce.	
Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Junior Ulu, Director Pacific People's Health 2DHB
Endorsed by	Fionnagh Dougan, Chief Executive Officer 2DHB
Presented by	Junior Ulu, Director Pacific People's Health 2DHB
Purpose	To provide a plan for the development of the 2DHB Pacific Health Workforce to address health disparities for Pacific people.

Executive Summary

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 was agreed in late 2020. This paper provides an update in relation to:

- the approach to developing the Pacific Health Workforce
- the importance of a Pacific health workforce in addressing health disparities
- the significant gaps in the Pacific health workforce in New Zealand
- the profile of the current 2DHB Pacific health workforce
- Initiatives underway, and newly developed to increase and strengthen the Pacific health workforce.

Strategic Considerations

Service	N/A
People	N/A
Financial	Investment to implement Workforce plan
Governance	Pacific Health Strategy jointly owned by the DHBs and the Pacific community. DHBs work collaboratively with the Pacific community in the transformation of our health system to improve health outcomes and ability to achieve equity for Pacific people.

Identified Risks

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

Attachment/s

1. Pacific Health & Wellbeing Strategic Plan 2020-2025 Update: A Focus on the 2DHB Pacific Health Workforce.

Pacific Health & Wellbeing Strategic Plan 2020-2025

Update: A Focus on the 2DHB Pacific Health Workforce

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020 – 25 was agreed in late 2020. This paper provides an update on the approach to developing the 2DHB Pacific health workforce, and includes:

- An explanation of the role of a Pacific health workforce in addressing health disparities
- The significant gaps in the Pacific health workforce in New Zealand.
- Provision of a profile of the 2DHB Pacific health workforce.
- Initiatives underway, and newly developed to increase and strengthen the Pacific health workforce.

Contents

1. Introduction

In the months since the launch of the Pacific Health and Wellbeing Strategic Plan 2020 – 2025 there have been significant changes within the health sector. The outcome of the Health and Disability Review reinforces the disparities that continue to plague Pacific people, and the need to support the strategic vision: "Pacific peoples are empowered and enabled to live longer quality lives, supported by a culturally responsive health system".

Of the Strategy's six priority pillars a key focus area is the 2DHB Pacific health workforce. Health inequities continue to disproportionately affect Māori and Pacific people, with a limited health workforce we are unable to respond effectively. This is further compounded by the current climate of Covid-19 where the need to mobilise the Pacific health workforce for testing and vaccinations continues to pose significant challenges. While there are initiatives underway to strengthen the development of a 2DHB Pacific health workforce, a more coordinated approach is required and new initiatives must factor learning from past experiences to avoid failed attempts. The purpose of this paper is to describe the plan and range of initiatives.

2. The Importance of a Pacific Health Workforce

The recently launched Bula Sautu – *A window on quality: Pacific health in the year of COVID-19* (launched 5 July 2021) is a comprehensive analysis of the health status of Pacific people in New Zealand. The report acknowledges that a stocktake of the Pacific health workforce in 2011 showed that Pacific peoples are significantly underrepresented in the health workforce, comprising approximately 2.3% of the registered or health professional workforce.

Statistically the categories where Pacific are underrepresented include: allied and scientific, midwifery, nursing, resident medical officers and senior medical officers. The only categories where the Pacific workforce matches or over-represents the population are care and support roles (including hospital orderlies, cleaners and health care assistants), corporate and other (including administrative support staff). The need for equity in the New Zealand health workforce representation as well as prioritised funding towards growing and upskilling a Pacific health workforce helps meet the needs of Pacific populations who face health, social, economic and educational disparities.

The data indicates an increase in respiratory illnesses, higher Ambulatory Sensitive Hospitalisations (ASH), Emergency Department attendances, higher caesarean rates[1], lower breastfeeding rates, higher sudden infant death rates, increasing complexities such as gestational diabetes, child development poverty, mental health & addictions and family violence amongst Pacific people. Investing resources and funding into

[1] Health and Wellbeing of Under-five year olds in Hutt Valley, Capital & Coast and Wairarapa 2017

growing the Pacific health workforce will enable us to close the gap and make a difference in how healthcare is delivered and optimum health is achieved for Pacific in New Zealand.

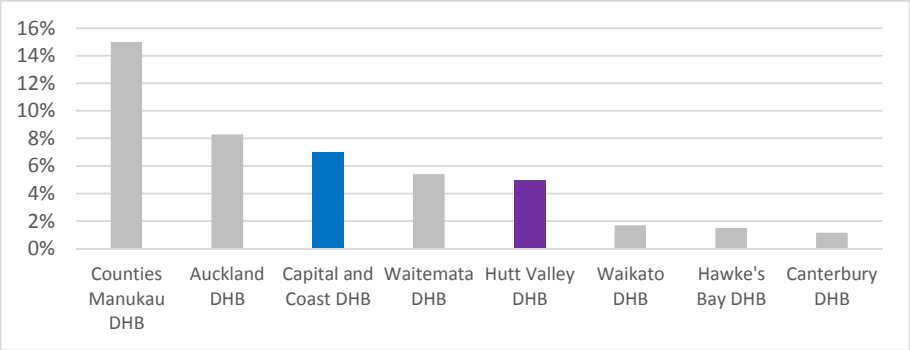
Developing the Pacific health workforce is a priority because ethnic and linguistic diversity among health professionals is associated with better access to and quality of care for disadvantaged populations[2]. Pacific health workers bring connections with Pacific communities, personal understanding of Pacific issues, and Pacific culture and language skills. The Pacific health workforce can positively influence equity in health outcomes by integrating cultural practices, concepts and diverse worldviews into high-quality, evidence informed health services.

Health literacy amongst many Pacific communities is still relatively low and a contributing factor to health disparities. A strong Pacific health workforce can help Pacific people navigate complex health systems, understand and locate health information, and translate medical terms.

3. 2DHB Pacific Health Workforce Profile

The 2DHB employs 697 people who identify as Pacific: 586/ 6278 at Capital and Coast – 7% of its workforce, and 111/2441 at Hutt Valley - 5% of its workforce. Figure 1 shows where we sit against the eight DHB's that have significant Pacific personnel. It is important to note that there may well be more Pacific personnel, noting that CCDHB and HVDHB have the third and fourth highest percentage of ethnicity being 'unknown' in our workforces, therefore raising issues on data quality.

Figure 1: DHB Pacific workforce

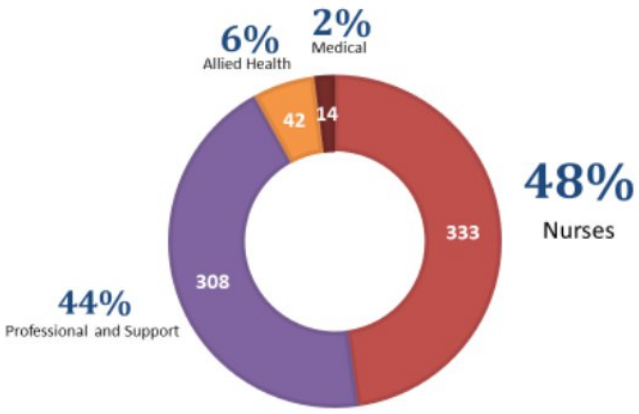


The data collected shows that the 2DHB employ 14 Pacific medical staff 6/899 Capital and Coast and 8/388 at Hutt Valley. There are potentially more than this figure based on anecdotal evidence, the Pacific Directorate have carried out two meet and greets with Pacific medical staff to identify this cohort more accurately. The largest representation who identify as Pacific are the 333 Pacific nurses across 2DHB:

[2] Ala Moui: Pathways to Pacific Health and Wellbeing 2014-2018

290/3186 at Capital and Coast and 43/1080 at Hutt Valley. This cohort make up 48% of Pacific staff. The second biggest cohort are the 308 Pacific professional and support personnel – 44% of Pacific staff, who cover professional/ management roles; administration who are 50% of this group, maintenance, orderlies, store person, drivers, cleaners and kitchen staff, Pacific are over-represented in this category. There are 42 Pacific allied health staff, 30/901 at Capital and Coast and 12/458 at Hutt Valley. The majority of allied health workers are technicians, social workers, with a small number of therapists. Figure 2 depicts this breakdown.

Figure 2: Breakdown of 2DHB Pacific Health Workforce



This data shows that while 2DHB Pacific staff are well above the 3% national average of Pacific people employed by a DHB, the percentages need to shift from over-representation in support roles, to a more clinically and professionally based staff group to really see changes occur in Pacific health statistics. What therefore needs to happen to address this problem, and what is possible within the timeframe of the Strategy?

4. Initiatives

To adddress the challenges outlined in this paper it will take bold initiatives that realistically require time to deliver significant results. While it would be tempting to only work on 'low hanging fruit' initiatives, to see a systems change work smoothly, an investment in long term development opportunities that may not be seen for years to come is necessary. What is clear is the initiatives must build on past, exisiting, and new approaches that focus on three tiers: recruitment, retention, and promotion of Pacific people. The coordination of initiatives need to be driven by all relevant 2DHB stakeholders working collaboratively with the Pacific Directorate. These initiatives are a shared responsibility that will only succeed if all participate, and operate within the values of the organisation. The tables below provide an overarching workforce plan to address the gaps. Note the initiatives listed are not a comprehensive list and this will be updated as new initiatives are developed. A monitoring and evaluation framework will also be built to measure the success and opportunities that arise from these initiatives.

Recruitment

Recruitment of the Pacific health workforce needs to be deliberate, with a focus on strengthening the medical, nursing, allied health, and professional areas. Recruitment initiatives include:

INITITIVES UNDERWAY	NEW INITIATIVES/ WAYS TO PROGRESS INITIATIVES UNDERWAY
Pro-Equity People-based Commissioning Policy	This policy provides a foundation on which to build a Pro-Equity Pacific health workforce plan.
Nurse Entry to Practice Programme (NETP): The 2DHB Chief of nursing has proactively identified Pacific people who will join the 2DHBs through NETP.	
Nursing & Midwifery Recruitment and Retention Strategy: This document sets out the strategic direction in which the 2DHBs will work towards recruiting and retaining a dedicated nursing and midwifery workforce with innovative recruitment initiatives to attract Pacific people. This includes interviewing all Māori and Pacific candidates who meet the minimum criteria for nursing and midwifery positions.	We also intend to work with Pacific health organisations such as Tausi Soifua Samoa Nurses Association, Tongan Nurses Association, Fiji Nurses, and Tokelau Nurses to create a pipeline to support this strategy. There is work underway to ensure that any recruitment advertising and marketing reflects our diverse workforce, and are actively encouraging Pacific people's applications. The utilisation of targeted job boards – such as Kumara Vine – which are aimed specifically at the pacific demographic. Engaging with local schools, to form a partnership where we are actively engaging students early to encourage consideration of a career in Nursing or midwifery. This includes careers fairs and open days.
The Midwifery Accord Nationally, only about 3% of the total midwifery workforce are Pacific, while 10% of women giving birth are Pacific. Return to Practice Programme: Work is underway to encourage former midwives back into their vocation. Midwives who wish to practice after an absence of three years or more are required to complete the Return to Practice Programme to make sure they have the latest training and certifications. To overcome the financial barrier to midwives, who have previously had to self-fund this education, the	• **Active recruitment of local Pacific midwifery students with ad hoc initiatives:** ▪ Collect Pacific expression of interests when engaging with families utilising midwifery services ▪ Engaging with secondary schools. • **Submit MoH Business case**: three year initiative to fund Pacific midwifery scholarships. • **Promotion of midwifery career among Pacific people working within 2DHB**

Government will now fund partial or full costs, depending on how long they have been away from the profession.	
Allied Professions Lead for Pacific Peoples Health: Allied Health have developed a .6FTE role that will sit in SLT with a soft line to the Director Pacific.	One of the functions of the position is to increase Pacific allied health personnel and this will be linked to the Pacific Careers Programme. MHAIDS are considering a similar arrangement.
Careers Expo Capital & Coast/ Hutt Valley	Focus efforts on Pacific students to attend these events.
	Pacific Careers Programme (Yr. 9 – 13): The development of a Pacific Career Programme' targeted at Years 9 – 13 aims at increasing the overall number of Pacific working in the health and disability sector. The programme will support growth in the Pacific health workforce that is more reflective of the communities the workforce serves and supports. We will partner with the Ministry of Education and the Ministry of Social Development to target schools in the greater Wellington area to ensure that Pacific students are taking the relevant subjects to progress a career in health. Areas where mentorship should be encourages: midwifery, dental, mental health.
	2DHB Pacific Human Resources Plan to encourage recruitment processes that suit a Pacific demographic
	Emergency Department Pacific Recruitment initiative: ED can be a demanding, but rewarding environment to work. We have been approached for ways to increase Pacific recruitment into this area where there is currently no Pacific personnel.

Retention

Data shows that 49% of Pacific people employed by the 2DHBs have worked here for more than five years, compared to 40% for non-Maori and non-Pacific. In comparison to other DHB's the 2DHB retain Pacific workforce longer (7.8 years for CCDHB; 8.6 years for HVDHB), however for the total workforce CCDHB has some of the lowest retention rates as demonstrated in Figure 3.

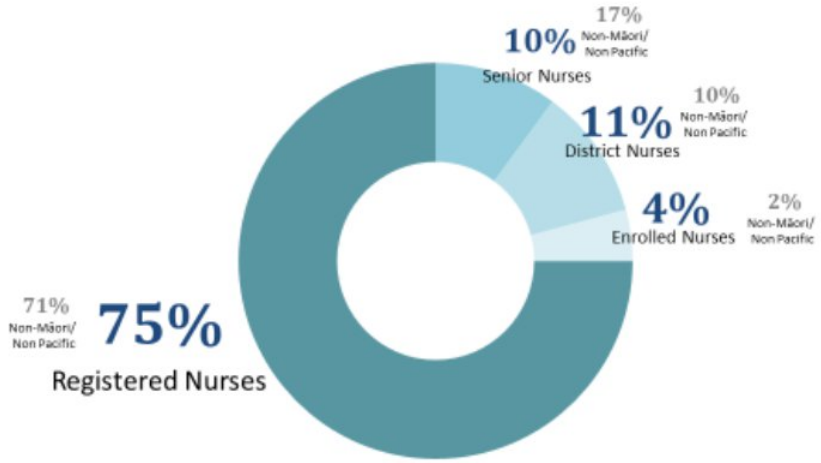
Figure 3: Mean length of service by occupation group and DHB

DHB	Nursing	Corporate and other	Allied and scientific	Care and support	SMO	RMO	Midwifery	All staff
Whanganui	10.1	9.9	10.5	9.9	9.6	1.2	11.3	9.7
Taranaki	10.4	10.3	9.5	10.3	8.0	1.9	8.0	9.6
Southern	10.8	9.6	8.7	8.4	11.1	2.4	8.8	9.5
MidCentral	10.2	9.3	8.9	8.4	10.9	2.1	8.7	9.3
Canterbury	10.1	7.9	9.7	9.1	11.4	2.5	9.1	9.1
West Coast	10.1	7.0	10.3	10.2	5.9	1.4	8.8	9.0
South Canterbury	9.9	8.7	8.5	10.0	6.8	1.1	6.6	8.8
Lakes	9.8	8.6	8.3	7.4	8.3	1.7	7.6	8.5
Tairāwhiti	10.2	7.6	7.9	7.7	8.3	1.2	5.7	8.5
Bay of Plenty	9.5	9.0	7.5	7.3	9.3	1.7	7.3	8.4
Nelson Marlborough	9.6	7.3	7.9	8.2	10.5	1.7	6.3	8.3
Hutt Valley	9.0	8.5	8.1	8.7	8.8	1.1	7.0	8.0
Hawke's Bay	8.3	8.4	8.5	7.3	9.7	1.8	7.0	8.0
Wairarapa	8.8	6.8	9.1	7.2	8.3	0.3	5.0	7.9
Waikato	8.4	8.2	8.3	6.9	10.1	2.1	7.2	7.9
Auckland	7.8	8.0	8.1	8.6	10.5	1.0	7.2	7.9
Northland	8.4	8.8	8.6	5.3	8.8	1.6	7.6	7.8
Counties Manukau	6.9	8.0	7.0	6.7	10.3	0.9	7.7	7.0
Waitematā	7.0	7.1	7.8	6.6	10.0	0.9	6.8	7.0
Capital & Coast	7.0	6.9	6.8	8.0	10.3	1.5	7.1	6.9
Grand Total	**8.6**	**8.1**	**8.2**	**7.7**	**10.1**	**1.6**	**7.5**	**8.1**

Promotion

Data of the Pacific health workforce reflect that there are very few Pacific people in leadership roles. Figure 4 shows that while there are 333 Pacific nurses working in the 2DHB, only 10% are in official senior nurse positions. This may be a result of many reasons that are not necessarily a negative reflection of the 2DHB, but in order to retain the health workforce, promotional opportunities should be identified across all disciplines, and pathways are created within appraisals processes for Pacific staff to aspire to.

Figure 4: Breakdown of 2DHB Pacific Nursing Positions



Initiatives to improve retention and promotion include:

INITITIVES UNDERWAY	NEW INITIATIVES/ WAYS TO PROGRESS INITIATIVES UNDERWAY
Allied Health/ MHAIDS/ Nursing Scholarships and professional development opportunities :	Often Pacific staff are unware of professional development opportunities and scholarships that are available. As part of the plan, we will work with the **Communications** and the **People and Capability** teams to ensure Pacific are taking advantage of all opportunities.
The Aniva Nursing Leadership Programme: This is a Pacific workforce initiative commissioned by the Ministry of Health 10 years ago. The programme supports senior Pacific nurses and midwives to achieve postgraduate qualifications with a focus on responding to the challenges facing health care in order to better serve Pacific patients and their families. The Aniva programme has made a significant contribution to developing New Zealand's Pacific nursing workforce, with over 250 enrolments as part of the Master's pathway since 2012.	We are actively encouraging Pacific nurses to take up this opportunity. The Communications team have released stories on current Pacific nurses who have completed the course to promote the Aniva Programme across the 2DHB.
Nursing & Midwifery Recruitment and Retention Strategy:	There are initiatives listed in this strategy that creates secondment opportunities, working on discreet projects, temporary acting leadership roles. Typically Pacific nurses are intimidated by these opportunities and subsequently are overlooked. A systems change can occur and be strengthened through **Cultural Competency Training** offered by the 2DHB Pacific Directorate if requested by different parts of the organisation.
The Midwifery Accord **Midwife Clinical Coaches programme.** This programme is an innovative approach that has been identified by the Midwifery Accord Group as a potential solution to stabilise the workforce. Clinical coaches will provide clinical and pastoral support for midwives.	• **Regular engagement with Pacific midwifery students** (Victoria and Otago) to improve retention rate. • **Birth for Every Body Conference:** Opportunity to promote midwifery.

Quality Improvement Training Courses: There are currently two training course options being offered to help grow and improve skills and experience. Option 1: Quality Improvement (QI) Fundamentals: Option 2: QI 12 week Course:	We are working with a Pacific Quality Improvement Advisor on encouraging Pacific staff to enrol for these training opportunities to strengthen their existing skillset. To help scope future needs and support for Pacific, participants can complete self-identified ethnicity on feedback forms to better inform this.

Assumptions

These initiatives are largely based on the assumption that 2DHB staff acknowledge the importance of growing the Pacific health workforce to mitigate Pacific health disparities. Furthermore 2DHB staff have a shared responsibility and will work collaboratively with the Pacific Directorate to deliver the initiatives underway, and develop new recruitment, retention, and promotion initiatives for Pacific. It also assumes more Pacific young people will choose health as their chosen career, and existing Pacific health workers utilise opportunities to strengthen their skills and experiences.

Board Decision – Public

4 August 2021

Disability Support Advisory Committee (DSAC) Items for Board Approval and Noting from Committee meeting dated 21 July 2021

Action Required

The Boards approve:

Item 3.1 – Suicide Prevention Postvention Annual Action Plan 2021/2022

(a) 3DHB Suicide Prevention Postvention Annual Action Plan 2021/2022.

The Boards note:

Item 3.1 – Suicide Prevention Postvention Annual Action Plan 2021/2022

(a) The subregion's *Suicide Prevention and Postvention Action Plan* has been refreshed to align with the *He Tapu te Oranga o ia Tāngata: Every Life Matters – Suicide Prevention Action Plan 2019-2029.*

(b) The Action Plan aligns with the goals Taurite Ora Māori Health Strategy 2019-2030 and Te Pae Amorangi Maori Health Strategy 2018 -2027.

(c) The Action Plan also reflects the purpose of Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 and the Sub-Regional Disability Strategy 2017 – 2022 - Wairarapa, Hutt Valley and Capital & Coast District Health Boards

(d) The Suicide Prevention and Postvention Action Plan governance group has endorsed the Suicide Prevention and Postvention Action Plan.

(e) The support of our intersectoral partners is being coordinated through our locality relationships.

(f) The implementation and progression of The Suicide Prevention and Postvention Action Plan and the related activities across the four domains of health promotion, prevention, intervention and postvention.

(g) That the timing of the DSAC meeting has meant the paper is yet to be presented to the Maori Partnership Board, and Subregional Disability Advisory Group and that their advice will be incorporated in the Action Plan.

Item 3.3 - Creating Enabling Maternity Care: Dismantling Disability Barrier - Mums and Babies' Experience at the 3DHB

(a) the 3DHB review of disabling barriers to maternity care at 3DHB

Item 3.4 – 3DHB Final Draft Annual Plans 2020/21

(a) the CCDHB, HVDHB, and WrDHB final draft annual plans 2021/22

Item 3.5 - Mental Health and Addiction Commissioning Forum

(a) The establishment of a Mental Health and Addiction Commissioning Forum to steer the design and implementation a whole of population, equitable, mental health and addiction system of care to support the wellbeing of the people in our subregion.

(a) The appointment of office holders and members to the Mental Health and Addiction Commissioning Forum from four groups: DHB system leaders; people with lived experience; Māori; and clinical/expert leaders.

(b) The Mental Health and Addiction Commissioning Forum's role to provide advice and recommendations to the Chief Executive, Hutt Valley and Capital & Coast DHBs.

(c) The Mental Health and Addiction Commissioning Forum will provide governance for our DHBs' delivery on the mental health and addiction strategic priority; driving system transformation as we transition to a new health and disability system.

(d) The plan to hold the first meeting of the Mental Health and Addiction Commissioning Forum in August 2021

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

(a) the update on the implementation of the Sub Regional Disability Strategy 2017 – 2022.

(b) the disability question has been prototyped included in our regional booking processes and systems established to allow people to request reasonable accommodations if required.

(c) the Disability Equity e-learning modules are now available on Connect Me, Ko Awatea and Health On Line.

Item 4.2 – 3DHB MHAIDS Service Performance Update

(a) the attached data report from MHAIDS.

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	Gain Board approval for decisions endorsed by DSAC, noting any discussions or areas of concern, 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 decisions seeking Board approval have been endorsed by the Disability Support Advisory Committee (DSAC) in its meeting on 21 July 2021. There were no amendments requested by the Committee. The full papers can be located on the DHB websites or in the DSAC Diligent Book for 21 July 2021.

Strategic Considerations

Service	As noted in the DSAC papers
People	As noted in the DSAC papers
Financial	As noted in the DSAC papers
Governance	As noted in the DSAC papers

Engagement/Consultation

Patient/Family	As noted in the DSAC papers
Clinician/Staff	As noted in the DSAC papers
Community	As noted in the DSAC papers

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	As noted in the DSAC papers				

Attachment/s

n/a

Board Information – Public

4 August 2021

Health System Committee (HSC) update from Committee meeting dated 28 July 2021

Action Required

The Boards note:

(a) The papers are in the Diligent Board book for the HSC meeting dated 28 July 2021.

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

Item 2.2 Kāpiti Community Health Network update

(a) Kāpiti CHN is the first Network to be developed within the district, with establishment beginning in July 2020.

(b) The Kāpiti CHN is being developed in partnership with mana whenua (Te Ātiawa ki Whakarongotai), CCDHB and Tū Ora Compass Health in the first instance.

(c) Development of Kāpiti CHN in year one has been delivered in two overlapping phases; Development and Establishment of the Network Foundations and Implementation of a Network team and work programme.

(d) We will continue to invest in the development and implementation of Kāpiti CHN in 2021/22. Learnings from Kāpiti and alignment with the planning for locality networks through Health NZ, will inform the roll-out of Networks across the district

Item 3.1: Health Outcomes for Kāpiti Residents

(a) that looking at a range of indicators for mothers and babies, children, youth, people living with long term conditions and older people, Kāpiti residents generally experience better health outcomes than residents living in other areas served by CCDHB.

(b) that despite this, the equity gap persists with poorer outcomes in almost every area reviewed for Māori and Pacific peoples. Data is not available to assess the position for disabled people.

(c) there has been a continued increase over time in the amount of outpatient services provided either face to face locally or via telehealth in the Kāpiti district.

Item 3.2: Localities and Community Networks – Our Approach

(a) our approach to localities and community networks

Item 4.1: Regional Public Health Report

(a) this regular update from Regional Public Health

(b) this update on COVID-19, vaping in schools and food systems

Item 4.2: Q3 Non-Financial MOH Reporting – 2020/2021

(a) the summary from two key reports:

i. CCDHB and HVDHB's Non-Financial Quarterly Monitoring Report for Q3 2020/21 (January to March 2021) – refer Attachment 1 and 2

ii. CCDHB and HVDHB's Q3 2020/21 Health System Plan and Vision for Change dashboard – refer Appendices to Attachment 1 and 2.

(b) that CCDHB received an 'Achieved' or 'Partially Achieved' for 40 indicators, and 'Not Achieved' for 7 indicators.

(c) that HVDHB received an 'Achieved' or 'Partially Achieved' for 39 indicators, and 'Not Achieved' for 7 indicators. This is a decrease on Q2 performance.

(d) that this decrease on Q2 performance is driven by immunisation targets falling from 'achieved' to 'not-achieved'. This is consistent with the rest of New Zealand.

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

(f) overall results for CCDHB and HVDHB demonstrates:

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

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

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

(g) that the reduction of midwifery support in our communities appears to be contributing to a reduction in the number of women exclusively breastfeeding.

Endorsed by	Fionnagh Dougan, Chief Executive Health System Committee
Presented by	Sue Kedgley, Health System Committee
Purpose	Provide the Boards with an update regarding the content of the meeting
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. The papers can be located on the DHB websites or in the HSC Diligent Book for 28 July 2021.

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

n/a

Board Decision – Public

4 August 2021

2022 Board and Committee dates and Board work plan

Action Required

The Boards approve:

a) the meeting schedule for the HVDHB and CCDHB Boards and Committees for 2022 in attachment 1.

The Boards note:

a) the meeting schedule is to June 2022 only, due to the timing of the health system reform

b) the HVDHB and CCDHB Board meetings will be held concurrently

c) the HVDHB and CCDHB Finance, Risk and Audit Committee (FRAC) meetings will be held concurrently

d) the location of all meetings will alternate between the Hutt Hospital and the Wellington Regional Hospital

e) the meeting dates and approach for the Heath System Committee (HSC) and Disability Support Advisory Committee (DSAC) involves:

   i. one scheduled meeting for 16 March 2022 (HSC morning and DSAC afternoon)

   ii. one placeholder scheduled for 8 June 2022 noting that the Chair will make a decision (in consultation with the Committee Chairs) on whether the meeting is required, once there is greater clarity on the work programme required for 2022 and the transition to Health NZ.

f) the draft 2022 Board Work Plan in attachment 2 which will be updated as progress on the strategic priorities is made and the health system reform progresses.

Strategic Alignment	The Board governance structure supports the strategic priorities adopted by the Boards
Author	Sally Dossor, Director Office of the Chief Executive and Board Secretary
Endorsed by	Board Chair, David Smol and Chief Executive, Fionnagh Dougan
Contributors	2DHB ELT
Consultation	Board and Committee Chairs

Executive Summary

This paper confirms the dates for Board and Committee meetings and the draft 2022 Board work plan. Given the timing of the health system reform and supporting legislation, meetings are not set beyond June 2022. The schedule has been set in consultation with the Board Chair and Chairs of the Committees. The draft Board work plan will be updated at the end of 2021 to reflect progress on the agreed strategic priorities, and will evolve if decisions are required to respond to issues that arise in the transition period.

Strategic Considerations

Service	Governance
People	N/A
Financial	The meeting schedule ensures that the Board and FRAC undertake timely monitoring of financial and operational performance.
Governance	The meeting schedule supports the governance role of the Board and Committees

Board and Committee Schedule For 2022

The proposed dates for the Board and Committee meetings are on the attached calendar for the first 6 months of 2022 (attachment 1).

Frequency and flow

To plan for 2022, staff have reflected on the 2021 meeting schedule and considered feedback from members. We have also conferred with other DHBs (in particular the 3 Auckland DHBs) on both scheduling that has worked for those DHBs in the past and what is planned for 2022. As a result of these discussions, a 6 weekly Board meeting cycle is proposed. The dates are proposed by working backwards from 22 June 2022, which is considered as the appropriate timing for the final meeting of the Boards.

The Chief Financial Officer has confirmed that the schedule will ensure appropriate monitoring of operational and financial performance by the Boards and/or FRACs. Although the process for planning for 2022/23 and the transition to Health NZ is not yet known, the Executive is satisfied that the meeting timing and frequency will enable us to deliver to what ends up being required for 2022/23 planning and budgeting processes.

The table below shows the reporting timing for financial and operational performance:

Financial and operational performance reporting 2022		
Reporting period	**Reporting to**	**Meeting Date**
November 2021	Board	16 February 2021
December 2021	Board	16 February 2021
January 2022	FRAC	3 March 2021
February 2022	Board	30 March 2022
March 2022	FRAC Board	27 April 2022 13 May 2022
April 2022	FRAC	1 June 2022
May 2022	Board	22 June 2022
June 2022	N/A	N/A

In prior years, the first meeting of the calendar year has been held as a strategic planning workshop to set the direction for the calendar year and plan the annual plan and budget process for the forthcoming financial year. As the Boards agreed the 2DHB strategic priorities at the 7 July 2021 meeting and the focus is now on implementation, this is not proposed for 2022. This approach is consistent with the remaining lifespan of the DHBs under the health system reform.

It is recommended that Board and FRAC meetings of CCDHB and HVDHB continue to be held concurrently to support an integrated approach to service planning and delivery across the two DHBs. It is also recommended that Major Capital Projects Advisory Committee (MCPAC) meets on the same day as FRAC, and at the same frequency as FRAC. This is a change from 2021, as currently MCPAC meets monthly, but is considered to be appropriate in light of the Committee work programme.

The meeting dates and approach for the HSC and DSAC involves:

- One scheduled meeting for 16 March 2022 (HSC morning and DSAC afternoon)
- One placeholder scheduled for 8 June 2022 to enable a decision to be made (in consultation with the Chair of the Board and Committee Chairs) on the need for the meeting, once there is greater clarity on the transition to Health NZ.

Where papers presented to Committees require decisions to be made by the Boards, the timeframes enable sufficient time to brief, discuss and review these papers.

Meeting dates

The Board Chair and Committee Chairs have all been consulted to ensure availability on the dates proposed. Given the number of members who are also elected members of Greater Wellington Regional Council and Upper Hutt and Hutt City Councils, the meeting schedules for those have been cross referenced and clashes avoided where possible. However, it is recognised that the proposed timeline may contain some clashes with other commitments for some members.

Location and meeting times

Board and Committee meetings will generally alternate between the Hutt Hospital campus and the Wellington Regional Hospital campus. Meeting times for the meetings are:

- Board 9.00am-4pm.
- FRAC: 9.00am-12noon
- MCPAC: 12.30pm-2.30pm
- HSC: 9.00am-12noon
- 3DHB DSAC: 1pm- 4pm.

During 2021, time was scheduled before each concurrent meeting for each Board to meet (on an alternating monthly basis determined by location) for 'HVDHB or CCDHB Board only time' for discussion on matters (but no decisions can be made). This can be repeated for 2022 (from 8am-9am) should members provide feedback that this is continued, however as these are not notified meetings, this is not included in the meeting schedule.

Board work plan

The draft Board work plan for 2022 is attached (attachment 2). The work plan sets out the regular reporting and performance monitoring to the Boards to support members' monitoring and accountability responsibilities. The draft Board work plan will be updated at the end of 2021 to reflect progress on the strategic priorities, and will also evolve if decisions are required to respond to issues that arise in the transition period. At that time the Boards will also consider whether the service spotlights continue for the remaining meetings of the Boards.

Remuneration

Remuneration of members for attendance at Committee meetings will remain as it is currently paid and is subject to the relevant Cabinet guideline

Attachments

Attachment 1: Meeting schedule for 2022, until 30 June 2022.
Attachment 2: Draft work plan for 2022, until 30 June 2022.

DRAFT BOARD AND COMMITTEE DATES 2022

JANUARY

MON	TUE	WED	THU	FRI	SAT	SUN
31					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

FEBRUARY

MON	TUE	WED	THU	FRI	SAT	SUN
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16 BOARD	17	18	19	20
21	22	23	24	25	26	27
28						

MARCH

MON	TUE	WED	THU	FRI	SAT	SUN
	1	2	3 FRAC MCPAC	4	5	6
7	8	9	10	11	12	13
14	15	16 HSC DSAC	17	18	19	20
21	22	23	24	25	26	27
28	29	30 BOARD	31			

APRIL

	TUE	WED	THU	FRI	SAT	SUN
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27 FRAC MCPAC	28	29	30	

MAY

MON	TUE	WED	THU	FRI	SAT	SUN
						1
2	3	4	5	6	7	8
9	10	11	12	13 BOARD	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

JUNE

MON	TUE	WED	THU	FRI	SAT	SUN
		1 FRAC MCPAC	2	3	4	5
6	7	8 HSC DSAC (PLACE HOLDER)	9	10	11	12
13	14	15	16	17	18	19
20	21	22 BOARD	23	24	25	26
27	28	29	30			
						11

Key Public Holidays School Holidays

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

DRAFT - 2DHB BOARD WORK PLAN 2022

	Wed 16 February	Wed 30 March	Fri 13 May	Wed 22 June
	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight (TBC)				
Quality and Safety/Health and Safety				
2DHB Quality and Safety	2DHB Quality and Safety (and selected focus area)	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report (and selected focus area)
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting				
Financial and Operational Performance CCDHB	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022
Financial and Operational Performance HVDHB	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022
Scheduled reporting				
People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
Facilities and Infrastructure Report inc. Enviro Sustainability	Facilities and Infrastructure Report		Facilities and Infrastructure Report	
3DHB Digital Report	Q2 Report		Q3 Report	
Māori Stratey (Te Pae Amorangi and Taurite Ora)	Q2 Report		Q3 Report	
Pacific Health and Wellbeing Strategic Plan	Q2 Report and selected focus area (To be advised)		Q3 Report and selected focus area (To be advised)	
Committees				
FRAC items for Board Approval		FRAC items for Board Approval from meeting dated 03/03/22	FRAC items for Board Approval from meeting dated 27/04/22	FRAC items for Board Approval from meeting dated 01/06/22

	Wed 16 February	Wed 30 March	Fri 13 May	Wed 22 June
HSC update and items for Board Approval		HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval		DSAC update and items for approval from meeting dated 16/03/22		
MCPAC update		MCPAC update from meeting dated 03/03/22	MCPAC update from meeting dated 27/04/22	MCPAC update from meeting dated 01/06/22
Engagement				
Te Upoko o te Ika Māori Council (TUI MC)		Boards meet with TUI MC		Boards meet with TUI MC
Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group	
Annual Planning and Reporting				
Budgets/Annual Plan	Planning process for 2022/2023 – subject to confirmation of process required for HNZ			
Annual Report	N/A			
Strategic Priorities				
Pro-Equity				
Strategic Priorities Overview	Reporting on implementation and engagement on next steps			
Our Hospitals				
Commissioning and Community				
Mental Health and Addiction Services				
Enablers				
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)				
Workshop				
Site Visit				

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 4 August 2021

Resolution to exclude the Public

Moved that the public be excluded from the following parts of the proceedings of this meeting, namely:

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

TABLE

Agenda item and general subject of matter to be discussed	Grounds under clause 34 on which the resolution is based	Reason for passing the resolution in relation to each matter, including reference to OIA where applicable
Confirmation of minutes of previous meeting (public excluded session) and Matters Arising from those minutes.	paragraph (a) i.e. the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982	OIA, section 9(2)(ba) to protect information which is subject to an obligation of confidence where the making available of that information would be likely to prejudice the supply of information from the same source, and it is in the public interest that such information should continue to be supplied. OIA, section 9(2)(j) to enable this organisation to carry on, without prejudice or disadvantage negotiations.
Chief Executive In Confidence	As above	As above
Hutt Valley and Capital & Coast DHB Quality & Safety Report	As above	As above
MHAIDS Quality and Safety Report	As above	As above
Workplace Health and Safety Report	As above	As above
HVDHB Financial and Operational Performance Report – June 2021	As above	As above

CCDHB Financial and Operational Performance Report – June 2021	As above	As above
Commissioning Schedules – Decision made under Delegation	As above	As above
Service Spotlight – Oncology	As above	As above
Tranche Two: Renewal of Vertical Transport (Lifts)	As above	As above
2DHB People and Culture Report	As above	As above
MCPAC Update from meeting dated	As above	As above
Minutes of Previous Meeting	As above	As above
Matters Arising from Previous Meetings	As above	As above
Chair's Report and Correspondence	As above	As above
Chief Executive's Report	As above	As above
General Business	As above	As above

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

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