HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Thursday, 28 November 2019 Te Aro room, Front+Centre 69 Tory Street, Wellington Commencing at 11.00 am
BOARD	**PUBLIC SESSION**

	Item	Action	Presenter	Min	Time	Pg
1.	**PROCEDURAL BUSINESS**			15	11.00 am	
1.1	Karakia					3
1.2	Apologies	ACCEPT	Chair			
1.3	Continuous Disclosure 1.3.1 Capital & Coast DHB Interest Register • Board • ELT 1.3.2 Hutt Valley DHB Interest Register • Board • ELT	ACCEPT	Chair			4 9
1.4	HVDHB Minutes of Previous Meetings – 31 October 2019	ACCEPT	Chair			13
1.5	HVDHB Matters Arising from Previous Meeting	NOTE	Chair			19
1.6	CCDHB Minutes of Previous Meetings – 30 October 2019	ACCEPT	Chair			20
1.7	CCDHB Matters Arising from Previous Meeting	NOTE	Chair			26
1.8	Chair's Report	VERBAL	Chair			27
1.9	Chief Executive's Report	VERBAL	Chief Executive			
2.	**PRESENTATION**					
2.1	Consumer Presentation		Trish Harris	10		30
3.	**AGENDA FOR CHANGE**					
3.1	Draft Sub-Regional Pacific Health & Wellbeing Strategic Plan Item 3.1.1 Appendix 1 Sub-Regional Pacific Health & Wellbeing Strategic Plan	NOTE	Director Pacific People's Health	10		31 33
4.	**DHB PERFORMANCE**					
4.1	HVDHB September 2019 Financial Performance Report	NOTE	GM Finance & Corporate Services	5		72
4.2	CCDHB September 2019 Financial and Operational Performance Report	NOTE	Chief Financial Officer	5		100
4.3	Combined People & Capability Report	NOTE	GM Human Resources & Organisational Development (HVDHB) GM People & Capability (CCDHB)	5		127
4.3.1	HVDHB Māori Health Report – Te Pae Amorangi – Increasing Maori Workforce Update	NOTE	Director Māori Health	5		147
5	**CAPITAL PROJECTS**					
5.1	New Children's Hospital Program of Works Status Report	NOTE	Executive Director Corporate Service (CCDHB)			156
6.	**COLLABORATIVE ACTIVITY**					
6.1	3DHB ICT Report	NOTE	Chief Digital Officer	5		161

	Item	Action	Presenter	Min	Time	Pg
6.2	Sub-Regional Public Health Services Update	NOTE	Director Provider Services	5		181
7	**SUB COMMITTEE REPORTS**					
7.1	CCDHB Health System Committee Report	NOTE	HSC Chair	5		203
8.	**OTHER**					
8.1	General Business	NOTE	Chair	5		
8.2	Resolution to Exclude the public	ACCEPT	Chair	5		215
DATE OF NEXT MEETING: Board Pōwhiri, Induction and Board Meeting - 18 December 2019						

Karakia – Whakataka te hau

Whakataka te hau ki te uru
(Cease the winds from the west)

Whakataka te hau ki te tonga
(Cease the winds from the south)

Kia mākinakina ki uta
(Let the breeze blow over the land)

Kia mātaratara ki tai
(Let the breeze blow over the ocean)

E hī ake ana te atakura
(Let the red-tipped dawn come with a sharpened air)

He tio, he huka, he hau hū
(A touch of frost, a promise of the glorious day)

Tīhei mauri ora!

CAPITAL & COAST DISTRICT HEALTH BOARD

Interest Register

30 MAY 2019

Name	Interest
Mr Andrew BLAIR *Chair*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board • Chair, Hutt Valley DHB Hospital Advisory Committee • Chair, Queenstown Lakes Community Housing Trust • Member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement and Information Management System business case • Member, Hutt Valley DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast Health Systems Committee • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Dame Fran WILDE *Deputy Chair*	• Ambassador Cancer Society Hope Fellowship • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair, Kiwi Can Do Ltd • Chair National Military Heritage Trust • Chair, Remuneration Authority • Chair Wellington Lifelines Group • Deputy Chair, Capital & Coast District Health Board • Director Museum of NZ Te Papa Tongarewa • Director Frequency Projects Ltd
Dr Kathryn ADAMS *Member*	• Member, Capital & Coast District Health Board • Fellow, College of Nurses Aotearoa (NZ) • Reviewer, Editorial Board, Nursing Praxis in New Zealand • Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health • Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa • Member, National Party Health Policy Advisory Group

Name	Interest
Dr Roger BLAKELEY *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • 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
Ms Eileen BROWN *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa • Executive Member of Health Benefits of Good Work • Nephew on temporary CCDHB ICT employment contract.
Ms 'Ana COFFEY *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development
Ms Sue DRIVER *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs • Daughter, Policy Advisor, College of Physicians
Ms Sue KEDGLEY *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council • Step son works in middle management of Fletcher Steel
Ms Kim NGARIMU *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Capital & Coast District Health Board, FRAC Committee • Member, Medical Council of New Zealand (MCNZ)

Name	Interest
	• Member, Specialist Education Accreditation Committee (Australian Medical Council) • Member, Māori Heritage Council • Member, Waitangi Tribunal • Board Member, Te Māngai Pāhō (Māori Broadcasting Agency) • Board Member Eastern Institute of Technology • Board Member Heritage New Zealand • Director, Taaua Ltd (Public policy and management consulting company) • Trustee, Judith and Taina Ngarimu Whānau Trust (has shareholdings in various health related companies – share acquisition and sale is independently managed)
Mr Darrin SYKES *Member*	• Board Member, Capital & Coast District Health Board • Chair, Capital & Coast District Health Board, FRAC committee (effective 21 February 2018) • Member, Capital & Coast District Health Board, Remuneration Committee (effective 21 February 2018) • Trustee, Wellington Regional; Sports Education Trust (trading as Sports Wellington) • Board Member, Sport and Recreation New Zealand (trading as Sport NZ) • Chief Executive, Crown Forestry Rental Trust • Reviewer, Health Quality & Safety Commission Performance Improvement Framework (PIF) Review (effective 31 January 2019)

CAPITAL & COAST DISTRICT HEALTH BOARD

Interest Register

EXECUTIVE LEADERSHIP TEAM

29 AUGUST 2019

Fionnagh Dougan *Chief Executive Officer*	• Board member, Children's Hospital foundation • Adjunct Professor University of Queensland • Member, Wellington Hospital Foundation
Sandy Blake *Executive Director, Quality Improvement & Patient Safety*	• Advisor to Patient Safety and Reportable Events programme, Health Quality Safety Commission • Adviser to ACC re adverse events • Son is Associate Director of Deloittes
Thomas Davis *Executive Director, Corporate Services*	• Wife's cousin Facility & Property Manager Victoria University of Wellington
Taima Fagaloa *Executive Director, Pacific Peoples Health*	• Sister is a Registered Nurse for 3DHB MHAIDS
Nigel Fairley *3DHB General Manager MHAIDS*	• President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Fellow, NZ College of Clinical Psychologists • Director and shareholder, Gerney Limited
Arawhetu Gray *Executive Director, Māori Health*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Member, Te Hauora Rūnanga o Wairarapa Board
Rachel Haggerty *Executive Director, Strategy Innovation & Performance*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Emma Hickson *Chief Nursing Officer*	• None
Delwyn Hunter *Executive Director, Surgery, Women & Children*	• Partner is employed by CCDHB (MHAIDS) • Director, Allied Laundry
Arish Naresh *Chief Allied Health Officer*	• President NZ Dental and Oral Health Therapists Association • Board Director, UNICEF New Zealand • Executive Council Member, Allied Health Association of NZ • Board Member, Federation of Primary Health • Founder, Opportunities without Discrimination Movement • Member, Asia NZ Foundation Leadership Network

29 August 2019

	• Advisor, NZ Federation of Multicultural Councils • Director, Naresh Professional Services • Director, Elev8 Communications • Locum Oral Health Consultant
Mr John Tait *Chief Medical Officer*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Board member, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC
Carey Virtue *Executive Director, Medicine Cancer &Community*	• None
Andrew Wilson *Interim Executive Director, People & Capability*	• Director and shareholder of ForeConsulting Business Services Ltd — contracts to health services • Family member is a midwife employed by CCDHB • Family member is employed by TAS
Anna Chalmers *Communications Manager*	• Vice President of the National Council of the Motor Neurone Disease Association of New Zealand
Michael McCarthy *Chief Financial Officer*	• Director/Trustee Prime Site Properties Ltd • Business relationship with Teresa Wall (Chair of CCDHB MPB) in primary care consulting and the Ahuriri Health Trust. • Trustee of the Wellington Hospital Foundation • Daughter works in cervical screening programme • Son-in-law works for Audit NZ • Wife works for WSP Opus (construction engineers)
Roger Palairet *Chief Legal Officer*	• Chair and Trustee of Carers NZ (non-profit organisation promoting the interests of family carers; funders include MoH, MSD and Waitemata DHB) • Chair and Trustee of the Wellington Community Trust • Sister-in-law is a paediatric nurse at CCDHB
Tracy Voice *Chief Digital Officer*	• Secretary, New Zealand Lavender Growers Association • Board member, Primary Growth Partnership with PGG Wrightsons/Grassland Seed Technology Innovation

Hutt Valley Board INTEREST REGISTER

Name	Interest
Graeme Andrew Blair *Chair*	• Chair, Capital & Coast DHB • Chair, Hutt Valley DHB • Chair, Hutt Valley DHB Hospital Advisory Committee • Member, Hutt Valley DHB Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast DHB Health Systems Committee • Owner and Director of Andrew Blair Consulting Ltd • Former member of the Hawke's Bay DHB (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO, Acurity Health Group Limited • Advisor to Southern Cross Hospitals Ltd and Central Lakes Trust in relation to establish an independent surgical hospital facility in the Queenstown Lakes region • Chair, Queenstown Lakes Community Housing Trust • Member of the State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement & Information Management System business Case • Advisor to the Board of Breastscreen Auckland Ltd • Advisor to the Board of St Marks Women's Health (Remuera) Ltd
Wayne Guppy *Deputy Chair*	• Upper Hutt City Council Mayor • Deputy Chair, Hutt Valley District Health Board • Deputy Chair, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Wife employed by various community pharmacies in the Hutt Valley • Trustee - Orongomai Marae • Director MedicAlert • Chair – Wellington Regional Mayoral Forum • Chair – Wellington Regional Strategy Committee
Lisa Bridson *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Hutt City Councillor • Chair, Kete Foodshare
Ken Laban *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Trustee, Hutt Mana Charitable Trust • Member, Ulalei Wellington • Chairman, Hutt Valley Sports Awards • Member, Greater Wellington Regional Council • Commentator, Sky Television • Broadcaster, Numerous Radio Stations • Member, Christmas in the Hutt Committee • Trustee, Te Awakairangi Trust • Member, Computers in Homes

David Ogden *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Regional Councillor • Principal, Oak Chartered Accountants Limited • Accountant, affiliated, with Simple Accounting Services Limited, which has various clients involved in the Health Sector • Daughter is a Doctor in Clinical Psychology and working within a District Health Board outside of the Central Region • Former Mayor and Councillor, Hutt City Council.
John Terris *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • National President of Media Matters in NZ – a viewer advocacy group work in the area of TV and the internet, and incorporating Children's Media Watch • Patron – Hutt Multicultural Council Inc
Prue Lamason *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Deputy Chair, Hutt Mana Charitable Trust • Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
Yvette Grace *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Deputy Chair, 3DHB combined Disability Support Advisory Committee • Chair, Hutt Valley District Health Board Community and Public Health Advisory Committee • General Manager, Rangitane Tu Mai Ra Treaty Settlement Trust • Husband, Family Violence Intervention Coordinator Wairarapa DHB • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt
Tim Ngan Kee *Member*	• Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • General Practitioner, Churton Park Medical Care • Partner, Churton Park Medical Care
Kim von Lanthen	• Member, Hutt Valley District Health Board • One third shareholding Kim von Lanthen and Associates Ltd • One half shareholding Commodity Markets (NZ) Ltd • Nephew seconded as a cardiology registrar • One third shareholding NZ Bio Forestry Ltd

Hutt Valley DHB Executive Leadership Team

Interest Register

Name	Interest
Fionnagh Dougan *Chief Executive* *Hutt Valley & Capital and Coast DHB*	• Board member, Children's Hospital foundation • Adjunct Professor University of Queensland • Member, Wellington Hospital Foundation
Nigel Fairley *General Manager, 3DHB Mental Health Addictions & Intellectual Disability Service*	• Fellow, NZ College of Clinical Psychologists • President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Director and Shareholder, Gerney Limited
Melissa Brown *Acting Chief Operating Officer*	• Member of the Australian College of Midwives
Tofa Suafole Gush *Director Pacific Peoples Health*	• Member of the Te Awakairangi Health Board • Pacific Member, Board of Compass Health • Husband is an employee of Hutt Valley DHB
Dr Sisira Jayathissa *Chief Medical Officer*	• Member of the Medicine Adverse Reaction Committee MedSafe (MOH) • Member Standing committee on Clinical trials (HRC) • Member Editorial Advisory Board NZ formulary • Member Internal medicine Society of Australia and NZ • Australian and New Zealand Society for Geriatric Medicine • Writer NZ internal Medicine Research Review • Clinical Senior Lecturer and Module convenor Clinical Skills module (HUTT campus), University of Otago
Judith Parkinson *General Manager, Finance and Corporate Services*	• Director of Allied Laundry
Bridget Allan *Chief Executive, Te Awakairangi Health Network (PHO)*	• Chief Executive, Te Awakairangi Health Network (PHO) • Board member of Vibe • Healthy Families Lower Hutt Leadership Group member
Helen Corrigan *Acting Communications Manager*	• First cousin is sitting Member of Parliament
Helene Carbonatto *General Manager Strategy Planning & Outcomes*	• Sister is a GP in CCDHB • Husband is a general manager at the Health Promotion Agency
Fiona Allen *General Manager Human Resources & Organisational Development*	• No interests declared

Kerry Dougall *Director of Māori Health*	• Board Chair, Kokiri Marae Māori Women's Refuge • Board member, Ta Kirimai te Ata Whanau Collective
Chris Kerr *Director of Nursing*	• 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
Debbie Gell *General Manager Quality, Service Improvement and Innovation*	• Member of consumer council for Healthy Homes Naenae
Christine King *Director of Allied Health, Scientific and Technical*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Kristine McGregor *Executive Officer*	• Husband works in 3DHB ICT
Tracy Voice *Chief Information Officer* *ICT 3DHB*	• Secretary, New Zealand Lavender Growers Association • Board Member, Primary Growth Partnership with PGG Wrightsons/Grassland Seed Technology Innovation

BOARD **PUBLIC**

HUTT VALLEY DHB	**MINUTES** Held on Thursday, 31 October 2019 Boardroom, Pilmuir House, Hutt Hospital, Lower Hutt **Commencing at 9.05 am**
BOARD	**PUBLIC SECTION**

PRESENT

Andrew Blair	Chair
Wayne Guppy	Deputy Chair
Kim von Lanthen	Member
Tim Ngan Kee	Member
Lisa Bridson	Member
Ken Laban	Member
Prue Lamason	Member
Yvette Grace	Member
David Ogden	Member
John Terris	Member

APOLOGIES

Nil

IN ATTENDANCE

Fionnagh Dougan	Chief Executive
Christine Rabone	Committee Secretary
Judith Parkinson	General Manager - Finance and Corporate Services
Joy Farley	Interim Director Provider Services
Anna Chalmers	Interim Communications Director
Kerry Dougal	Director Māori Health
Rod Bartling	Interim General Manager Strategy, Performance & Outcomes
Debbie Gell	General Manager Quality, Service Improvement & Innovation
Nigel Farley	3DHB General Manager Mental Health Addiction & Intellectual Disability

GUESTS

Richard Stein, newly elected Board member
Josh Briggs, newly elected Board member
Keri Brown, newly elected Board member
Naomi Shaw, newly elected Board member

1 Member of the public

BOARD **PUBLIC**

1. PROCEDURAL BUSINESS

1.1 KARAKIA

The meeting opened with a karakia.

The Board welcomed newly elected Board members who were attending this Board Meeting as observers.

1.2 APOLOGIES

The Board **NOTED** there were no apologies.

1.3 CONTINUOUS DISCLOSURE

The Board **CONFIRMED** that it was not aware of any matters (including matters reported to, and decisions made by the Board at this meeting) that required disclosure.

1.3.1 INTEREST REGISTER

The Board **NOTED** that one change to the interest register was declared during the meeting, which is that Lisa Bridson is no longer a Hutt City Councilor.

1.3.2 CONFLICT OF INTEREST

The Board **CONFIRMED** that it was not aware of any matters (including matters reported to, and decisions made, by the Board at this meeting) that require disclosure and that there would be an opportunity to declare any conflicts prior to discussion on each item of the agenda.

1.4 MINUTES OF PREVIOUS MEETING

The Board **RESOLVED** to approve the minutes of the Member's (Public) Meeting held on 26 September 2019 as a true and accurate record of the meeting.

The Board **RESOLVED** to approve the minutes of the Members (Public) Meeting held on 29 August 2019 as a true and accurate record of the meeting.

MOVED: Prue Lamason **SECONDED:** Kim von Lanthen **CARRIED**

1.5 ACTION LIST AND MATTERS ARISING

The Board **RECEIVED** the matters arising from the previous meeting, and **NOTED:**

- Item B2019-7 is marked for delivery in early 2020.
- Item B2019-8 is ongoing. Bi-cultural signage is slowly being replaced and temporary signage has been erected.
- B2019-4 has been included under agenda item 2.1.2 for discussion at today's meeting.

1.6 DRAFT 2019 BOARD WORK PLAN

The Board noted the updated 2019 Work Plan and that the Work Plan for 2020 is currently in development.

1.7 CHAIR'S REPORT

The Board Chair provided a verbal report to the Board noting:

01 October	Letter from Director-General MoH inviting board members or senior executives to attend the MoH Forum: Delivering equity of health & wellbeing in Aoteroa.
15 October	Email from Jenny Black regarding advice from Sarah Turner (Deputy Director-General MoH) on DHB Board member terms – including Chairs and Deputy Chairs.

BOARD **PUBLIC**

Meetings

Various	Weekly telephone calls with the CE
7 October	RGG & CR CE's Meeting was cancelled

Engagements Attended

21 October	Public Trust Hall Grand Opening
29 & 30 October	Ministry of Health Forum: Delivering equity of health and wellbeing in Aotearoa (Attended with Fionnagh Dougan, Rod Bartling (Acting GM Strategy, Planning & Outcomes), & Tracy Voice (Chief Digital Officer)

Upcoming Meetings

6 – 7 November	National Chairs Meeting

Media Requests

Nil

Other Matters

Election Results	The Chair congratulated existing re-elected members and thanked out going members for their input over the past 3 years. It was noted that an orientation is being planned for new members which will take place in December 2019. A farewell for outgoing members will take place at the Combined November 2019 Board Meeting. Ministerial appointments are unlikely to be confirmed before December.

The Board **NOTED** the contents of the verbal report.

1.8 CHIEF EXECUTIVE'S REPORT

The Board:

a) **NOTED** HVDHB is the lead for distribution of the replenished stock of measles vaccines to prioritised at risk groups nationwide.

b) **NOTED** the update on the Maternity Services Review which included:

   a. Concerns from College of Midwifery around international recruitment, and the extent to which they were working with the Ministry of Health to increase the number of training midwives.

   b. Recruitment of a Director of Midwifery and interim Service Manager.

2. PERFORMANCE

2.1 HVDHB FINANCIAL AND OPERATING PERFORMANCE REPORT

2.1.1 August Financial Performance Report

The paper was taken as **READ**.

The Board:

a) **NOTED** August 2019 year to date had an unfavourable variance to budget of ($180k) against the annual budget deficit of $8.1 million;

b) **NOTED** the Funder result for August 2019 year to date was $988K favourable, Governance $92K favourable and Provider ($1,260K) unfavourable to budget;

c) **NOTED** the key variances to budget outlined in this report including overspends in nursing personnel (including use of minders for one to one care), support staff MECA settlement, and treatment related costs partially offset by reduced IDF outflow;

d) **NOTED** the quantified financial risks for 2019/20 of up to $4.9 million;

e) **NOTED** the Inter district flows (IDF) inflows and outflows for August 2019 year to date have been updated with information from Capital and Coast DHB.

2.1.2 Operational Performance Report

The paper was taken as **READ**.

The Board:

a) **NOTED** that Hutt Valley DHB's performance against the *Improved Access to Elective Surgery* health target as of 10 October 2019 was 96% for discharges and 91% for case weights;

b) **NOTED** that Hutt Valley DHB's performance against the *Faster Cancer Treatment* target for September was 87.5% percent for the 62 day target, and 91.1% for the 31 day target;

c) **NOTED** that for September, Hutt Valley DHB achieved 89.2% percent against the *Shorter Stays in ED* health target, which is a 5% improvement on last month;

d) **NOTED** that Hutt Valley DHB's performance against the radiology targets for September/October was 88% for ultrasound, 74% for MRI and 88% for CT;

e) **NOTED** that for September, Hutt Valley DHB achieved 87% against the target of 95% of patients being offered smokers information and advice to quit.

The Board discussed:

- Recent announcement of a Request for Proposal (RFP) for funding of Maori / Pacific mental health services.
- Co-design process for large scale projects.
- Process HVDHB undertakes to follow up with those presenting to ED that are not enrolled in a PHO.

2.2 STRATEGY, PLANNING AND OUTCOMES UPDATE

The paper was taken as **READ**.

The Board:

a) **NOTED** good progress is being made in advancing the 2DHB joint hospital service network planning, with financial and sustainability modelling being developed and planned for high-level service configuration and placement options.

b) **NOTED** that a range of initiatives are being progressed through our Wellbeing Plan, including the staff wellbeing programme 'Mauri Ora', the Tobacco Control Action Plan, and the Water in Schools project.

c) **NOTED** the progress being made in addressing the investment gaps in our adult mental health acute care continuum, as well as the investment proposal for Te Whare Ahuru.

d) **NOTED** that the Ministry of Health has released its first Request for Proposals for improved integrated primary mental health services and the sub-region is providing one joined-up response, led by the sub-region's four Primary Healthcare Organisations, in collaboration with the 3DHBs and NGO mental health providers.

e) **NOTED** that the *First 1000 Days Partnership Project* is complete, including whānau engagement, and a report is currently being drafted, which is expected to be provided to the Board later this year. This does not replace the work of a wider child and youth strategy.

f) **NOTED** that Hutt Valley DHB's final draft 2019/20 Annual Plan was sent to the Ministry of Health on 18 October 2019 and will be amongst the first tranche of plans to be submitted to the Minister of Health for approval.

BOARD **PUBLIC**

2.3 MĀORI HEALTH UPDATE

The paper was taken as **READ**.

The Board:

a) **NOTED** the work underway in the following areas of Te Pae Amorangi Hutt Valley DHB Māori Health Strategy (Te Pae Amorangi):

- Te Pae Aronga Tuatahi – Increasing Māori workforce across the system;
- Te Pae Aronga Tuarua – Organisational Development and Cultural Safety;
- Te Pae Aronga Tuatoru – Commissioning;
- Te Pae Aronga Tuawhā – Mental Health and Addictions;
- Te Pae Aronga Tuarima – First 1,000 Days.

b) **NOTED** the 20 DHB Chief Executive's endorsement of Te Tumu Whakarae's position statement on increasing Māori participation in the workforce and the approved six targets to support the position statement and increase Māori participation in the workforce;

c) **NOTED** a Hutt Valley DHB Te Tiriti o Waitangi Policy has been developed by the Pou Tikanga and was approved by the Executive Leadership Team;

d) **NOTED** the work underway as part of the Māori Health Operational Work Programme;

e) **NOTED** the development of an investment plan for implementation of Te Pae Amorangi.

2.4 HEALTH AND SAFETY UPDATE

The paper was taken as **READ**.

The Board:

a) **NOTED** the report for October 2019;

b) **NOTED** the Hutt Valley DHB Quality Awards;

c) **NOTED** the Quality Safety Markers for Quarter 2 2019.

3. OTHER

3.1 GENERAL BUSINESS

Nil

3.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Board **RESOLVED** to **AGREE** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public (aside from newly elected board members) are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the 27 June 2019 Board agendas	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in the 27 June 2019 Board agendas	
Chief Executive's report	Information contained in the paper may be subject to change as the information has not yet been reviewed by the FRAC Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(f)(iv) Section 9(2)(j) Section 9(2)(i)(j)
Final 2019/20 Regional Services Plan		
Fire Safety Risk & Legal Advice		

BOARD		PUBLIC
Sub-Delegations for HVDHB	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations.	
Risk Management Strategies Update		
Health Round Table Report July 2018 – June 2019		
Update on Ministers Letter of Expectations		
2018/19 Annual Report		
Adverse Event / HDC / Coroners Quarterly Update		
Holidays Act Review Update		
Finance Risk & Audit Committee Update		

* Official Information Act 1982.

MOVED: Prue Lamason **SECONDED:** Wayne Guppy **CARRIED**

7. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 28 November 2019, in the Te Aro Room, Front+Centre, 69 Tory Street, Wellington.

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

DATED this day of 2019

ANDREW BLAIR
CHAIR
HUTT VALLEY DISTRICT HEALTH BOARD

BOARD **PUBLIC**

MATTERS ARISING FROM PREVIOUS MEETINGS

Original Meeting Date	Ref	Topic	Action	Resp	How Dealt with	Delivery date	Completed Date
26 September	B2019-7	Patient Story	The Board requested the General Manager Quality, Service Improvement & Innovation arrange for a patient story from the Mental Health, Addictions and Intellectual Disability Service; and a story from a staff members perspective.	General Manager Quality, Service Improvement & Innovation	To be considered as upcoming topics in the new year.	Early 2020	
	B2019-8	Vision for Change Dashboard	The Board requested the General Manager Strategy, Planning and Outcomes arrange to update posters around the HVDHB campus to reflect the current strategic goals.	General Manager Strategy, Planning & Outcomes	Posters around campus to be updated	Ongoing	

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Board
Held on Wednesday 30 October 2019 at 12.30pm
11th Floor Boardroom, Grace Neill Block, Wellington Regional Hospital, Wellington

PUBLIC SECTION

PRESENT:	Mr A Blair (Chair)
BOARD	Dame F Wilde, DNZM, QSO
	Ms E Brown
	Ms S Kedgley
	Ms K Ngarimu
	Dr R Blakeley (arrived 2.30pm)
	Ms S Driver
	Ms A' Coffey (arrived 12.45pm)
	Dr K Adams
STAFF:	Ms F Dougan (Chief Executive Capital & Coast and Hutt Valley DHB))
	Mr J Tait (Chief Medical Officer)
	Ms J Farley (Interim Executive Director Provider Services)
	Mr Thomas Davis (Executive Director, Corporate Services)
	Mrs S Blake (Executive Director, Quality Improvement & Patient Safety)
	Mr M McCarthy (Chief Financial Officer)
	Ms R Haggerty (Executive Director, Strategy, Innovation and Performance)
	Ms A Chalmers (Communications Manager)
	Mr N Fairley (General Manager, 3DHB MHAIDS)
	Mrs R Fitzgerald (Board Secretary)
	Ms R Prebble (Senior Manager, Organisation Development)
	Ms A Gray (Director, Maori Health Development Group)
	Mrs A Stewart (Director, Operations QIPS)
	Ms C Goodyer (Manager, Maori Health Development Group)
ATTENDEES:	Mr T Ngan Kee (HVDHB member)
	Mr K von Lanthen (HVDHB member)
	Ms V Simpson (newly elected CCDHB member designate)
	A member of the public and media present.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

Kim Ngarimu opened the meeting with a karakia. The Capital & Coast District Health Board Chair, Andrew Blair, welcomed the Board members, support staff, guests, members of the public, and the Executive Leadership Team. The chair welcomed Vanessa Simpson, Board member designate, current Hutt Valley Board members Kim von Lanthen and Tim Ngan Kee, and introduced Joy Farley, Interim Executive Director Provider Services for both CCDHB and HVDHB.

1.2 APOLOGIES

Board was notified of the late arrival of Roger Blakeley.

1.3 INTERESTS

1.3.1 Register of Interests
There were no items on the agenda that would cause any conflict.

CONFLICTS RELATED TO ITEMS ON THE AGENDA
No other conflicts were identified in respect of items on the current agenda but there would be an additional opportunity at the beginning of each item for members to declare conflicts of interest.

1.4 MINUTES OF PREVIOUS MEETING 25 SEPTEMBER 2019

RESOLVED THAT:
The minutes of the CCDHB Board meeting held on 25 September 2019, taken with the public present, were confirmed as a true and correct record.

Moved: Kim Ngarimu **Seconded**: Sue Kedgley **CARRIED**

1.4 MATTERS ARISING UPDATE

1.6 ACTION LIST
The Board:
(a) **Noted** the reporting timeframes on the other open action items.

1.7 CCDHB WORK PLAN 2019
Noted.

Action
1. Management to develop 2020 workplan and meeting schedule.

1.8 CHAIR'S REPORT
The chair gave a verbal update on:
- Farewell for departing Board members scheduled for 28 November
- Pōwhiri for new and returning Board members on 18 or 19 December

Meetings
- Ministry of Health Forum 29-30 October – Delivering equity throughout Aotearoa
- Meeting with Benefactor of the New Children's Hospital, last week
- Attended the opening of the Public Trust Grand Hall
- Next Regional Chairs and CEOs meeting scheduled for 4-5 December
- Next National Chairs' meeting scheduled for 6-7 November

1.9.1 CHIEF EXECUTIVE'S REPORT
The Chief Executive (CE) gave a verbal update on:
- Her experiences with staff and patients during a shift at the Wellington Regional Hospital and Hutt Hospital Emergency Departments during Labour weekend
- Joint planning on CCDHB and HVDHB update

Action
2. Board Secretary to send out presentation by CEO.

2 PRESENTATION

2.1 KORERO MAI

In attendance were:

Sarah Imray Clinical Nurse Specialist (CNS), Patient at Risk service – Project Lead
Donna Mclennan, Clinical Nurse Manager (CNM) 7N
Robert Dano, CNM 6E
Laura Ellis Consumer Engagement Manager
Sheila Becker Consumer
John Tait Consumer

The Board **noted** Korero Mai was launched in all adult inpatient areas across the Wellington campus on 21 October 2019.

2.2 MĀORI PARTNERSHIP BOARD

In attendance were:

Dr Bryan Betty, GP
Teresa Wall (Chair)
Peter Jackson (Kaumatua)
Members of Maori Partnership Board
Maori Health Team staff

The Board:

(a) **Noted** the presentation on Concentration of Complexity by Dr Bryan Betty, Chair VLCA-Youth Service Council;
(b) **Noted** and **received** the presentation of Taurite Ora and Action Plan to the Board.

Action

3. Management to provide a copy of Dr Betty's presentation to the Ministry of Health.

3 FOR DISCUSSION

3.1 HEALTH AND SAFETY REPORT

The paper was taken as **read.**

The Board:

(a) **Noted** that there were no reported Notifiable Events in September;
(b) **Noted** there were no lost time injuries (LTIs) reported for September;
(c) **Noted** that the current updated Health and Safety Risks are included in the Board Risk Report;
(d) **Noted** that CCDHB have achieved primary status from the recent ACC Provider Audit report.

3.2 CCDHB HEALTH AND SAFETY INCIDENT MANAGEMENT FRAMEWORK

The paper was taken as **read.**

The Board:

(a) **Noted** the description of the CCDHB Incident Management Framework

(b) **Noted** the statistical comparison of incident frequency metrics between District Health Boards.

3.3 FINANCIAL PEFORMANCE UPDATE AUGUST 2019

The paper was taken as **read.**

The Board:

(a) **Noted** that the DHB YTD result was $1.1 million unfavourable to forecast budget for August 2019

(b) **Noted** that the DHB YTD result was $2.4 million unfavourable to forecast budget for August 2019;

(c) **Noted** that we are focused on delivering on our agreed savings strategies;

(d) **Noted** that acute volumes are rising, affecting elective surgery volumes;

(e) **Noted** that the current strike action is impacting patient services and DHB income.

3.4 CHILDREN'S HOSPITAL PROGRAMME UPDATE

The paper was taken as **read.**

The Board:

(a) **Noted** that there has been 1 minor, personal harm incident, since the last report.

(b) **Noted** that the forecast budget tracking is in a positive position

(c) **Noted** that McKee Fehl are still forecasting Project Handover on 14th April 2021 @ 12.09.2019

(d) **Noted** that the CCDHB internal Facility Management (FM) & clinical teams & CCDHB external consultants are continuing towards 100% Detail Design.

(e) **Noted** that FF&E budget has been agreed with the Benefactor and is progressing to procurement stages.

(f) **Noted** that the CCDHB Engineering Services parcel of work is entering the procurement stage

(g) **Noted** that GNB reconfiguration works Building Consent is issued, that demolition works are complete and Naylor Love construction work is underway.

(h) **Noted** Wellington Blood and Cancer Centre (WBCC) Building Consent is being prepared for lodging with Council.

4 FOR INFORMATION

4.1 HEALTH SYSTEM COMMITTEE RECOMMENDATIONS

The minutes and paper were taken as **read.**

The Board:

(a) **Endorsed** the Strategy, Innovation and Performance (SIP) team to move to implementation of the recommended model of care for young people in Porirua with the focus on the establishment of a YOSS (subject to increased funding);

(b) **Noted** the update on housing activities in the CCDHB district;

(c) **Noted** that of the 60 non-financial performance indicators reported to Ministry of Health (MoH) in quarter 4 2018/19 we achieved and partially achieved 56 indicators, did not achieve three and one was not assessed ;
(d) **Noted** the initiatives to optimise antimicrobial use within the hospital and community of CCDHB;
(e) **Noted** that the dashboard reporting is part of SIP's process of improving our understanding of how our investments in services are working for our population including equity (or not) of access to health services and outcomes achieved.

4.2 SAFE AND SUPPORTED WORKPLACE STUDY

The paper was taken as **read.**

The Board:

(a) **Noted** the findings of the Safe and Supportive Workplace Study Report;

(b) **Noted** the actions of directorates to address areas of low safety;

(c) **Noted** the elements supporting areas of high safety;

(d) **Noted** the proposed next steps.

4.5 UPDATE ON ENVIRONMENTAL SUSTAINABILITY UPDATE

The paper was taken as **read.**

The Board:

(a) **Noted** the KPIS demonstrating results from sustainability activities;

(b) **Noted** the Terms of Reference which underpin the work of the Green Team Committee including the goals identified;

(c) **Noted** the themes/activity proposed for the next quarter.

5.1 GENERAL BUSINESS

Nil.

5.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Board **NOTED** and **RESOLVED** to:

RECOMMENDATION

It is **recommended** that the Board:

(a) **Agrees** that the 2019 newly elected Capital & Coast and Hutt Valley District Health Board member designates who wish to attend the Public Excluded part of the meeting be permitted to attend as observers;
(b) **Agrees** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers.	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers.	
Chair's report CEO's report Clinical Council report FRAC Recommendations Risk Report Financial Performance Report September 2019 Financial Sustainability Update Holidays Act Update Children's Hospital Works Programme Status Update Quality Improvement & Patient Safety Update Tu Ora Company Cyber Security Breach	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)
2019/20 Capital Report and Reprioritisation Final Annual Report 2018/19 Draft Annual Plan 2019/20	Subject to Ministerial approval	9(2)(f)(v)
Litigation and Legal Risk Update	Maintain legal professional privilege	9(2)(h)

* Official Information Act 1982.

Moved: Fran Wilde **Seconded**: Roger Blakeley **CARRIED**

The meeting closed at 2.30pm.

6 DATE OF NEXT MEETING

Thursday 28 November, 11.00am, Front + Centre, Thorndon Room, 69 Tory Street, Wellington.

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

DATED this .....day of.....2019

Andrew Blair
CHAIR CCDHB

Capital & Coast District Board Action Schedule 2019 - Public

All actions have been completed

Action No	Date of Meeting	Agenda Item Number	Topic	Action	Designated to	How Dealt With	Due Date
P0096		2.2	**Maori Partnership Board**	Management to provide a copy of Dr Betty's presentation to the Ministry of Health	Board Secretary	Email	October
P0095		1.9.1	**Chief Executive's Report**	Send out presentation of CCDHB and HVDHB joint planning.	Board Secretary	Email	November
P0094	**31 October 2019**	1.7	**CCDHB Work Plan 2019**	Management to develop 2020 workplan and meeting schedule	Management	Report	December

From: Ashley.Bloomfield@health.govt.nz
Date: 1 October 2019 at 1:10:58 PM NZDT
To: patsneddn@adhb.org.nz, ailsac@adhb.govt.nz, andrew@blairconsulting.co.nz, Chris.fleming@southerndhb.org.nz, craig.climo@hawkesbaydhb.govt.nz, dale.oliff@wairarapadhb.org.nz, David.meates@cdhb.health.nz, david.scott@tdh.org.nz, Deryck.shaw@apr.co.nz, dot@moorelaw.co.nz, Dale.bramley@waitematadhb.govt.nz, Blue-duck@xtra.co.nz, chair@waitematadhb.org.nz, Karen.poutasi@waikatodhb.health.nz, Kevin.snee@waikatodhb.health.nz, Nick.chamberlain@northlanddhb.org.nz, Peter.bramley@nmdhb.govt.nz, Margie.apa@middlemore.co.nz, Fionnagh.Dougan@ccdhb.org.nz, Helen.mason@bopdhb.govt.nz, Jenny.black@nmdhb.govt.nz, Jim.green@tdh.org.nz, Kathryn.cook@midcentraldhb.govt.nz, Kathy.grant@gallawaycookallan.co.nz, Kevin.atkinson@penkev.co.nz, Nick.saville.wood@lakesdhb.govt.nz, ntrainor@scdhb.health.nz, Pauline.lockett23@gmail.com, rjlux@xtra.co.nz, Rosemary.clements@tdhb.org.nz, Russell.simpson@wdhb.org.nz, sallygmac@xtra.co.nz, sally@sallyw.co.nz, paul@aehl.co.nz, Mark.gosche@middlemore.co.nz
Subject: Health Forum October 29 & 30

Last month, I invited you to attend the upcoming forum convened by the Ministry of Health – Delivering equity of health and wellbeing in Aotearoa on 29 and 30 October 2019.

The forum is the first opportunity for our sector to come together in two years, and my first forum as Director-General. It is also a chance for the health and disability system to reflect on our successes since receiving significant investments to improve access to primary care and mental health and addiction services, and to understand how we can improve our services to address the challenges that remain.

The purpose of the forum is simple – we want participants to work with the Ministry to discuss and agree on priorities for the system's equity and wellbeing focus so we can deliver a stronger and fairer public health system.

I am keen to have a high level of participation by DHB Chairs and Chief Executives. I understand that you have already received an email invitation to attend the forum. Please keep this invitation as you will be required to register your details using the link provided in the email (if you'd like to attend).

As the leaders of health in your health respective regions I hope that you can join us in October. If you can't attend and wish to nominate another Board member or Senior Executive, please let us know.

If you have any questions, please email the forum team at healthforum2019@health.govt.nz

Kind regards

Ashley

Dr Ashley Bloomfield
Director-General
Ministry of Health
email: ashley.bloomfield@health.govt.nz
Mobile: +64-21-926 302
www.health.govt.nz
****
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Capital & Coast District Health Board
UPOKO KI TE URU HAUORA

21 November 2019

Dear Bill

I am writing on behalf of the Capital & Coast DHB Board to express our gratitude and thanks for the ongoing work that the Wellington Hospitals Foundation and its volunteers do every year.

Your team and volunteers are a vital part of the work that Capital & Coast DHB does as an organisation to deliver safe quality services to our patients – not to mention the wonderful work Hospi does to put smiles on the faces of children and families at the Wellington Children's Hospital.

My fellow Board members and I are also hugely appreciative of the great work you do each year to bring the festive holiday spirit into the hospital.

People coming into hospital – whether as patients or visitors – are often not at their best, and can be feeling vulnerable. Seeing the decorated atrium or Children's Hospital, and hearing Christmas carols upon entering the hospital, no doubt adds a little brightness and holiday cheer to what may otherwise be a daunting or stressful time.

On behalf of the Board, I would like to wish you and your team a very safe and happy holiday season. We hope you all manage to get a good break over summer, enjoy quality time with family and friends, and we look forward to seeing you again in the New Year.

Happy holidays.

Yours sincerely

Andrew Blair
Chair
Capital & Coast DHB Board
Hutt Valley DHB Board

Capital & Coast DHB | Private Bag 7902, Wellington South
Wellington Hospital, Riddiford Street, Newtown, Wellington 6021
Phone: 04 385 5999 | Fax: 04 385 5856

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA / HUTT VALLEY DHB	**BOARD PRESENTATION**
	Date: 28 November 2019
Author	Executive Director, Quality Improvement and Patient Safety – Sandy Blake GM Quality, Service Improvement & Innovation – Debbie Gell
Endorsed	Chief Executive – Fionnagh Dougan
Subject	**CONSUMER PRESENTATION**

RECOMMENDATION

It is **recommended** that the Board:

(a) Note the contents of this paper.

1. INTRODUCTION

1.1 Purpose

This paper is provided as background to the patient story being presented at the joint Board meeting on Thursday, 28 November 2019.

2. BACKGROUND

2.1 Overview of Consumer Presentations

Consumer presentations are used as a means to assist us in exploring and understanding how a patient and/or their family/whānau experience care being delivered by Capital and Coast and/or Hutt Valley DHB.

The aim is to provoke conversations and reflection that will highlight areas for learning and improvement in a complex health system.

All patients/family/whānau have given informed consent for their story to be presented and are provided with feedback following the Board meeting.

2.1.1 Consumer Presentation Trish Harris

Trish Harris is a writer. Trish developed Juvenile Rheumatoid Arthritis when she was six years old. Her memoir, *The Walking Stick Tree*, tells that story and also includes thoughtful personal essays.

She spent time in the children's wards at Wellington Hospital, at Queen Elizabeth Hospital in Rotorua and in the orthopaedic ward at Hutt Hospital. During her most recent Hutt Hospital stay (for two months) she kept a journal and those jottings form the basis of the poems in her second book, *My wide white bed*.

Trish believes it's vital that stories and writing represent a wide range of people and experiences. She says seeing ourselves reflected in stories can affirm and help us feel connected to each other and that when we read of experiences different from our own it can build empathy. All of this, plus a love of language, drive her writing and teaching.

She is co-founder of *Crip the Lit*, a group aimed at increasing and celebrating the voice of disabled writers and their stories. This year she edited their pocket book: Here we are, read us: Women, Disability and Writing. In it she says she is a part-time crane operator!

PUBLIC

Date:28 November 2019	**BOARD DECISION**
Author	Director Pacific Health - Tofa Suafole Gush
Endorsed by	Chief Executive Officer - Fionnagh Dougan
Subject	**DRAFT - SUB REGIONAL PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN 2020-2025**

RECOMMENDATIONS

It is **recommended** that the Boards:

a) **NOTE** the content of the Draft Plan

b) **NOTE** the extensive community consultation undertaken by the DHB with the support of the Sub-regional Pacific Heath Advisory Group

c) **ENDORSE** the Draft Sub Regional Pacific Health & Wellbeing Strategic Plan 2020-2025.

d) **AGREE** to the dissemination of the Draft–Sub Regional Pacific Health & Wellbeing Strategic Plan 2020-2025 to stakeholders for their feedback

APPENDIX

1. Draft Sub Regional Pacific Health and Wellbeing Strategic Plan 2020-2025

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to provide a six monthly Pacific Health update on progress for the 3 DHBs and seek the endorsement of all 3 Boards to dissemination of the Draft - Sub Regional Pacific Health and Wellbeing Plan 2020-2025.

1.2 Previous Board Discussions/Decisions

The Wairarapa and the joint Capital Coast and Hutt Valley Boards in their respective meetings of February 2019 approved the approach to developing a 'One Pacific Health and Wellbeing Plan' for the sub region to guide and inform decision making around Pacific people's health in all 3 District Health Boards.

2. BACKGROUND

The Hutt Valley and Wairarapa DHBs Pacific Plan **(*Paolo mo Tagata ole Moana*)** expired in 2018. A performance review of the implementation of the expired strategy was tabled and approved by the Boards in November 2018. The visual presentations made to community and stakeholders were well received. Discussions with Pacific stakeholders also provided us with feedback on what we need to do more of to benefit the Pacific people and their communities. The CCDHB Pacific Plan ***(Toe timata le Unpeg***) is due to expire in 2020.

The national Pacific strategy ***'Ala Moui'-Pathway to Pacific Health and Wellbeing 2014-2018*** sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities.

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

PUBLIC

The development of **a single plan** for all three DHBs has been closely aligned to the national strategy and is consistent with what our local communities needs are, and what has been fed back during the community consultation /fono process.

The accompanying Pacific Population Health Profile for the 3DHBs is the first we have done. It collates demographic and health information for this population and was used to inform this current draft 3DHB Pacific Health and Wellbeing Plan. It will also inform future Health Needs Assessment for the Pacific population in our sub region.

2.1 CONSULTATION – THE VOICE OF THE COMMUNITY

The development of the Sub Regional Pacific Health and Wellbeing Strategic Plan 2020-2025 is the result of six months' of work including extensive community and stakeholder fono/meetings to ensure the voice of communities have been heard. Feedback identified key opportunities for joint work with PHOs, Pacific providers, Regional Public Health and NGOs.

3. THE PLAN

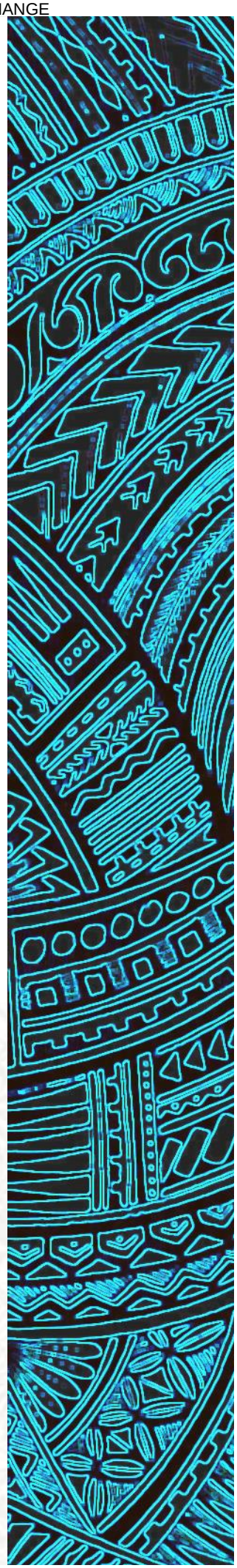
There are six priorities to action in this Plan. We have intentionally selected this number of priorities from what the community have said during the consultation process as well as what our Pacific data has confirmed are areas of health need. The same priorities are closely aligned to what we are required in relation to the equity indicators by the Ministry to report on. The Plan also adopts the strategic directions outlined in key strategic documents for our 3DHBs to guide our response to improving the health and wellbeing of the Pacific communities in the sub-region.

4. NEXT STEPS

With the Board's endorsement we will arrange for the draft to be disseminated to the key stakeholders, Pacific Providers & NGOs for their feedback before a formal launch of the document in the community in May, in time for the start of the financial year.

1. consult on the draft with a key group of stakeholders
2. refine the plan based on this feedback
3. seek the 3 Boards' approval of the final plan
4. formal launch.

Funding for the implementation of the Plan is expected to be from the DHBs baseline in 2019/20 and out-years with most initiatives building on existing DHB and PHO programmes for improvement of the health of the Pacific population.



DRAFT SUB REGIONAL PACIFIC HEALTH AND WELLBEING STRATEGIC PLAN 2020-2025

DRAFT

Capital & Coast District Health Board
Wairarapa District Health Board
Hutt Valley District Health Board

Contents

Acknowledgement 1
Foreword 1
Introduction 2
Our Vision for Pacific in the Sub Region 4
Our Strategic Outcome 4
System Enablers 4
Principles of Pacific Healthcare delivery across the 3DHBs 5
So'oso'o Le Upega Framework for guiding this Plan 6
Our Strategic Priorities and Measuring Progress 7
Priority One: Pacific Child Health & Wellbeing 11
Rationale: 11
What the data tells us: 11
What we are going to do? 14
What is working well: Case Study 15
Priority 2: Pacific Young People 16
Rationale: 16
What the data tells us: 17
What we are going to do? 18
What is Working Well: A Case Study 19
Priority 3: Pacific Adults and Aging Well 20
Rationale: 20
What the data tells us? 20
What we are going to do? 21
What is working well: Case Study 22
Priority 4: Pacific Health Workforce & Pacific Providers/NGOs 23
Rationale 23
What the data tells us? 24
What we are going to do? 25
What's working well: Case Study 26
Priority 5: Culturally Responsive & Integrated Health System 27
Rationale: 27
What we are going to do? 28
What's working well: Case Study 29
Priority 6: Social Determinants of Health 30
Rationale 30
What the data tells us? 31
What we are going to do? 32
What's working well: Case Study 33
APPENDIX: Pacific Health Data across the Sub-Region 34

DRAFT

Acknowledgement

We wish to acknowledge the invaluable contributions of all those who provided input to the development of this Pacific Sub-regional Strategic Health and Wellbeing Plan. In particular, our gratitude is extended to the Pacific communities who supported the development of this plan by contributing their voices, stories, ideas and insights as well as our provider community and DHB staff across the entire sub-region. We were delighted at the response we received from communities and the interest there is to improving Pacific health outcomes.

Foreword

It is our privilege to present the Pacific Sub regional Health and Wellbeing Strategic Plan 2020-2025 for the Capital Coast, Hutt Valley and Wairarapa District Health Boards. This plan represents the blueprint for meeting the changing needs of Pacific individuals, families and communities over the next five years.

This plan outlines the three District Health Boards strong commitment to improving the health and wellbeing of Pacific people. Pacific peoples do not always enjoy the same access, service experiences and health and wellbeing outcomes as non-Pacific peoples. This plan recognises that we need a specific and targeted approach to redressing inequities that exist within our health system. We believe that a core role of District Health Boards is to apply the revenue they receive to provide the best health care services that are culturally responsive to the needs of our Pacific populations.

We acknowledge that a range of factors such as education, housing, income, employment and social policies have a significant impact on achieving better health outcomes for Pacific peoples. We also recognise that we are operating in an increasingly complex and challenging health environment, with competing financial pressures and health interests, emerging health technologies and pharmaceuticals, shortages of health workforce, and changing demographics.

To this end, improving Pacific people's health is not only a mandate of the three District Health Boards, but it should be everyone's business. Our vision for Pacific peoples is empowered and enabled Pacific peoples living longer quality lives, supported by a culturally responsive health system.

There are many health challenges facing our Pacific communities. The priorities and strategies identified in this plan represent the key touch points which we believe will enable us to leverage improved outcomes as efficiently and effectively as possible. These priorities are as follows:

- *Pacific Child Health and Wellbeing,*
- *Pacific Young People,*
- *Pacific Adults and Ageing Well,*
- *Pacific Health Workforce & Pacific Providers/NGOs,*
- *Culturally Responsive & Integrated Health System,*
- *Social Determinants of Health*

The above strategies do not cover all possible approaches to reducing health inequalities, but rather the emphasis is on priorities where there is good reason to believe action by the DHBs and its partners outside of health will lead to the attainment of better health and wellbeing outcomes for our Pacific people.

The 3DHBs are committed to implementing this Pacific health and wellbeing strategic plan and we look forward to continuing to work with the Pacific communities, partners and stakeholders to achieving equity in access and, most importantly, equity in health outcomes for Pacific people and communities.

Fionnagh Dougan

Chief Executive
Capital & Coast District Health Board
Hutt Valley District Health Board

Dale Oliff

Chief Executive
Wairarapa District Health Board

DRAFT

Introduction

This Pacific Sub Regional Health and Wellbeing Strategic Plan represents the beginning of a new way of approaching service design and delivery for Pacific families and communities and builds on the progress of previous plans;

"Paolo mo Tagata o le Moana" HVDHB & WrDHB Pacific Health Action Plan 2015-2018,

"Toe timata le Upega" CCDHB Pacific Health Action Plan 2017-2021.

This plan adopts a human rights based approach to health. There is a growing body of evidence confirming that health services reflect the dominant economic or cultural group. Consequently in practice, Pacific communities do not receive equitable care.1 Varying degrees of social isolation, acculturation, the impact of migration, and different views of illness between Pacific communities all impact on the ability to provide services that appropriately meet needs.2 As a Sub-region we are committed to ensuring policies, programmes and services provide a level playing field and equal opportunities for best health possible for Pacific people regardless of age, gender, ability, religious beliefs or social economic backgrounds.

We acknowledge the gains and milestones reached in the last five years, with some improvement in access and interaction of Pacific people with the health system, partnerships across the health sector, AND innovations delivered in the community by Pacific providers for example Pacific Nurse led services (Vaka Atafaga Nursing service, Pacific Health Service Hutt Valley Primary nurses and Thriving Cores Well Child services, Pacific Navigation Services), Pacific Churches and community leaders to name a few.

Unfortunately, Pacific people's health, as measured by most major indicators of health, still remains poorer when compared to non-pacific. Whilst many of the barriers Pacific peoples face such as cost, are shared with other groups in the Subregion, there are issues that are unique to Pacific peoples.
Differences in health outcomes confirm that there are also issues for specific groups within Pacific communities.[3]

We are determined to build on the achievements particularly focusing on programmes and services that address health inequity and reduce discrimination. This will be done by advancing strategies that support locally developed solutions, cultural and collaborative models of health care that support individuals and families from a holistic perspective and tailored to meet local need across the Sub-region.

We recognise that many other organisations outside of the health sector hold the levers to progress health outcomes. Inter-professional and inter-disciplinary teamwork, partnering across health service providers and cooperation across sectors, as well as including the voices of Pacific people, families and communities opens the way for new and collaborative partnerships for shared solutions and innovative planning.

1 Southwick, M., Kenealy, T., Ryan, D. (2012). Primary Care for Pacific People: A Pacific and Health System Approach. Wellington: Pacific Perspectives.

2ibid

3 Southwick, M., Kenealy, T., Ryan, D. (2012). Primary Care for Pacific People: A Pa Health System Approach. Wellington: Pacific Perspectives.

Key Strategic Directions

This plan applies a Pacific approach and lens to the strategic directions outlined in key strategic documents which guide our response to improving the health and wellbeing of the Pacific communities in the Wellington Sub-Region. These include;

- *CCDHB Health System Plan 2030,*
- *HVDHB Vision For Change 2017-2027,*
- *WrDHB Well Wairarapa- Better Health for All vision 2017*
- *Ministry of Health refreshed Pacific Health Plan 2020-2025*
- *Faiva Ora National Pasifika Disability Plan 2014-2016*
- *The Child and Youth Wellbeing Strategy 2019, Department of the Prime Minister*
- *PHARMAC Pacific Responsiveness Strategy 2017-2026*

The Key strategic directions include:

1) Equity – advancing decisions, solutions and innovations that eliminate health inequalities for Pacific people.

2) Collaboration– strengthening partnerships including integrated planning and service delivery with both health and non- health partners across different sectors AND Pacific communities themselves.

3) Strengthening Accountability and Performance monitoring across the health system - To hold ourselves liable and answerable to ensuring we are doing more than enough to achieve equitable health outcomes for Pacific peoples through consistent reporting and measurement of progress.

4) Building the Pacific workforce - strengthening Pacific health providers providing sustainable resources for long-term, rather than short-term funding.

5) Inclusiveness – ensuring that Pacific disabled children, youth and adults and their families are also at the centre of service and programme decision making and are not left behind. Recognising that those with a disability may have extra barriers to overcome in accessing health services than most.

6) Robust Evidence Base- Implementing and investing in what is already working and building evidence through research, monitoring and evaluation.

7) Integrated Planning - Strengthening integrated planning and service delivery and accelerating the shift of services closer to home.

8) Culturally Responsive Services - Developing and Sustaining a culturally safe and competent health services and work settings including elimination of racism and developing strategies to mitigate negative attitudes and behaviours.

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Our Vision for Pacific in the Sub Region

Our Pacific peoples are enabled and empowered to live longer and enjoy meaningful physical, mental, emotional and spiritual wellness supported by a culturally responsive health system.

Our Strategic Outcome

To work in partnership, collaboration and in an integrated way with Pacific communities, Pacific providers, health and multisector partners to deliver culturally responsive, fanau centred, accessible, appropriate, quality and timely health care services that meet the needs of the Pacific peoples.

System Enablers

Partners and Networks

Build new and strengthen existing partnerships and networks with multiple organisations, Pacific communities and individuals. Leverage off strengths and skillsets of different organisations. Also look at new partnerships to create a shared sense of ownership and responsibility to deliver the best services for Pacific peoples.

Commissioning

The way we commission services and invest will be more intentional and targeted. System funding should be aligned, sustainable and equitable to ensure resources are distributed to scaling up and supporting programmes that are already working and meet the needs of the Pacific community. For instance initiatives that are run in the Community by Pacific providers or Faith based Pacific organisations. In addition priority activities are explicitly outlined in contracting work to ensure a strong equity focus for Pacific.

Influence & Advocacy

Leverage off the influence we have to accelerate and progress change at not only at policy, planning, service and programme levels locally, regionally and nationally.

ICT and Knowledge Resource

We have access to the technology, evidence based data and resources that can be utilised and shared across to our Primary care and Community based partners to ensure decision making, investments and design processes.

DHBs as an employer

We have a mandate to create a culturally sensitive work environment that entices and supports employees to feel and be their best. In addition, we can influence creating a work environment that attracts Pacific skilled workforce to want to be a part of.

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Principles of Pacific Healthcare delivery across the 3DHBs

In the development of this plan, it is important to foreground Pacific peoples as diverse with unique values, cultural intelligence, social capital, differing languages and "lived experiences". The term 'Pacific peoples' is an umbrella term used to describe a population made up of 16 distinct and diverse cultures of peoples from Melanesia, Polynesia and Micronesia. In the Wellington sub-region the seven largest ethnic groups are, Samoan, Tongan, Cook Island Maori, Niuean, Fijian, Tokelauan, Tuvaluan (Statistics New Zealand, 2018).

By making this the focal point, we commit as District Health Boards to ensure that Pacific people are actively involved in co-designing services and programmes that help address difficulties based on "one size does not fit all" due to the growing diversity of Pacific peoples and their ability to access quality and responsive services. We are putting a stake in the ground and acknowledging that as navigators of this wide ocean that we call the health system, we owe it to our Pacific communities and other indigenous ethnicities to reconstruct a system that they can voyage through without difficulty.

We have chosen five key principles or values common across Pacific cultures which have been weaved through this plan, and will guide our work alongside the input of Pacific communities through community leaders, churches, providers and others.

The Five key Principles include;

Family. Family underpins identity, genealogy, relationships and a sense of belonging for Pacific people. It lies at the heart of who Pacific people are as every Pacific person belongs to an aiga or kainga.

Environment. Built and natural environments is important to Pacific people. Their connectedness and experiences of both plays a huge role in the holistic approach to health and wellbeing.

Spiritual. Churches have historically played a crucial role in the lives of Pacific people providing spiritual guidance with values such as faith, integrity, truth and trust. Churches are still an integral part of Pacific communities and their everyday lives.

Respect. Showing respect when relating to one another is an important aspect of Pacific people right from an early age. This includes respect towards elders, people in positions of authority, each other, women and children.

Culture. Cultural diversity such as the different languages, ethnicity, gender, generational issues, religion, and sexual orientation influences how Pacific people view and respond to health services. This diversity is also evident and seen in individuals and family practices, behaviours, understanding and responsiveness to the world around them.

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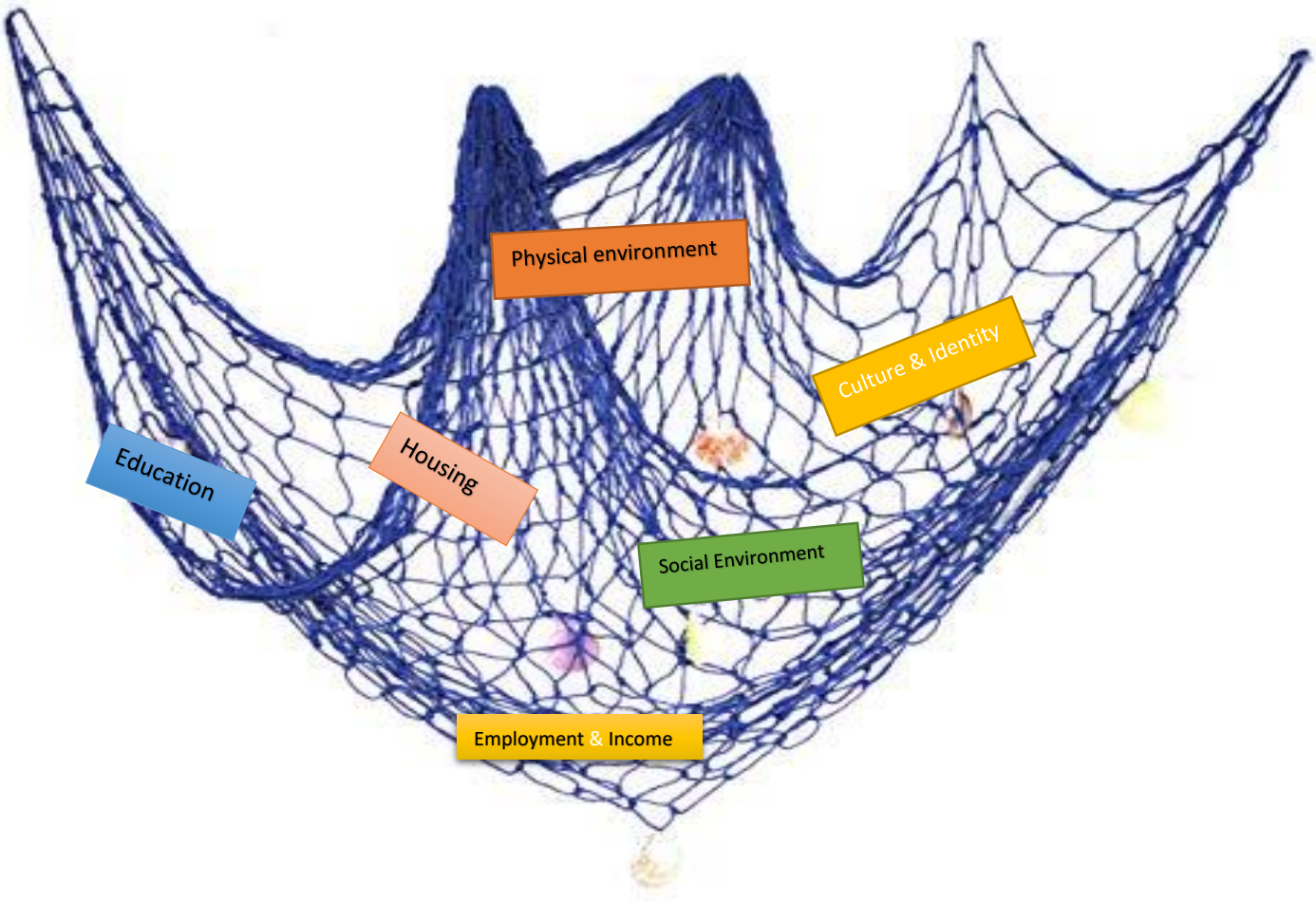
So'oso'o Le Upega Framework for guiding this Plan

The plan adopts a well utilised and known Pacific framework to illustrate how the Sub Region is going to work with its partners collectively to achieve better health and wellbeing outcomes for Pacific peoples.. Upega (fishing net) is a Samoan fishing proverb and so'oso'o means connect. So'oso'o le Upega therefore means to connect (*so'oso'o)* other agencies to health and vice versa so that the Pacific families we serve are being provided the best services that support them addressing issues that have an impact on their health and wellbeing. By being purposeful and intentional in drawing on the knowledge, expertise and understanding of the Pacific communities to partner with the District Health Boards to bring about much needed and sustainable changes across areas of need in the health system.

By utilising this framework, we acknowledge that the cultural wisdom of Pacific peoples still defines and shapes how information is processed, harnessed and acted out. Therefore meaningful and respectful relationships with community are imperative to the design and implementation of this Plan. This ensures that the Pacific communities we serve are not just passive beneficiaries of services but are stewards of their own health care and management.

So'oso'o le Upega Framework



Our Strategic Priorities and Measuring Progress

Our six Strategic Priorities as identified and informed by the Pacific communities are

1) Pacific Child Health & Wellbeing
2) Pacific Young People
3) Pacific Adults & Aging Well
4) Pacific Health and Disability Workforce & Pacific Providers
5) Culturally Responsive & Integrated System
6) Social Determinants of Health

These strategic priorities and priority actions, activities and performance indicators with accompanying budgets will be embedded into the Annual Plan and existing performance and accountability mechanisms of each District Health Board. Indeed, accountability and responsibility towards reporting against this strategic Pacific health and wellbeing plan and achieving measurable outcomes for Pacific peoples should be the responsibility of all levels of management.

We know we have been successful when we see improvements in the following areas;

Priority One: Pacific Child Health & Wellbeing

	Measures
1.	Increased uptake of antenatal and postnatal maternity services that are culturally responsive and wrapped around needs of Pacific mothers and children.
2.	A decrease in Ambulatory Sensitive Hospital Admissions (ASH) rates for Pacific children and adults through improved coordination between community, primary care and secondary care providers and other sector partners.
3.	Coordinated approach with stronger links across health, education and social service providers to reach greater number of Pacific families through home visiting programmes, culturally appropriate parenting education and support.
4	Increased number of Pacific families accessing warmer drier homes through the Well Homes Healthy Housing initiative
5	Increased number and uptake of Pacific mothers, infants and children with disabilities and their families accessing the right maternity and services and receiving funded disability support services.
6.	Support increased uptake of healthy lifestyles programs targeting nutrition, exercise, sleep, smoking and mental for Pacific families in the communities and in schools.

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Priority Two: Pacific Young People

	Measure
1.	Increased number and uptake of Pacific young people with disabilities and their families accessing the right services and receiving support
2.	Support existing and new programmes and initiatives like the Piki free youth Mental Health services, community driven mental health programmes like Taiala mo le Ola Manuia (A Guide to Healthy Living) Mental Health project with Church communities.
3	Encourage and better use of social media to promote health messages and campaigns to reach Pacific young people
4.	Establish collaborations with Health & P.E & Science Heads of Departments in Colleges to promote health as a career in schools but also to collaborate on health promotion initiatives driven by Pacific young people

Priority Three: Pacific Adults and Aging Well

	Measures
1.	Improved access to primary, secondary and tertiary health care closer to home and in the communities
2.	Increase in accessibility to medications and faster treatment pathways for Pacific patients
3.	Increase uptake of healthy lifestyle programmes and early prevention health promotion programmes
4.	Increase and improvement in early screening rates for cancer such as Bowel, Breast and Cervical screening programmes, uptake of diabetes checks and early intervention programs for diabetes, cardiovascular, respiratory, smoking and high blood pressure.
5.	Decreased number of prescriptions unfilled due to cost and increased access to Pharmacies and Pharmaceuticals
6.	Ensure new funding in early intervention mental health services meets the needs of Pacific people and is appropriate
7	Reduced ASH rates and Pacific people admitted to hospital due to complications from chronic conditions

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Priority Four: Pacific Health Workforce & Pacific Providers/NGOs

	Measures
1.	Increase in Pacific skilled workforce being interviewed for positions and employed within the District Health Boards in different areas.
2.	A review of commissioning and contracting processes within the DHBs is undertaken to ensure Pacific providers are utilized and resourced to support primary and secondary care to reach and serve Pacific peoples.
3.	Work with Pacific health workforce community organisations e.g. Tausi Soifua Samoa Nurses Association, Tongan Nurses Association, Tokelau Nurses, Pacific Social Workers Association, Pacific Pharmacy Association, to provide mentoring & scholarship support not only to students undertaking nursing and social work studies. But also work across to mainstream providers to ensure there are pathways in place for mentoring and leadership trainings for the current workforce.
4	Strengthen reporting mechanisms through ensuring the right support with Technology and backroom admin support to our Pacific providers and NGOs as required

Priority Five: Culturally Responsive and Integrated System

	Measures
1.	Increase in the number of specialist and health care services closer to home and out in the community
2.	Strengthen connection and support of Pacific providers to mainstream services for example Health Care Homes and Community Integration projects in primary care.
3.	Number of Mandatory Cultural Competency trainings rolled out across Secondary and Primary care services.
4.	Scale up support for Integration projects that are working and across the Sub-region
5.	Establish a Pacific specific sub regional health pathways for the 3D Health Pathways programme.

Priority Six: Social Determinants of Health

	Measures
1.	Strengthening partnerships and work in collaboration with housing organisations, Ministry of Social Development, Ministry of Pacific Peoples, Ministry of Education, Pasifika Future, Local councils and other sectors and leverage off programmes such as Pasifika PowerUP Education programmes and Living wage
2.	Advocate for free or cheaper visits to general practice and prescriptions for 15-18 year olds, especially for large families with three or more children.
3.	Promote the Well Homes service to Pacific families and services, which helps families' access housing interventions such as insulation, heating, curtain banks, beds, bedding, and carpets.

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Our Pacific peoples in the Wellington Sub Region

The Wellington Sub-Region is home to an estimated **35,165 Pacific people** which is 8% of the total population. This is higher compared to the national average of 6.5%. We have a youth bulge with an increasingly aging population. There has also in the last 5 years been a steady number of live births across the sub-region. The greatest proportion of Pacific people across the sub-region reside in Lower Hutt and Porirua City.

Porirua City and Lower Hutt City have the greatest portion of Pacific peoples

Life Expectancy has increased by 7-8 years

4% Increase in population over next 5 years

29% Of Pacific population in the Wellington SubRegion are Under 15 years old

60% New Zealand Born,40% born in the Islands but have lived in NZ for over 10 years and through Quota system

99% Pacific people in the Wairarapa enrolled with a PHO

98% Pacific people in the Hutt Valley enrolled with a PHO

97% Pacific people in Capital & Coast enrolled with a PHO

The largest ethnic groups are Samoan, Cook Island Maori, Tongan, Niuen, Fijian, Tokelauan

Our Pacific Peoples Health Status

51% CCDHB, 40% HVDHB, 36% WrDHB Pacific living in the most deprived áreas.

Top ASH Conditions for Pacific Children (0-4years)

Asthma, Dental conditions, Gastroenteristi/dehydration, Upper Respiratory Tract infections and Cellulistis

Top ASH Conditions Pacific Adults

Angina & Chest Pain, Cellulistic, Pneumonia, Stroke, Myocardial Infarcion, Chronic Obstructive Pulmonary Disease, Gastroenteritis/dehydration

Pacific enrolled with Compass PHO in the Wairarapa saw a GP or Nurse 5 times

Pacific enrolled with Compass or Ora Toa PHOs in Wellington saw GP or nurse 4.5 times

Pacific enrolled Te AHN PHO and Cosine PHO saw GP 3.5 times

Pacific aged 65 and over had the most visits to GPs on average followed by Ages 45-64 and Pacific children Under 5.

Priority One: Pacific Child Health & Wellbeing

Our goal is to give Pacific children and their families the best possible start in life AND ensure they meet key childhood developmental milestones through culturally responsive and safe services and support.

Rationale:

With a fast growing young population, Pacific children, their families and support networks will benefit from early fanau centred health and wellbeing interventions that are culturally sensitive, community determined, partnerships driven and system enabled. The early years, and in particular the first 1,000 days of life is a crucial time and a window of opportunity whereby efforts need to be concentrated to enable the best start to life for our Pacific children.

What the data tells us:

Latest data tell us that children aged under 15 years, make up 33% of the Wairarapa Pacific population, 29% in the Hutt Valley and 27% for Capital & Coast DHB respectively. And that over 60% of the Pacific population in the Wellington Sub-region are now New Zealand born. There have been improvements in health outcomes as evidenced by a decrease in ASH rates for Hutt Pacific and Capital & Coast for Pacific children in the last 5 years. Including increased newborn enrolment with a General Practice and Community Oral health service. Also improvements in immunisation rates, increased percentage receiving WellChild or Tamariki Ora core checks in their first year and B4 School Checks by the time they are four years old.

However, despite improvements in health we are also seeing higher rates of caesarean for Pacific mothers, lower uptake of antenatal or postnatal maternity services, or pregnant Pacific mothers registering and seeing a Lead Maternity carer in their first trimester, increasing complexities due to gestational diabetes and having heavier babies. Pacific children also made up 55% of CCDHB children aged 0-14 years, 33% of the HVDHB and 12% of Wairarapa living in the most deprived areas.

Most of the ASH presentations of Pacific children to hospital were for asthma, dental conditions, gastroenteritis/dehydration, upper respiratory tract infections and cellulitis across the three DHBs.

There also remains a disparity in the percentage of Pacific children being caries free by the age of five, higher rates of obesity or overweight and Pacific children turning 1 year old were less likely to have had all their scheduled core checks than children of other ethnicities excluding Maori. For Wairarapa Pacific children, 70% had received all their core checks, 57% of Hutt Pacific and 69% of Capital & Coast Pacific.

Efforts should be focussed on the provision of culturally responsive maternal health services that support healthy pregnancies and delivered close to and in people's homes and in the communities. We want to see easy access and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.

In addition, we need to progress health services support and care that focus on good nutrition and physical activity, smoking, positive parenting, immunisation, warm homes, mental health and wellbeing of parents are crucial for healthy physical and social development.

Certainly approaches that focus on the strengths of Pacific families with a spotlight on parents, a mothers overall wellbeing, focus on role of grandparents, strengthening communities and empowering families economically, socially and educationally will provide environments and foundations that bring up strong healthy Pacific children. Research and literature affirms that if we focus our efforts on fanau centred approaches that provide support and work with whole families and what they care about in their homes, our young children benefit.

We want the Wellington sub-region to be one of the best places in New Zealand to raise healthy thriving Pacific children. These actions will focus on supporting timely and quality access to health care and advocating and influencing early childhood development initiatives in other sectors like education and social sectors. We will also be specifically focussed on working collaboratively to improve access and engagement of Pacific families with

- *Primary Health Organisations (PHOs) & Pacific Providers,*
- *Well Child Tamariki Ora (WCTO) Providers,*
- *Addressing causes and issues with Ambulatory Sensitive Hospitalisation,*
- *Mental health and wellbeing*
- *Cross agency collaborations & integrated partnerships to address social determinants of health,*
- *Childhood obesity focussed initiatives*
- *Good oral health*
- *Breastfeeding Rates*
- *Smokefree and Warm healthy homes*

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What we are going to do?

Support and invest in new initiatives and support programmes already working that are fanau centred and targeted at addressing;

- First 1,000 days of life
- Healthy relationships, healthy pregnancy, positive parenting, parents and child mental health
- Healthy nutrition, sleep and physical activity
- Parenting programmes that support mothers and fathers focused on pre-conception, antenatal and postnatal
- Safe environments for bringing up Pacific children including warm homes, safe sleeping, reducing smoking and alcohol consumption
- Ensuring 100% of Pacific newborn's in the Wellington sub-region are enrolled with a General Practice, AND Well Child Tamariki Ora service by 3 months of age
- Focused on making sure 100% of Pacific infants and pre-school aged children receive oral health checks by 1 years of age.
- Improved and timely immunization uptake and rates
- Invest in programmes that build capacity and capability of primary and secondary workforce to build relationships with parents and families.
- Support investment in services and initiatives that provide home visits to families.
- Investigate initiatives and improve access to information and services that address Family violence and work with relevant stakeholders
- Strengthened approach to working across agencies to address timely access to maternity services and birthing options
- Support Pacific families through a inter-sectoral model for health education in schools and in the communities.
- Leverage off Pacific specific Well Child services and build up these providers to reach the most vulnerable families.
- Support the Well Homes initiative to ensure Pacific families have access to warm dry homes
- Implement strategies to increase rates and duration of breastfeeding
- Integration with general practice & Health Care Homes, PHOs and other services with shared plans and ability to cross-refer electronically.

What is working well: Case Study

Thriving Cores Pacific Well Child Tamariki Ora is the only Pacific run WellChild Tamariki Ora service provided through Pacific Health Service Hutt Valley (PHSHV) in the Wellington Sub-region. PHSHV is a not-for-profit agency based in Naenae in the Hutt Valley. The Thriving Cores service is a mobile service that has successfully worked with over 1,000 Pacific families over the years by conducting Core checks in people's homes and also running out of hours clinics to suit working mothers and parents.

They have provided social services support and working alongside Lead maternity carers to offer educational support to the families. They have also facilitated a lot of Pacific infants through provision of transportation to get infants and parents to their dental and specialist appointments. This service also helps with Car seat rental discounts, and provision of free Pepi Pods for safe sleeping for babies. They also offer a range of culturally appropriate parenting programmes and support groups. The service is fanau focused, strengths based, relational and the programmes provided are complementary and are designed to improve the outcomes for families/aiga and children.

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Priority 2: Pacific Young People

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

Rationale:

Pacific young people growing up in the Wellington sub region are contributing positively to their families and society and are progressing well in many areas. However with the majority now classified as New Zealand born and identifying with more than one ethnicity, our Pacific young people still face issues that previous generations may not have experienced due to exponential social, technological, economic, cultural and educational changes over the years.

What the data tells us:

Various school based health services are provided in low decile colleges, Teen parent units and alternative education centres delivered by Regional Public Health, VIBE, Evolve and some specific DHBs health services across the sub-region. Doctors and Nurses provide students with advice, treatment and referrals to other services on problems including general health, sexual health, and mental health. They also provide routine Health assessments to Year 9 students. Based on the most recent data available for the 2017 calendar year, in Wairarapa 27 Pacific students were seen by School based health services (79% of eligible students) and had on average 2 visits. Hutt Valley School Based health nurses saw 133 Pacific students (28% of eligible students) who had on average 2 visits. 100 Pacific Year 9 students in Hutt Valley received a routine health assessment. Capital & Coast School based health nurses saw 589 Pacific students (94% of eligible students) who had on average almost 2 visits.

Even though we see improvements and the availability of youth centred health services and programmes targeted to our young people in schools, we are seeing a rise in mental health issues, suicide attempts, sexually transmitted infections, smoking, preventable injuries, obesity and family violence. Our young people identified during the consultations the close

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link between mental health issues and the result of identity crises, poverty, lack of cultural sensitive health care models, stigmatisation and discrimination.

Tackling the risk factors associated with these issues alongside sufficient investment to advancing progress made in some areas and investment in new and innovative ways to support our young people to thrive is our goal. Particularly given that across the Sub-Region in the next 10 years most of the Pacific growth will be in the age groups 15-29 years a 8% increase4

We know that youth is a key transitional period in the life of a young person where they make decisions around relationships, career pathways, and responsibilities alongside rapid brain and body transformations. Research and the data tells us that enabling environments that foster healthy behaviours, resilience and confidence of young people puts them in good stead to transition into adulthood. The research and data also tells us that Pacific young people still face obstacles more so than other ethnicities due to socio-economic and educational disadvantage, inter-generational suffering and prejudice to name a few. We heard from our young people that they want to contribute to policies and programs that impact on them given the right support and opportunities to do so. Sport, music and the Arts are some of the areas they identified as having a significant impact in promoting a sense of wellbeing for them.

In light of this, the following actions will be taken to ensure we are supporting Pacific young people to strengthen their resilience, address mental health and wellbeing, establish the right support networks, improve sense of belonging, problem solving skills, strong connection to culture and family.

[4] 3DHB Pacific Plan Data sets 2019

What we are going to do?

- Support and strengthen initiatives that encourage young Pacific people to adopt healthy lifestyles, make informed choices about sexual health, smoking, and risk taking behaviors
- Accelerate strategies and innovations that focus on Pacific young people's improving access to appropriate and timely primary and secondary mental health services.
- Implement programs that prevent and address the problems caused by self-harm and violence
- Strengthen partnerships and collaborations with youth specific health, social and educational service providers
- Implement initiatives that promote strengthening pride in culture and identity
- Interventions and Cultural sensitive models of care are utilised when dealing with mental health, sexual and reproductive health issues of young people
- Encouraging parents and families to be positive role models;
- Strengthen the participation of Pacific young people in dialogue and decision-making opportunities and activities for monitoring of their health.
- Support programs that will focus on sensitizing and training health and disability workforce who with Pacific youth

What is Working Well: A Case Study

Evolve and Vibe Youth Health Services are providing free and confidential health care across the Sub-region including general, sexual and mental health, counselling, social support and youth development activities reaching low decile schools that have high percentage of Pacific students. These services also offer support for young people not in education, employment or undertaking any formal trainings who are between 16 or 17 years old amongst others. Pacific young people interviewed during the consultation phase identified that they were confident in the services provided through these school based clinics.

Regional Public Health through their School based health nurses and Social workers in schools are also reaching low deciles primary and intermediate schools and provide onsite health and social support to Pacific families and children.

Priority 3: Pacific Adults and Aging Well

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

Rationale:

Healthy Pacific adults and elders contribute positively to their families, churches, work places and society overall. Our Pacific elders play a crucial role as the custodians of traditional wisdom to help sustain cultural traditions, languages and practices, through passing on of knowledge, customs and generational blessings across generations. They are cultural champions that need to be engaged to ensure appropriate cultural approaches to health and wellbeing are utilised.

A social wellbeing survey undertaken by Statistics New Zealand in 2017 highlighted that Pacific adults reported higher levels of wellbeing despite challenging socio-economic situations. The life expectancy of Pacific adults has also increased showing that Pacific adults and elders are living an extra 7-8 years when compared to 20 years ago.

What the data tells us?

Data across the two Primary health organisations and the three DHBs in the Wellington Sub-region show that Pacific people have high rates of healthcare utilisation, accessing their General Practices 3.5 times more than others.

Pacific adults and elders continue to be high users of health services, and are still more likely to suffer and die prematurely from chronic diseases such as diabetes, heart disease, respiratory illnesses, strokes, cancer, obesity and high rates of avoidable ambulatory hospital admissions compared to others. Based on the NZ Health survey standardised rates, 92% of Pacific adults in Capital & Coast are overweight or obese and 89% of Hutt Valley Pacific. This is similar to all Pacific in New Zealand.

Amendable mortality rates for Pacific are also high particularly for people under the age of 75 due to causes that could have been prevented through treatment or better safety precautions. The causes of death include injuries, suicide, cancer and cardiovascular disease. Over the 5 years from 2011-2015, there were 176 deaths in Capital & Coast Pacific people and 71 Pacific Hutt Valley that could have been prevented. The standardised rate of

amenable mortality is higher for Pacific than non-Maori non Pacific people in Capital & Coast and Hutt Valley.

Based on coroner's information on suspected suicides, over the four years from 2014/15 to 2018/19, 5% of Hutt Valley deaths were Pacific people, 7% of Capital & Coast and none of the deaths in Wairarapa were Pacific people.

There is also an increasing trend of individuals suffering from multiple chronic conditions and this impacts on the quality of life of the individual and family due to complications from having more than one long term condition. This is despite improvements in treatments, management and access to clinical care services, wrap around programs and services that support and encourage the adoption of healthy lifestyles and focus on addressing social determinants of health.

Therefore we need to provide holistic and appropriate health promotion, prevention efforts and education to improve health literacy of Pacific adults and elders. We want to make sure that Pacific adults and elders are aging well and accessing the appropriate services including aged care facilities, palliative care services maximise their independence and reducing burden of health problems and disabilities.

What we are going to do?

- Implement early prevention, health education and promotion programmes that draw on Pacific traditional wisdom, languages and cultural strengths to address risk factors and treatment of long term conditions.
- Work in partnership with key stakeholders to increase and encourage participation in early screening programs (s cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).
- Continue to support healthy lifestyle programmes focussed on improving accessibility and affordability of nutritious food, sleep and increased physical activities for Pacific adults and elderly.
- Continue to complement system-wide health service delivery with targeted activities specifically aimed at chronic disease treatment and prevention
- Continue to fund the important 'Catalyst' Pacific radio programme and develop comprehensive social media campaigns to promote key messages and health information in the different Pacific languages that will raise awareness and support Pacific people to make the right lifestyle changes
    - Promote links across mental health and drug and alcohol services and continue to increase community awareness and education about the range of options for dealing with the impact of the use of drugs, alcohol and tobacco.
    - Implement strategies to promote resilience, empowerment and positive mental health
    - Strengthen healthy aging initiatives and optimise on opportunities to support Pacific elderly live quality lives in their homes.
    - Effectively integrate and socialise the idea of Advanced Care Planning with Pacific families and communities.
    - Continue to identify change levers in programme and service design which will make the greatest impact on a given health condition or issue including cultural competency training for non-Pacific workforce that work with Pacific people.

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What is working well: Case Study

Pacific Nurse Led Services and Navigation services out in the communities are achieving transformational cultural clinical and social outcomes for our Pacific peoples with long term conditions. These mobile nursing and social support services work with General Practices, Specialist services in the Hospitals and sectoral partners to wrap services in a culturally appropriate way around the patient and taking this care directly to their homes.

Examples of these Pacific services the Pacific Health Service Hutt Valley Primary Nursing Service and Vaka Atafaga, alongside Taeaomanino Trust, Vaka Tautua to name a few are reaching and supporting patients to complete and re-engage with their General Practices.

Priority 4: Pacific Health Workforce & Pacific Providers/NGOs

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

Rationale

The importance of building and maintaining a qualified Pacific health and disability workforce alongside investment in strengthening Pacific Providers is crucial to closing the gap in addressing the health inequalities that exist for Pacific people. A qualified Pacific health workforce with cultural understanding and who are well versed in the cultural nuances of Pacific people will improve and strengthen our ability to provide culturally responsive health system that benefits the communities we serve to engage them to become good and better stewards of their own health and wellbeing.

We want to ensure our current and future workforce is diverse and have the right skills and qualifications to deliver and provide continued improvement across all parts of the health sector. In addition, funding investments and commissioning of services are directed and help build up Pacific Providers with proven success in providing services that meet the needs of Pacific peoples.

Investing resources and funding into growing the Pacific health and disability workforce & Providers will enable the District Health Boards to close the gap and make a difference in achieving optimum health is achieved for vulnerable groups such as Pacific in the Wellington sub-region.

What the data tells us?

The Central Region District Health Boards Pacific Workforce Report as at 30 June 2019[5] identified that across the Wellington Sub Region, the Pacific workforce was spread across with the highest reported proportion of Pacific peoples in the Care and support occupation group with 20% in CCDHB, 2% in HVDHB and 0% in WrDHB. Followed by those working in Corporate, Admin and other, Nursing and with the lowest proportions in Midwives, Resident and Senior Medical Officers.

Across the Central Region, the proportion of Pacific staff with more than two years of accrued annual leave was typically lower than the proportion of all employees with this level

[5] TAS Central Region District Health Boards Dashboard Pacific Workforce Report June 2019,

of accrued leave, with no Pacific staff in the Midwifery, Resident Medical Officer or Senior Medical Officer Occupation groups reportedly accruing more than two years of annual leave. A cause for concern was the reported number of sick leave hours taken in April-June 2019, as a proportion of total paid hours, was typically higher for Pacific employees than the rate across all DHB employees.

The exceptions are the Midwifery and Resident and Senior Medical Officer Occupation groups, but this may be linked to the low numbers of Pacific employees in these occupation groups.

One of the limitations is that the data sets obtained does not include the Pacific workforce in primary and community health care. The DHBs workforce has also have an aging Pacific Health workforce

Certainly in the Wellington sub-region the forecast for the Pacific population is that there will be persistent inequities, increased demand on health services, increased social isolation with volumes of older people with complex health and social needs.

Hence a strong focus should be on investing now and making it a priority to grow the Pacific health workforce to meet the impact and increase in demand of the changing Pacific demographics and support an aging workforce who are small in numbers and are feeling the weight of supporting older people with long term conditions and other health issues affecting our Pacific populations.

Pacific Providers and NGOs in the community are small, we aim to support them by building their capacity further at all levels to collaborate (especially with other providers) as a key way to improve the range, access and cultural appropriateness of services to Pacific communities.

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What we are going to do?

- Increasing and attracting our Pacific human capital by targeting students via formal education settings, such as secondary schools to tertiary institutions. This pipeline needs to be socialised as well with the education sector. Explore and invest in cadetship programmes.

- Build effective pathways from schools to promote careers in health and focus on students, to transition with ease into higher education and professional institutions.

- Influence HR recruitment policies and processes across the 3DHBs to improve Pacific employment opportunities including increasing number of Pacific on shortlisting, interview panels, Steering groups and governance

- Focus on overseas/island trained health professionals with overseas training and qualifications and the pathways to get them qualified in the NZ health system

- Continue to fund and support improvement of "Pacific by Pacific" Pacific Health Service providers in the community and recognise the crucial part they play within the health system and the achievement of health outcomes.

Retention & Sustaining & Career Development:

- Retaining and supporting our current Pacific workforce includes looking at

1. mentoring programmes and support not only for current workforce, but those undertaking studies

2. flexible working arrangements to allow our Pacific workforce to focus on meeting their family/community obligations AND allow for family support

3. encouraging and developing succession plans for retention and professional pathways for Pacific health workforce alongside employment

What's working well: Case Study

The recruitment process in the Hutt Valley District Health Board has changed since 2018 to reflect the need to increase the number of Pacific in the nursing workforce by interviewing all Pacific and Maori applicants at the entry point of the process. There is still some fine tuning to this process and small positive changes are happening. But it is a process that needs to be scaled up and embedded across the sub region.

In addition, health specific scholarships through the Aniva Health Scholarships offered through the Ministry of Health as well as HVDHB specific Oral health Scholarships for three students over the last five years provide opportunities to grow our workforce.

Priority 5: Culturally Responsive & Integrated Health System

A culturally responsive and respectful health care system across the Wellington sub-region secondary/hospital care, specialist services, and aged care that meet the needs of Pacific peoples and are delivered close to home.

Rationale:

Culture for Pacific peoples plays a significant role in their decisions on how, where, when and why they should seek and engage with health services, acceptance of treatment protocols, adherence to treatment and follow up of appointments, as well as the ability to trust and be confident in the system.

Therefore, a culturally responsive and integrated system, culturally competent workforce will lead to more effective health service delivery that achieves equitable and better health outcomes for Pacific peoples. It will improve patient experiences and health outcomes.

We know that effective integration of services that wrap around a person's needs rather than service needs will enhance patient experience, achieve better and seamless care.

By working collectively across all areas clinical and non-clinical within the health system and various settings of care, we are improving the flow of information, continuity of care, and building strong and effective relationships and partnerships which are essential to integrated services and design.

What we are going to do?

- Develop and Implement a Sub-regional Cultural Competency Framework, Checklist and Training Package that nurtures a culturally responsive work environment and improve capacity of the health workforce to deliver culturally sensitive services.

- Build accountability and leadership for Pacific health outcomes by embedding accountability at all levels of management within the DHBs and also reporting requirements on health impact of Pacific across services.

- Strengthen and support Pacific Health Providers and align their work with General Practices and hospital services in particular with a focus on Health Care Homes and Integrated family health centres in primary care and the community.

- Strengthen links across the health system from clinical and nonclinical work streams and focus on better access to coordinated and multidisciplinary care.

- Establish a mechanism for collaborative operational planning, strategy development and service design across the 3DHB Pacific directorates

- Develop opportunities for regular consultations with Pacific communities to establish and hear views about healthcare delivery

- Embed Pacific cultural training as a key component of new employees orientation programme

- Explore opportunities for research that promote cultural responsiveness and safety in the workplace.

- Continue to support integrated programmes in primary care and hospital/specialist services focussed on early identification, treatment and support for individuals with risk factors such as the Community Integration initiative.

- Maintaining trusted relationships within the Pacific community such as Churches and with providers.

- Continue to give priority to improving quality of hospital care and specialist services and primary health care systems to ensure they are culturally sensitive and safe for Pacific people.

What's working well: Case Study

The Cultural Competency Mandatory Training programme currently being implemented in the Hutt Valley District Health Board and as part of the Cornerstone Accreditation Scheme for General practices through Te Awakairangi Health Network in Primary Care is proving to be a huge success. It has trained over 400 Community Pharmacists, GPs, Radiologists, Theatre staff, Regional Breast and Cervical Screening Services, Community Dental Therapists, Allied Health staff, Practice Managers, Nurses, Strategy and Planning staff, Administrators since it was put in place in 2018.

The Training programme is completed and delivered in two phases.

1) Mandatory Training for all Employees E-Learning Module
2) Face to face 2 hour Training

The training was implemented to support and equip non-Pacific colleagues across the hospital and community settings with practical tools, sound knowledge and understanding of Pacific people. Furthermore it was created out of a need to create a "Culturally Responsive" environment within the hospital and general practice settings with a strong equity focus to enhance how people engaged, worked and support both Pacific patients and staff.

Priority 6: Social Determinants of Health

A health system in the Wellington sub-region that is aligned and better connected to housing, education, employment, social services and other sectors to address environmental, social and economic inequities to achieve better health outcomes for Pacific peoples.

Culturally sensitive models of care are utilised and integrated into health care deliver, education and promotional strategies to enable the best possible mental health and wellbeing for pacific peoples

Rationale

The health and wellbeing of our Pacific communities is heavily influenced by the underlying social determinants of health. These include, housing and employment, health behaviours, clinical care and the physical environment.

What the data tells us?

A higher proportion of Pacific people are living in more deprived areas according to the NZ Deprivation Index. Based on the 2013 Census population, 51% of Capital & Coast Pacific people were living in the most deprived areas, 40% of Hutt Pacific people and 36% of Wairarapa Pacific people.

Research suggests that only about 20 percent of a person's health is determined by access to health care. The other 80 percent is determined by health behaviours and the social and environmental conditions where they live, work and play.6 The feedback from our Pacific people provided valuable insight on how the social determinants of health were impacting on their health and wellbeing.

Most importantly, the feedback highlighted what we need to prioritise to improve the health and wellbeing of our Pacific Peoples across Wellington, the Hutt Valley and Wairarapa.

It is well known that income is associated with health and wellbeing. Families on low incomes may struggle to pay all their bills, which can cause stress and tension within a family. The rise in housing costs in recent years, in particular, has put many families under financial strain – with a significant proportion of their income having to be spent on rents or mortgages. This may mean they are unlikely to afford items and activities that can have a positive impact on health and wellbeing. These may include, for example:

- healthy foods, like fruits, vegetables and milk
- team sports and other outdoor activities
- school outings and events
- joining and participating in local cultural or religious groups, hobby groups, or clubs
- appropriate clothing and bedding
- travel or holidays
- electricity for heating
- household items to help keep homes warm and dry, like heaters, curtains, draft stoppers and insulation.

[6] https://www.health.govt.nz/publication/health-and-independence-report-2017

Of course, low income will also impact on a family's ability to pay for health care, including regular check-ups and care when they are unwell.

Employment helps to raise a family's income, which can help pay for activities and items that improve health and wellbeing. However, employment can take a parent's time away from their family – especially if they are having to work more than one job, or work at nights and weekends, to make ends meet. Time away from their family while working can also have a negative impact on wellbeing.

Many Pacific families told us that both employment and income affect their health and wellbeing in different ways. Often, both the mum and dad were working and the family still did not have enough money coming in to meet all their ongoing bills and household costs. Sometimes the mum or dad had more than more job and were working different shifts and at weekends. Young Pacific people would also often be working to help support their family. Some said that they would often settle for less when interviewing for jobs.

We were also told that many Pacific people are not aware of the Government support available. When they do seek support, many felt the process was administratively burdensome, intrusive, and took away their dignity. The process involved too much paperwork and forms, and having to 'prove' they had low incomes. We were told that many Pacific people felt judged and humiliated by the process.

Income support was especially needed for Pacific families after a baby is born, for the first 12 months of the infant's life. During this time finances are particularly stretched because the family will lose the income of one parent. Additional income during this time would also relief financial stress and help the family provide support the baby during this critical period in a baby's life.

As expected, we were told that low income affects the ability of Pacific people to access health care. They told us that many Pacific people are not having regular check-ups with their general practice due to the health and medical costs.

DRAFT

What we are going to do?

- Support initiatives and innovative programs that promote effective partnerships between local services from different sectors that address the social determinants of health
- take action across key social determinants such as health, housing, education and employment;
- align program goals across sectors and leverage off existing partnerships, frameworks and programmes that are in place for example working with Pacific Whanau Ora collectives
- Strengthen working relationship with the Ministry of Social Development and Work and Income New Zealand to help them promote and inform Pacific people about the support that is available to them and help make their processes for applying for support easier and more user-friendly.
- Work with our health providers to ensure that they know what Government supports are available to their clients and can help people apply
- Support Pacific people and work alongside them and other agencies to help them apply for the Government support and help that they are entitled to.
- Advocate for free or cheaper visits to general practice and prescriptions for 15-18 year olds, especially for large families with three or more children.
- Promote the Well Homes service to Pacific families and services, which helps families' access housing interventions such as insulation, heating, curtain banks, beds, bedding, and carpets.

DRAFT

What's working well: Case Study

Pasifika PowerUP is an education programme that aims to actively support Pacific parents, families and communities to champion their children's learning out in the communities and close to where they live. Delivered through the Ministry of Education, PowerUp stations sessions have been delivered all over New Zealand and have proven to be very successfully in accelerating the learning and achievements of Pacific students. The sessions are delivered in a safe learning environment either through Church partnerships or within school settings, this programme also provides academic support to primary and secondary students using trained Pacific teachers.

The Pacific PowerUP Au Lotu model was launched this year as a partnership with Congregational Christian Churches in Wellington. This is a 10 week parent only programme delivered by key churches in specific communities. Au Lotu means the "church" group and is designed to work through the churches influence in Pacific communities. This model harnesses the strength of church pastoral care, inter-faith connections and networks.

DRAFT

APPENDIX: Pacific Health Data across the Sub-Region

APPENDIX

DRAFT

PUBLIC

Date 28 November 2019	**BOARD FINANCIAL**
Author	General Manager Finance & Corporate Services – Judith Parkinson
Endorsed by	Chief Executive Hutt Valley and Capital & Coast DHBs – Fionnagh Dougan
Subject	**FINANCIAL PERFORMANCE REPORT SEPTEMBER 2019**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Note** September year to date had an unfavourable variance to budget of ($967k) against the annual budget deficit of $8.1 million;

(b) **Note** the Funder result for September year to date was $1,193K favourable, Governance $141K favourable and Provider ($2,300K) unfavourable to budget;

(c) **Note** the key variances to budget outlined in this report including overspends in Nursing personnel including use of minders for one to one care, Support staff MECA settlement, outsourced services for Radiology, treatment related costs and Holidays Act provision partially offset by reduced IDF outflow and other external provider costs;

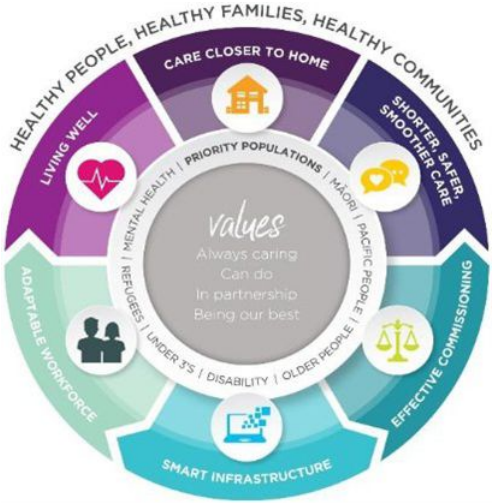
(d) **Note** the quantified financial risks for 2019/20 of up to $4.4 million;

(e) **Note** the HVDHB detailed finance report attached;

APPENDICES

1. HVDHB Finance Report September 2019

1. PURPOSE / STRATEGIC FIT



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This report provides an update on the following key finance-related activities that relate to the DHB Strategic enablers; *Effective Commissioning*, *Smart infrastructure*, and *Adaptable Workforce*:

- Financial result summary for September 2019;
- Financial risks 2019/20.

2. GOVERNMENT PRIORITIES

This paper reports on the DHBs progress in relation to the Government's key directions including:

- DHB performance and sustainability.

3. STEWARDSHIP OF RESOURCES

This paper addresses our strategic imperative for good stewardship of resources by providing an update on the financial position of the DHB, key financial risks and progress on actions related to risk mitigation.

4. SEPTEMBER 2019 FINANCIAL RESULT

The month of September had a total unfavourable variance to budget of ($787k).

4.1 Key results year to date (September 2019):

- Funder favourable by $1,193k;
- Governance favourable by $141k;
- Provider unfavourable by ($2,300k).

4.2 Material Variances year to date

Material variances year to date
Total Revenue favourable ($421k):
Devolved MoH Revenue favourable $988k,
Non-Devolved MoH Revenue unfavourable ($16k),
ACC Revenue $104k favourable mainly Plastics;
Other Revenue unfavourable ($1,171k),
IDF Inflows ($203k) unfavourable, Inter Provider Revenue unfavourable ($122k).

Personnel and outsourced Personnel unfavourable ($948k):
Medical favourable $296k; Outsourced medical is ($38k) unfavourable, internal staff $334k favourable.
Nursing unfavourable ($736k); continued increased workload year to date and continued high use of minders for one to one care.

PUBLIC

Allied Health favourable $88k, driven largely by vacancies.
Support Staff unfavourable ($316k); Employee costs are ($236k) unfavourable driven by back pay exceeding funding by $142k, and Outsourced are ($80k) unfavourable.
Management and Admin; unfavourable ($279k); unfavourable employee variance of ($77k) and Outsourced ($203k) which includes savings targets.
Annual leave Liability cost has increased $867k since September 2018, and there are approx. 442,726 outstanding leave days.
Sickness level for the month is 3.7%; this is lower than last month and this time last year.

Outsourced other expenses unfavourable ($244k); with overspends in clinical services of ($262k), mainly driven by Outsourced Radiology ($259k).
Treatment related Costs unfavourable ($908k); driven by Pharmaceuticals ($223k), Implants and Prostheses ($340k) and Treatment Disposables ($333k). Costs are expected to reduce when pharmaceutical rebates are confirmed.
Non Treatment Related Costs unfavourable ($373k); Holidays Act provision ($210k), Insurance Premiums ($68k) and other minor variances.
IDF Outflow favourable $885k, mainly due to volumes to Capital & Coast DHB.
Other External Provider Costs $691k favourable; mainly related to Disability support services timing of contracts, other HoP including pay equity and timing of Mental health contract.

Hospital activity;
For September year to date, discharges from the hospital for Medical were higher than budget and last year with more caseweights than budget and 5.7% more than the same time last year. Discharges for Surgical were just below budget and lower than the previous year and caseweights were on budget. ED volumes are 2.7% above budget and 2.5% above last year however, the ED admission rate is below budget and last year.

Cash position averaged $15.0m for September and $20.3m for August and was ($2.6m) in overdraft at the end of September. The cash flow forecast is very tight and the DHB as forecast, went into overdraft in September and is expecting to continue in overdraft by the end of each month.

Appendix one - HVDHB Finance report for September 2019.

5. FINANCIAL RISKS 2019/20

Financial risks of up to $4.4 million have been estimated including; the impact of future MECA settlements, Holidays Act compliance, rate increase on annual leave accruals, outsourced services, price increases and remaining savings targets.

A programme of work is underway to look at further efficiencies to help mitigate the financial risks.

Finance Report

September 2019

Strategic enabler; ***Effective Commissioning***

Fionnagh Dougan
Chief Executive

Judith Parkinson
General Manager Finance & Corporate Service

CONTENTS

CONTENTS 1
Financial Performance Overview 2
Summary of the financial performance of the DHB for September 2019 3
September Month Results: 4
Funder Financial Statement of Performance 5
Pharmaceutical Costs 8
Aged Residential Care 9
Personnel & FTE 10
Annual Leave 13
Sick Leave 14
IDF Analysis 15
Hospital throughput 17
Statement of Financial Position and Cash Flows 19
Financial Position as at 30 September 2019 19
Statement of Cash Flows to 30 September 2019 20
Weekly Cash Flow – Actual to 30 September 2019 21
Capital Expenditure – Actual to 30 September 2019 22
Summary of Leases – as at 30 September 2019 23
Treasury - as at 30 September 2019 24

Financial Performance Overview

The month of September has a total unfavourable variance to budget of ($787k) and an unfavourable variance of ($967k) year to date.

Key results YTD were:

- Funder favourable by $1,193k, Governance favourable by $141k, Provider unfavourable by ($2,300k)
- The draft full year forecast is ($8,966k) against a Budget of ($8,141k).

Material variances year to date
Total Revenue favourable ($421k):
Devolved MoH Revenue favourable $988k, Non-Devolved MoH Revenue unfavourable ($16k), ACC Revenue $104k favourable mainly Plastics; Other Revenue unfavourable ($1,171k), IDF Inflows ($203k) unfavourable, Inter Provider Revenue unfavourable ($122k).

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Summary of the financial performance of the DHB for September 2019

Month					Hutt Valley DHB Operating Report for the month of September 2019	Year end Result					Annual	Annual				
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance	
					Revenue											
38,545	37,458	1,087	36,626	1,919	Devolved MoH Revenue	113,777	112,789	988	108,223	5,555	451,956	450,868	1,088	434,235	17,721	
1,747	1,767	(20)	1,791	(44)	Non Devolved MoH Revenue	4,892	4,908	(16)	4,964	(72)	19,436	19,446	(10)	19,742	(307)	
644	616	28	761	(116)	ACC Revenue	1,964	1,860	104	2,115	(151)	7,345	7,341	4	7,539	(194)	
(402)	902	(1,304)	276	(678)	Other Revenue	1,550	2,721	(1,171)	1,547	3	9,900	10,891	(991)	6,987	2,913	
8,506	8,602	(96)	8,529	(23)	IDF Inflow	25,603	25,806	(203)	25,291	313	103,022	103,225	(203)	101,806	1,217	
421	326	94	476	(55)	Inter DHB Provider Revenue	857	979	(122)	1,114	(257)	3,793	3,915	(122)	4,577	(784)	
49,462	**49,672**	**(210)**	**48,459**	**1,003**	**Total Revenue**	**148,644**	**149,064**	**(421)**	**143,254**	**5,389**	**595,452**	**595,687**	**(235)**	**574,886**	**20,567**	1
					Expenditure											
					Employee Expenses											
4,652	4,777	125	4,320	(332)	Medical Employees	14,686	15,019	334	13,301	(1,385)	58,694	59,826	1,132	56,594	(2,100)	
5,773	5,610	(163)	5,895	122	Nursing Employees	17,987	17,474	(513)	17,043	(944)	71,611	69,893	(1,718)	69,463	(2,148)	
2,497	2,541	44	2,289	(208)	Allied Health Employees	7,798	7,930	132	7,270	(528)	31,944	32,008	64	29,882	(2,062)	
664	606	(58)	530	(134)	Support Employees	2,140	1,904	(236)	1,738	(402)	7,878	7,642	(236)	7,392	(487)	
2,382	2,363	(19)	2,100	(281)	Management and Admin Employees	7,502	7,426	(77)	6,707	(795)	29,590	29,481	(109)	27,228	(2,362)	
15,968	**15,897**	**(71)**	**15,135**	**(833)**	**Total Employee Expenses**	**50,112**	**49,753**	**(359)**	**46,059**	**(4,053)**	**199,717**	**198,850**	**(867)**	**190,558**	**(9,159)**	2
					Outsourced Personnel Expenses											
335	221	(115)	272	(63)	Medical Personnel	700	662	(38)	690	(10)	3,306	2,649	(657)	3,600	294	
220	87	(134)	214	(6)	Nursing Personnel	483	260	(224)	550	67	1,362	1,039	(323)	2,268	906	
67	29	(39)	(3)	(70)	Allied Health Personnel	130	86	(45)	123	(8)	388	344	(45)	502	114	
28	20	(8)	29	1	Support Personnel	141	61	(80)	58	(83)	324	244	(80)	323	(1)	
147	42	(105)	236	90	Management and Admin Personnel	328	126	(203)	461	133	774	502	(272)	1,299	525	
798	**398**	**(400)**	**749**	**(49)**	**Total Outsourced Personnel Expenses**	**1,783**	**1,195**	**(589)**	**1,883**	**99**	**6,154**	**4,778**	**(1,376)**	**7,991**	**1,837**	2
1,050	678	(372)	644	(407)	Outsourced Other Expenses	2,277	2,032	(244)	2,179	(98)	8,202	7,498	(704)	8,486	284	3
2,205	1,881	(325)	1,228	(977)	Treatment Related Costs	7,392	6,484	(908)	6,195	(1,197)	26,845	26,099	(746)	24,879	(1,966)	4
1,619	1,444	(175)	1,619	(0)	Non Treatment Related Costs	4,988	4,615	(373)	4,634	(354)	18,698	18,458	(239)	29,932	11,234	5
7,778	8,434	655	8,447	669	IDF Outflow	24,415	25,301	885	24,174	(242)	100,302	101,203	900	95,136	(5,167)	6
18,185	18,089	(97)	17,934	(251)	Other External Provider Costs	54,019	54,710	691	52,379	(1,639)	217,899	218,591	691	211,615	(6,284)	7
2,395	2,603	208	2,583	188	Interest, Depreciation & Capital Charge	6,916	7,266	351	6,782	(134)	26,602	28,352	1,751	26,163	(438)	8
49,998	**49,422**	**(577)**	**48,339**	**(1,660)**	**Total Expenditure**	**151,903**	**151,357**	**(546)**	**144,285**	**(7,618)**	**604,419**	**603,828**	**(591)**	**594,761**	**(9,657)**	
(537)	**250**	**(787)**	**120**	**(657)**	**Net Result**	**(3,259)**	**(2,292)**	**(967)**	**(1,031)**	**(2,228)**	**(8,966)**	**(8,141)**	**(825)**	**(19,876)**	**10,909**	
					Result by Output Class											
(274)	(479)	205	(520)	245	Funder	(274)	(1,467)	1,193	1,065	(1,339)	(4,413)	(5,906)	1,494	4,534	(8,947)	
58	9	49	22	36	Governance	118	(23)	141	130	(11)	(69)	(210)	141	(134)	65	
(320)	720	(1,040)	619	(939)	Provider	(3,103)	(803)	(2,300)	(2,226)	(877)	(4,485)	(2,025)	(2,460)	(24,276)	19,791	
(537)	**250**	**(787)**	**120**	**(657)**	**Net Result**	**(3,259)**	**(2,292)**	**(967)**	**(1,031)**	**(2,228)**	**(8,966)**	**(8,141)**	**(825)**	**(19,876)**	**10,909**	

There may be rounding differences in this report

September Month Results:

Unfavourable variance to budget of ($787k) for the month; the main variances are detailed below:

1. **Revenue:** Total revenue unfavourable ($210k) for the month.
   Devolved MoH revenue $1,087k favourable, driven by MoH Sub Contracts including PHO Capitation and Health of Older People.
   Non Devolved revenue ($20k) unfavourable, driven by Personal Health side contracts.
   ACC Revenue $28k favourable this month.
   Other revenue ($1,304k) unfavourable the month, including recoding of Pharmac Hospital rebates for the year to Pharmaceutical Expenses.
   IDF inflows unfavourable ($96k) for the month.
   Inter DHB Revenue favourable $94k, mostly for imaging services.

2. **Total Personnel** including outsourced unfavourable ($471k) for the month.
   - Medical personnel incl. outsourced favourable $10k. Outsourced costs are ($115k) unfavourable Medical Staff Internal are $125k favourable.
   - Nursing incl. outsourced ($297k) unfavourable. Employee costs are ($163k) unfavourable, driven by Senior Nurses ($43k), Internal Bureau Nurses ($105k) and Health Service Assistants ($120k), partly offset by Registered Nurses $123k. Outsourced was unfavourable ($134k), mostly driven by Health Service Assistants ($120k) in the General Medical Ward ($40k) and Surgical Women & Children's ($21k), with other minor variances.
   - Allied Health incl. outsourced $6k favourable, with outsourced unfavourable ($39k), offset by internal employees $44k.
   - Support incl. outsourced unfavourable ($66k), with Outsourced ($8k), and employee costs ($58k).
   - Management & Admin incl. outsourced unfavourable ($124k); internal staff unfavourable ($19k), Outsourced unfavourable ($105k), the later includes savings targets.
   - Sick leave for September was 3.7%, which is lower than the same time last year, which was 4.1%.

3. **Outsourced other** unfavourable ($372k) for the month, driven by Outsource Clinical Services ($349k) mainly Outsourced MRI Scans ($132k), Outsourced Radiology ($89k), Outsourced CT Scans ($46k) and Ophthalmology ($100k).
4. **Treatment related costs** unfavourable ($325k), driven by Pharmaceuticals ($12k), implants and Prostheses ($167k) and Treatment Disposables ($136k).
5. **Non Treatment Related costs** unfavourable ($175k) driven by the ongoing monthly provision for Holidays Act Compliance ($70k) and Insurance Premiums ($83k), software Licenses ($39k) mostly timing related, and Legal Fees ($11k).
6. **IDF Outflows** $665k favourable for the month reflecting lower than expected volumes to Capital & Coast DHB.
7. **Other External Provider** costs unfavourable ($97k), driven by Community Health Services ($305k), Residential Care ($165k), Primary Care Capitulated ($386k), Primary Health Care ($146k), General Medical subsidy ($27k) mostly offset by Laboratory $100k, Pharmaceuticals $100k and Mental Health $313k.
8. **Interest, Depreciation & Capital Charge** favourable $208k, driven by lower than expected Depreciation.

Funder Financial Statement of Performance

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of September 2019

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										
34,549	34,591	(41)	33,092	1,457	Base Funding	104,204	104,186	18	99,277	4,927	416,573	416,455	118	397,109	19,464
3,996	2,818	1,178	3,534	462	Other MOH Revenue	9,573	8,455	1,118	8,946	628	34,944	33,820	1,124	37,126	(2,182)
(853)	448	(1,301)	77	(930)	Other Revenue	106	1,343	(1,237)	131	(25)	4,315	5,372	(1,057)	654	3,661
8,506	8,602	(96)	8,529	(23)	IDF Inflows	25,601	25,806	(206)	25,291	310	103,020	103,225	(206)	101,806	1,214
46,199	**46,459**	**(260)**	**45,233**	**966**	**Total Revenue**	**139,484**	**139,790**	**(307)**	**133,644**	**5,840**	**558,851**	**558,872**	**(21)**	**536,694**	**22,157**
					Expenditure										
383	383	0	301	(82)	DHB Governance & Administration	1,149	1,149	0	844	(305)	4,597	4,597	0	3,467	(1,129)
20,126	20,032	(94)	19,070	(1,056)	DHB Provider Arm	60,174	60,097	(77)	55,182	(4,992)	240,465	240,388	(77)	221,939	(18,526)
					External Provider Payments										
2,852	2,963	111	3,278	426	Pharmaceuticals	9,795	8,992	(803)	9,406	(389)	36,078	35,275	(803)	37,728	1,650
4,229	4,329	101	4,234	5	Laboratory	12,693	12,988	295	12,712	19	51,659	51,954	295	51,172	(487)
2,859	2,479	(380)	2,060	(799)	Capitation	7,770	7,437	(333)	6,254	(1,516)	30,080	29,747	(333)	26,925	(3,155)
998	988	(10)	969	(29)	ARC-Rest Home Level	3,032	3,066	34	2,935	(97)	12,211	12,245	34	11,476	(735)
1,692	1,554	(138)	1,487	(205)	ARC-Hospital Level	4,930	4,815	(114)	4,613	(317)	19,345	19,231	(114)	18,224	(1,121)
3,172	2,821	(351)	3,220	48	Other HoP & Pay Equity	7,782	8,492	711	8,519	737	33,523	34,234	711	33,411	(112)
508	821	313	755	247	Mental Health	2,117	2,462	344	2,260	142	9,547	9,892	344	9,034	(513)
743	757	13	734	(9)	Palliative Care / Fertility / Comm Radiology	2,226	2,270	43	2,200	(26)	9,035	9,079	43	8,808	(227)
1,132	1,376	244	1,197	65	Other External Provider Payments	3,659	4,188	529	3,481	(178)	16,405	16,934	529	14,824	(1,581)
7,778	8,434	655	8,447	669	IDF Outflows	24,415	25,301	885	24,174	(242)	100,302	101,203	900	95,136	(5,167)
0	0	0	0	0	Provision for IDF Wash-ups	15	0	(15)	0	(15)	15	0	(15)	15	0
46,473	**46,938**	**464**	**45,753**	**(721)**	**Total Expenditure**	**139,758**	**141,257**	**1,499**	**132,579**	**(7,179)**	**563,264**	**564,778**	**1,514**	**532,160**	**(31,104)**
(274)	**(479)**	**205**	**(520)**	**245**	**Net Result**	**(274)**	**(1,467)**	**1,193**	**1,065**	**(1,339)**	**(4,413)**	**(5,906)**	**1,494**	**4,534**	**(8,947)**

There may be rounding differences in this report

(1) With Pay Equity been progressively devolved to DHB's, this is now combined with Other HoP.

The September result for the funder was $205k favourable.

Revenue

- Base Funding is unfavourable to budget for the month ($41k) and favourable YTD $18k.
- Other MoH revenue is favourable $1,178k for September and $1,118k YTD, driven by MoH Sub Contracts including PHO Capitation $786k and Health of Older People and $342k of CCDM funding carried over from 2018-19 receipted in September, partially offset by other variances.

- Other revenue is unfavourable ($1,301k) for the month and ($1,237k) YTD, mostly driven by Hospital medicine rebates now included in expenditure ($891k).
- IDF inflows are ($96k) unfavourable for the month and ($206k) YTD.

Expenditure

- Governance and Administration is on budget.
- Provider Arm payments are ($94k) unfavourable for the month and ($77k) YTD.

Funder Changes to Provider Arm Funding September 2019 ($000s)			
		Variance to budget	
Description	Funding Source	Month	YTD
Activity Based Wash-up			
Inpatient IDF Inflows wash-up	IDF Inflows	- 84.73	- 36.24
WAI - Mental Health Acute Beds	IDF Inflows	22	62
Air Ambulance Costs	PBF	14	(45)
Funding Changes			
Disability coordinator	PBF	-	(6)
WAI - Reduction in tobacco funding	IDF Inflows	(0)	(2)
Clinical Genetics Access	IDF Outflows	-	(6)
Child Development ASD/Alert Pilot	MoH Other Income	(45)	(45)
Rounding		-	-
Provider Arm Funding Variance		**(94)**	**(77)**

External Provider Payments:

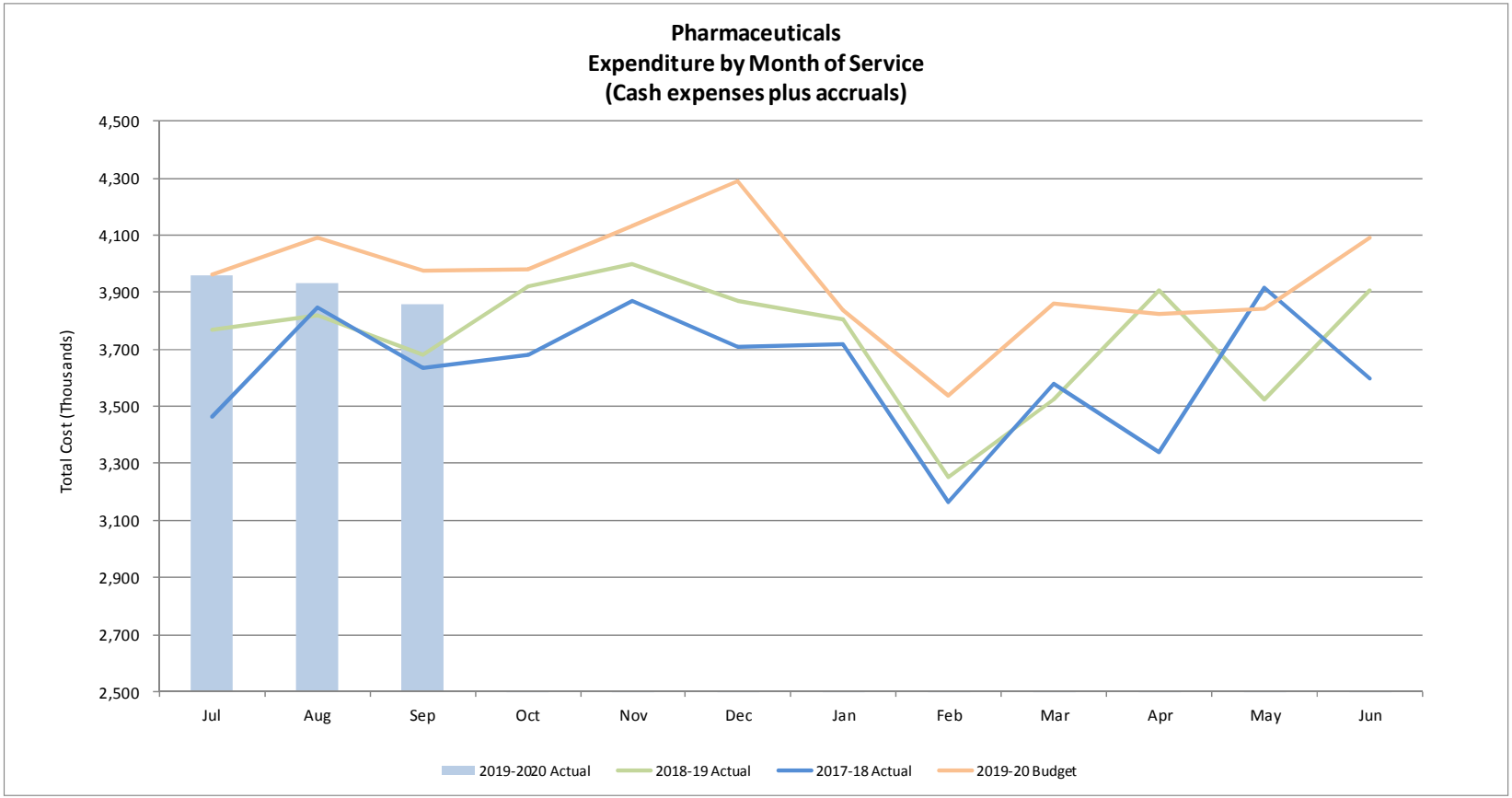
- Pharmaceutical costs are favourable $111k to budget for September and unfavourable ($803) YTD. Pharmaceutical rebates are yet to be confirmed.
- Laboratory costs are favourable to budget by $101k for the month and $295k YTD, reflecting lower than expected volumes.
- Capitation expenses ($380k) unfavourable for the month and unfavourable ($333k) YTD offset by an increase in revenue.
- Aged residential care costs are ($148k) unfavourable for the month ($80k) unfavourable YTD. The residential care loan adjustment (reported within other HOP) is favourable by $76k for the month and $127k YTD.
- Other HOP (including Pay Equity) costs are unfavourable by ($351k), and favourable for the month $711k YTD.
- Mental Health costs are favourable $313k for the month and $344k YTD.
- Palliative Care, Fertility and Community Radiology costs are favourable by $13k for the month, $43k YTD.
- Other external provider costs are favourable to budget $244k for the month, $529k YTD due to timing of contracts.

- IDF Outflows are overall favourable $665k for the month and $885 YTD.

IDF Wash-ups and Service Changes September 2019		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Medical Outpatients	637	837
Base	18	54
Personal Health various Service charges	(0)	(28)
FFS Washup	-	22
Rounding (timing) differences	-	-
IDF Outflow variance	**655**	**885**

Pharmaceutical Costs

Community Pharmaceuticals accruals are calculated on a consistent methodology, which takes into account the seasonality of the expenditure, and timing delays between the month of service and the month of payment. In the 2018/19 financial year, on average, 31.5% of the costs were paid in the month of service, 66.3% in the month following, and the remaining 2.2% spread across the following months.

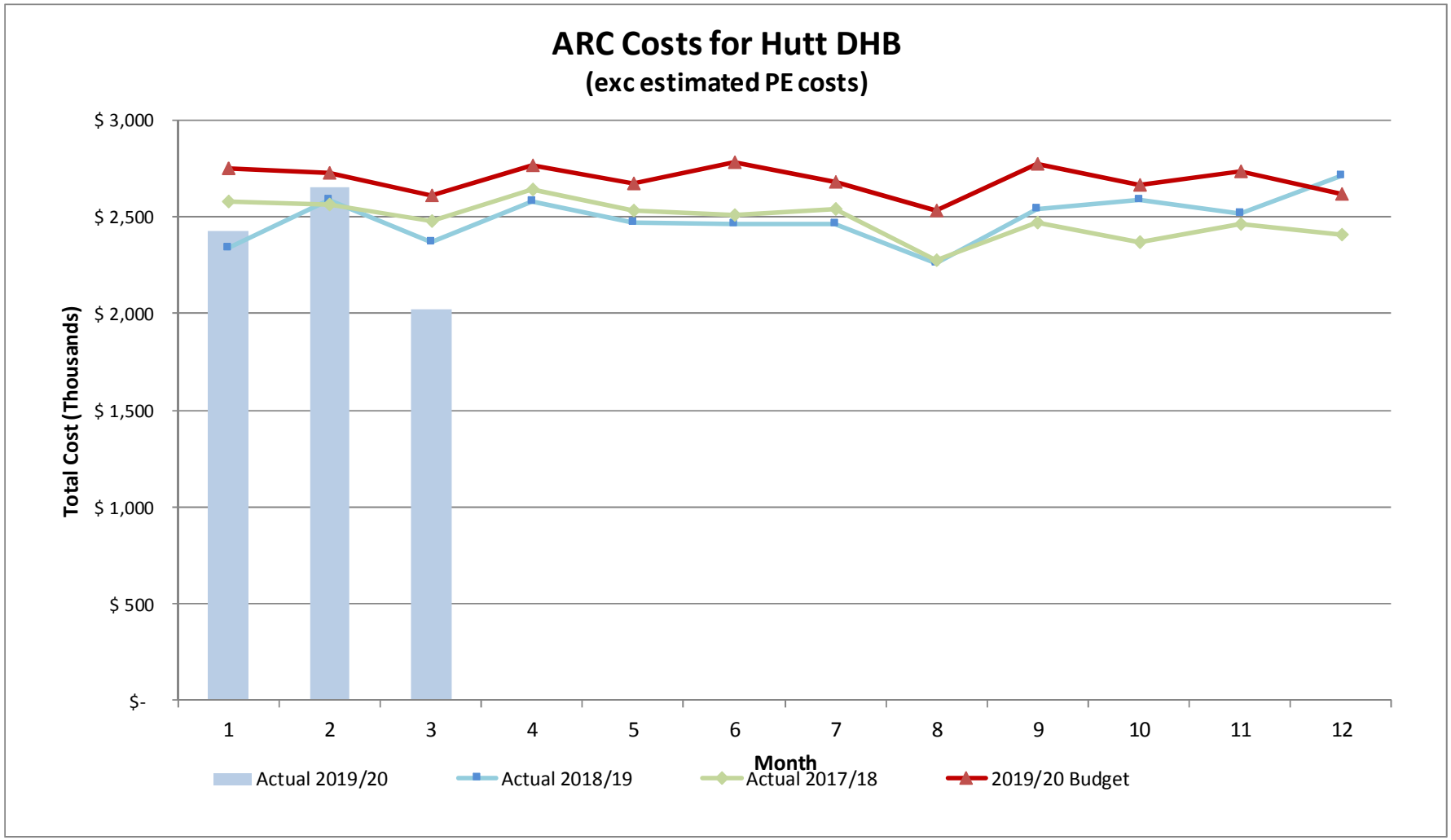


The graph above shows the expenditure on community pharmaceutical costs including the actuals for 2017/18 to 2019/20 together with the budget for 2019/20. The budget for 2019/20 has been phased based on trends of expenditure in previous years. The net amount reported as pharmaceutical costs in the accounts includes community pharmaceutical costs, Pharmac rebates, payments for National Haemophilia services and any transactions relating to the Discretionary Pharmaceutical Fund (DPF).

Aged Residential Care

The following graph shows the expenditure for aged residential care.

(Note that estimated costs of Pay Equity are excluded)



Personnel & FTE

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Sep-19	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
267	279	12	271	4	Medical	269	279	11	267	(2)	280	273
804	792	(12)	770	(34)	Nursing	799	792	(7)	765	(34)	792	776
389	409	21	387	(2)	Allied Health	387	408	21	386	(1)	408	387
137	135	(2)	135	(3)	Support	136	135	(1)	135	(2)	135	135
358	383	26	343	(15)	Management & Administration	365	383	19	346	(19)	383	353
1,954	**1,999**	**44**	**1,905**	**(49)**	**Total FTE**	**1,956**	**1,998**	**42**	**1,899**	**(57)**	**1,998**	**1,923**
					$ per FTE							
17,427	17,125	(302)	15,939	(1,488)	Medical	54,643	53,781	(862)	49,798	(4,844)	209,897	219,529
7,182	7,083	(100)	7,657	474	Nursing	22,513	22,062	(451)	22,288	(225)	90,413	90,022
6,422	6,207	(215)	5,921	(501)	Allied Health	20,147	19,436	(711)	18,825	(1,322)	78,257	82,741
4,845	4,484	(361)	3,936	(909)	Support	15,687	14,093	(1,594)	12,922	(2,765)	58,323	56,760
6,655	6,163	(492)	6,121	(535)	Management & Administration	20,567	19,368	(1,199)	19,371	(1,196)	77,218	83,574
8,170	**7,953**	**(217)**	**7,943**	**(227)**	**Average Cost per FTE all Staff**	**25,621**	**24,904**	**(717)**	**24,258**	**(1,363)**	**99,951**	**103,398**

Personnel & FTE Commentary

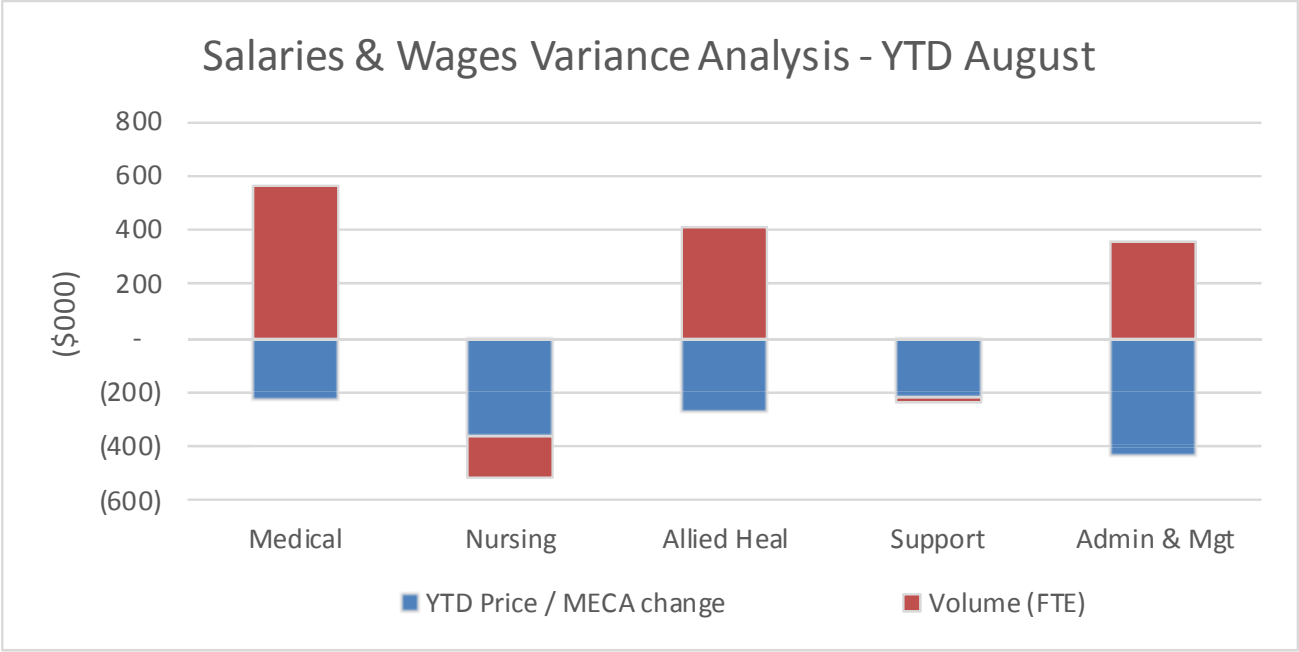
- **Medical** 12 FTE under budget for the month; **SMOs** under budget by 14 FTE, **MOSS** under budget by 1 FTE, partially offset by RMO's & House Officers.

- **Nursing** over by (12) FTE for the month. **Internal Bureau Nurses** are over budget (8) FTE, **Health Care Assistants** over budget by (29) FTE. Mostly offset by **Registered Nurses** under budget 19 FTE, **Registered Midwives** are under budget 2, with the balance in savings targets. Personnel cost variance for YTD September ($513k) is the result of a price variance of ($350k) mostly overtime and time based allowances and a volume variance of ($162k).

- **Allied** FTEs are under by 21 FTEs for the month due in the main to; Favourable variances in Health promotion offices & community support workers, Hand therapy, Audiology, social work and psychologists. The YTD September price variance is driven by Community Dental Nurses who have 10 weeks Annual Leave (net impact$124k) and Overtime and time based allowances ($146k).

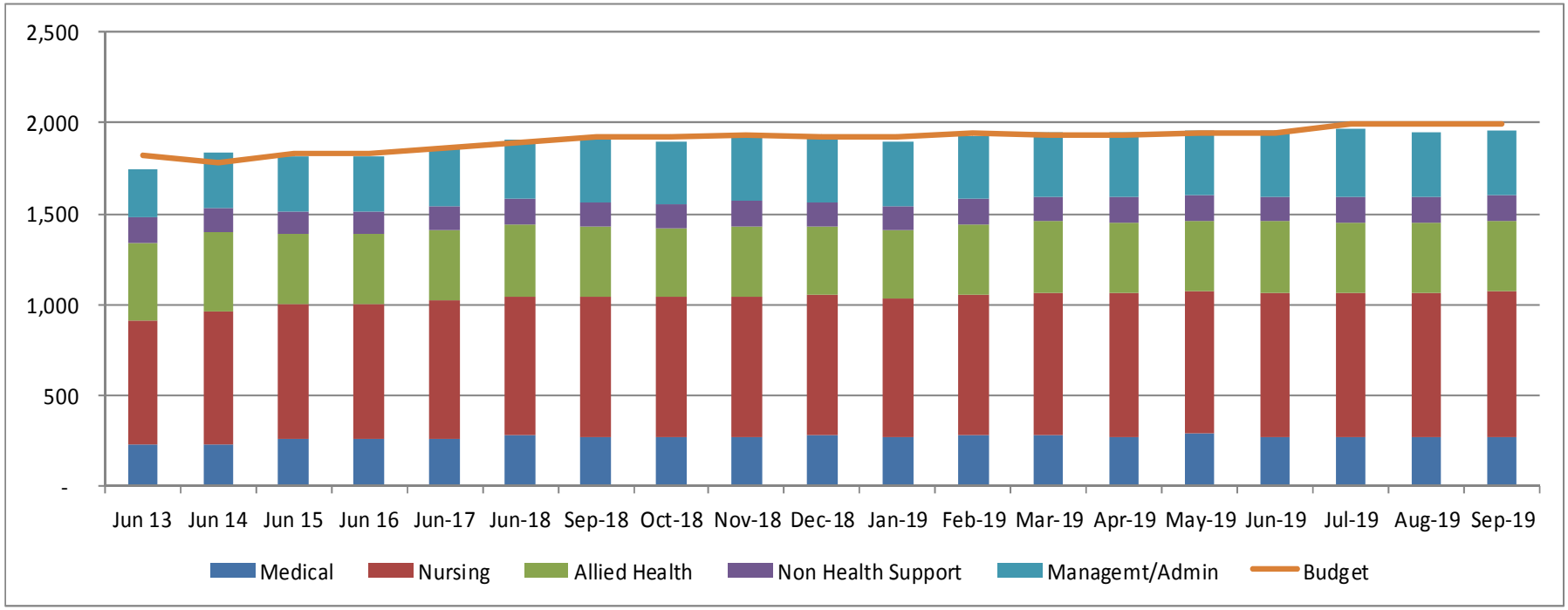
- **Support** FTEs are (2) FTEs over budget driven by Food services (3) FTE, offset by other variances. The ongoing cost variance is the result of this volume variance and the Local MECA settlement exceeding the provision provided.

- **Management & Admin** are under budget by 26 FTEs. Driven by administrative support staff vacancies and includes the capitalisation of resources on capital projects of 4 FTEs.



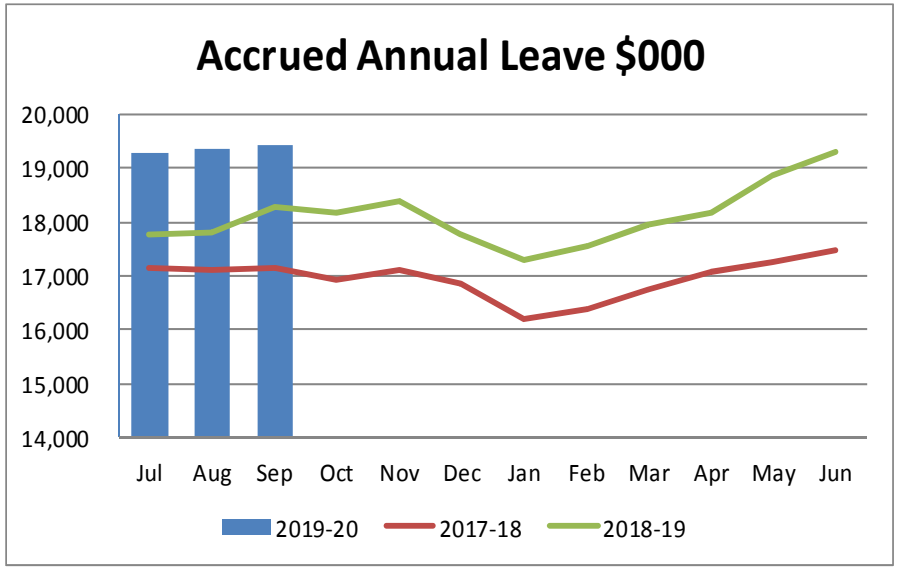
The following Table and Graph reflect the FTE Trend.

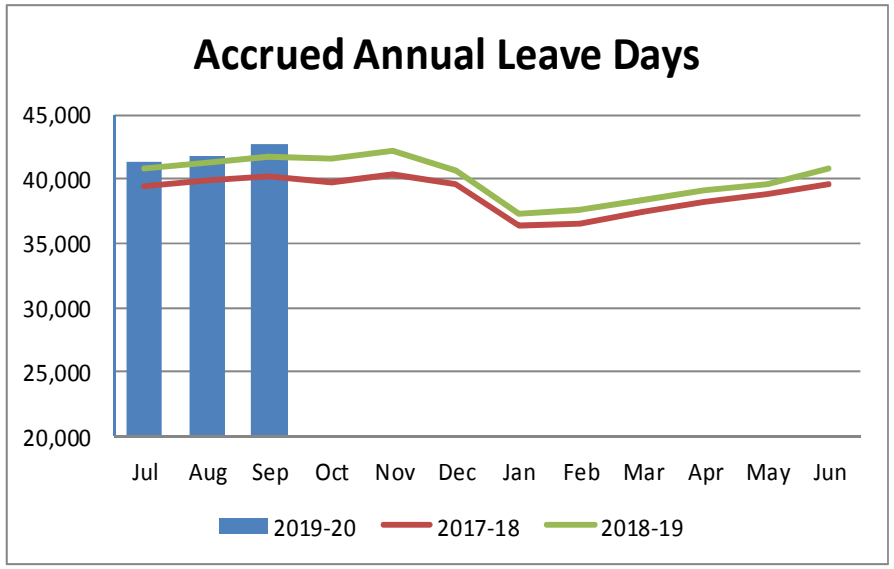
		Jun 13	Jun 14	Jun 15	Jun 16	Jun-17	Jun-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Actual	Medical	224	228	257	257	263	278	271	268	272	279	272	277	277	269	286	269	267	272	267
	Nursing	690	733	744	744	759	767	770	773	772	770	761	781	790	791	788	797	800	793	804
	Allied Health	428	435	385	385	385	396	387	381	389	383	380	387	389	392	391	392	386	386	389
	Non Health Support	133	135	129	129	131	137	135	132	136	133	132	136	136	136	135	136	135	137	137
	Managemt/Admin	272	305	302	302	330	330	343	346	349	352	354	352	358	359	361	364	377	361	358
Total	**Actual FTE**	**1,748**	**1,836**	**1,817**	**1,817**	**1,869**	**1,908**	**1,905**	**1,900**	**1,918**	**1,916**	**1,899**	**1,932**	**1,950**	**1,948**	**1,961**	**1,958**	**1,964**	**1,949**	**1,954**
	Budget	1,824	1,785	1,835	1,835	1,862	1,890	1,924	1,921	1,934	1,926	1,926	1,938	1,937	1,937	1,939	1,939	1,997	1,997	1,999



Annual Leave

The following graphs show the historical trends in annual leave for the last two years. The cost of annual leave increased compared to last month by $78k.

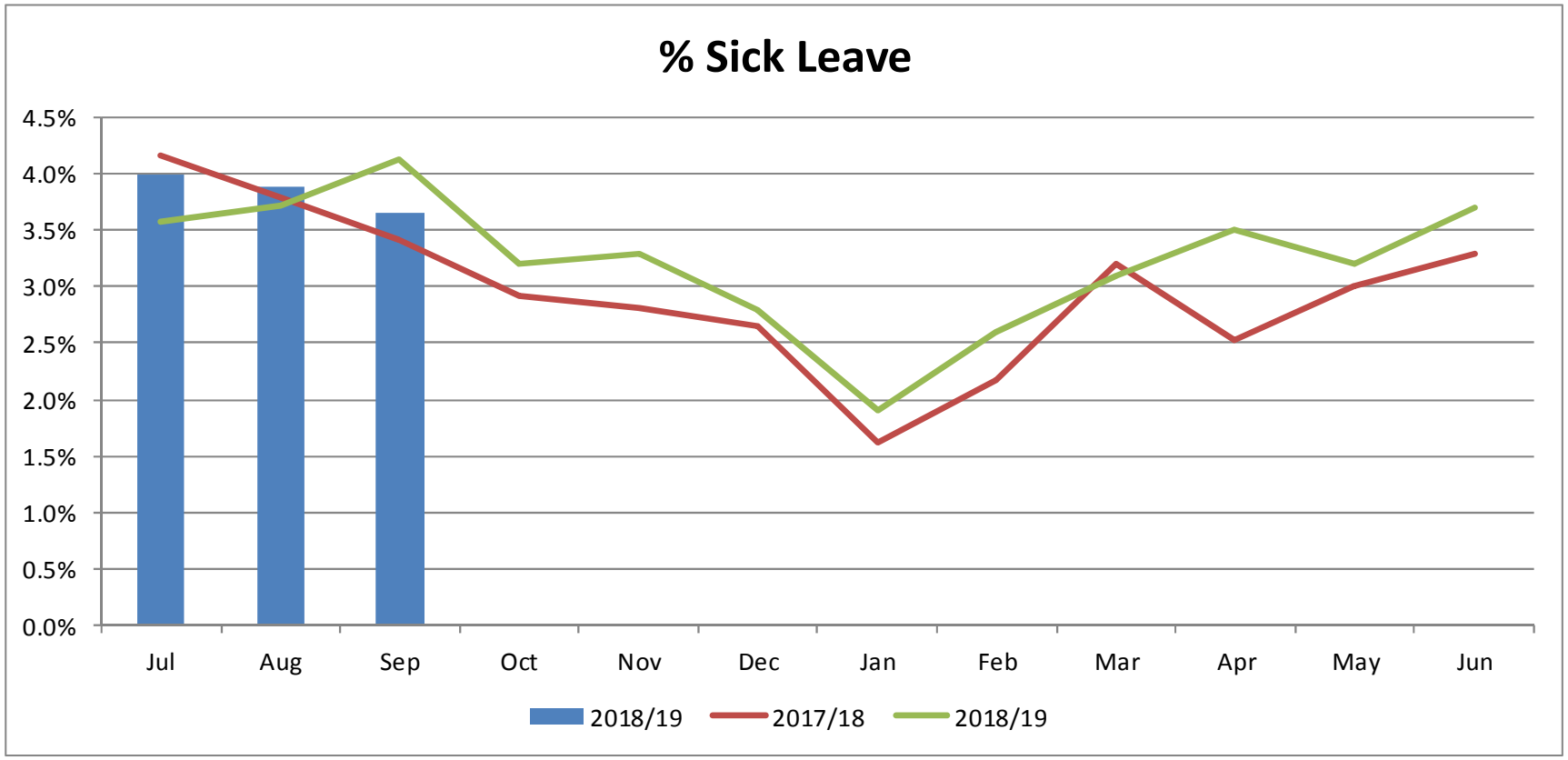




Category	Total staff with Annual leave days						
	Less than 20	20-30	30-40	Greater than 40	% of staff >40	Total Staff	**Total Leave Less LSL $**
Medical - Senior	69	35	14	41	26%	159	5,109,756
Medical - Junior	126	18	12	11	7%	167	1,441,636
Nursing	525	195	93	105	11%	918	8,050,557
Allied Health	357	70	31	18	4%	476	2,090,293
Support	67	32	18	20	15%	137	888,227
Mgmt/Admin	259	83	37	14	4%	393	1,843,638
Total*	1,403	433	205	209	9%	2,250	19,424,109

Sick Leave

The following graph shows the historical trends in sick leave for the last two years.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Medical	2.2%	1.7%	1.6%	1.3%	0.9%	1.5%	1.7%	1.5%	1.4%	1.8%	1.7%	1.7%	2.5%
Nursing	4.7%	3.6%	3.6%	3.6%	2.6%	3.6%	3.6%	4.0%	3.3%	4.0%	4.2%	4.5%	3.9%
Allied Health	4.4%	2.8%	3.8%	2.4%	1.7%	2.4%	3.0%	3.0%	3.1%	3.7%	4.6%	4.0%	4.2%
Support	4.0%	3.1%	4.6%	3.5%	2.4%	3.9%	3.2%	3.8%	3.9%	3.9%	4.3%	2.8%	3.7%
Admin	4.1%	3.6%	2.8%	3.0%	1.3%	2.4%	3.0%	4.3%	3.8%	4.6%	4.5%	4.6%	3.4%
Total	**4.1%**	**3.2%**	**3.3%**	**2.8%**	**1.9%**	**2.6%**	**3.1%**	**3.5%**	**3.2%**	**3.7%**	**4.0%**	**3.1%**	**3.7%**

IDF Analysis

Month					Inter District Flows (IDF) - $000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance	YTD Sep-19	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					IDF Inflows							
948	1,062	(114)	992	(44)	Acute	3,216	3,279	(64)	2,958	257	11,981	11,639
1,034	886	148	902	132	Elective	2,840	2,734	106	2,565	275	10,680	9,710
3,070	3,070	0	3,020	50	Laboratory	9,209	9,209	0	9,059	150	36,235	35,898
0	0	0		0	Prior year wash-up	0	0	0		0	0	0
3,455	3,585	(130)	3,616	(161)	Other Services	10,339	10,584	(245)	10,708	(369)	44,329	40,219
8,506	**8,602**	**(96)**	**8,529**	**(23)**	**Total IDF inflows**	**25,601**	**25,806**	**(206)**	**25,291**	**310**	**103,225**	**97,466**
					IDF Outflows							
2,154	2,643	489	2,417	262	Acute	7,451	8,161	710	7,232	(219)	30,969	30,204
1,015	1,221	206	1,483	468	Elective	3,174	3,771	596	3,519	345	14,328	13,388
1,977	1,977	0	1,878	(99)	Outpatient	5,932	5,932	0	5,635	(297)	22,540	21,527
341	341	0	346	5	Pharmaceutical Cancer Treatment	1,024	1,024	0	1,039	14	4,155	4,079
0	0	0		0	Prior year wash-up	0	0	0		0	0	0
2,291	2,251	(40)	2,322	32	Other Services	6,834	6,413	(421)	6,748	(86)	29,211	21,108
7,778	**8,434**	**655**	**8,447**	**669**	**Total IDF Outflows**	**24,415**	**25,301**	**885**	**24,174**	**(242)**	**101,203**	**90,306**
	0	0			Funder IDF provision		0	0			0	2,413
7,778	**8,434**	**655**	**8,447**	**669**	**Total IDF Net of provision**	**24,415**	**25,301**	**885**	**24,174**	**(242)**	**101,203**	**92,719**

Note: Timing differences when reporting on IDFs will have a bearing on year to date figures reported above

Note: Other Services Inflow includes: Outpatients, Mental Health, PHO, Older people services (incl ARC) and NGO (e.g. Fertility). Other Services Outflow is the same with the addition of laboratory

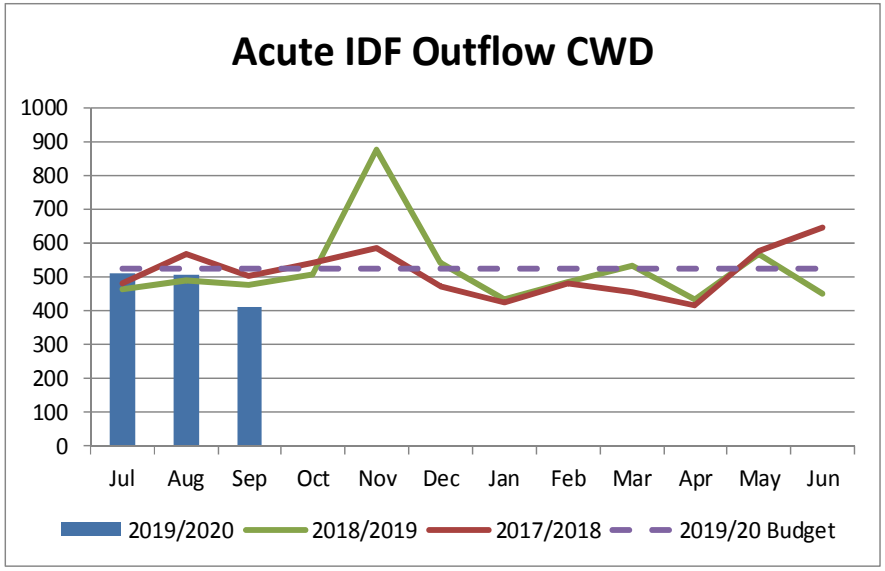
IDF inflow (revenue):

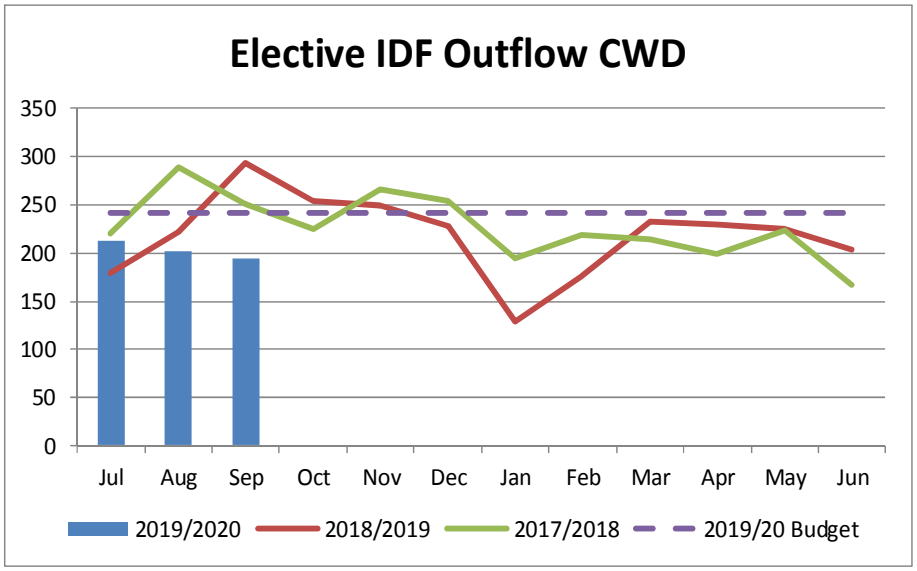
Overall IDF inflows are under budget YTD by ($206k), mainly due to inflows for other services being ($245k) under budget. Inpatient inflows are over budget by ($42k) so far mainly in Plastics and Gastroenterology while General Surgery is under budget.

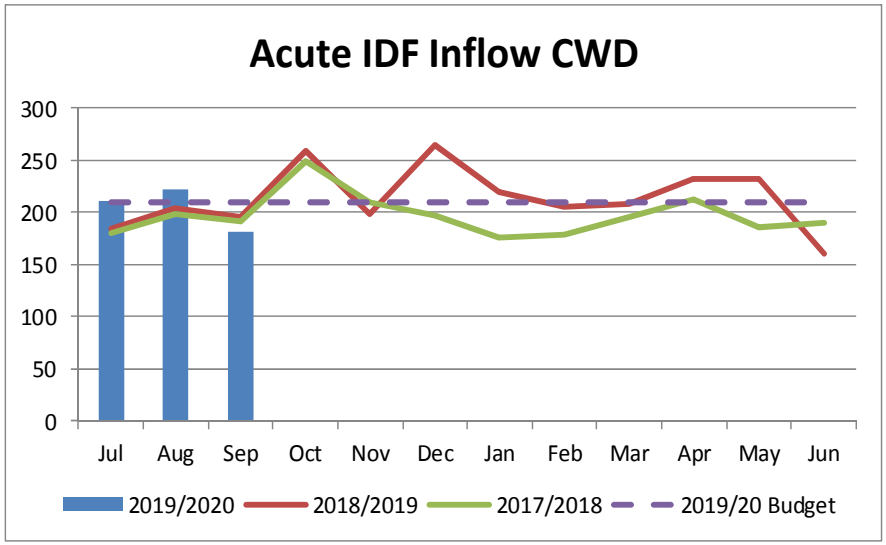
IDF Outflow (expense):

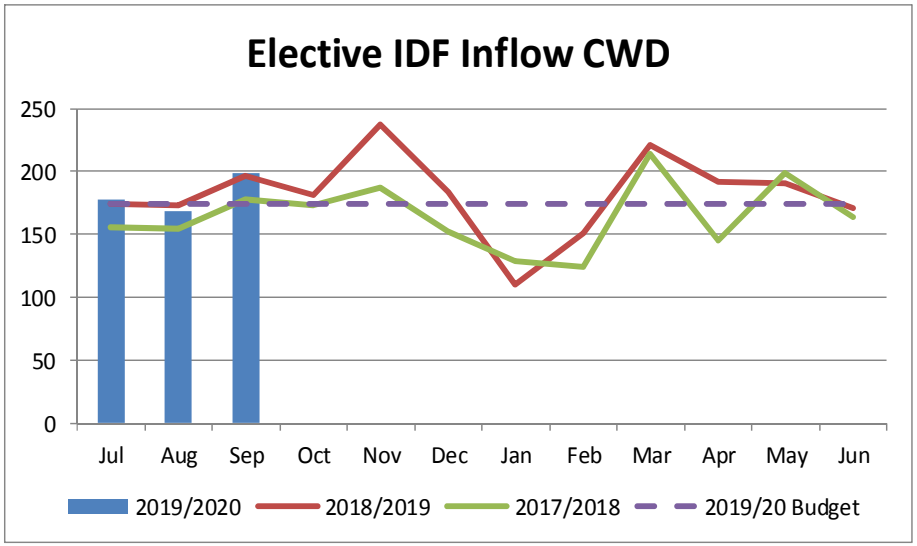
Overall IDF outflows are under budget for the month by $655k. Inpatient outflows are under budget year to date 3 months data from CCDHB and 2 month from other DHBs. Flows to CCDHB are under budget by 163 CWD in total and actual volumes are similar to the same time last year. Acute outflows under budget particularly in Renal and Neonates, but this is offset by being over budget in Orthopaedics and Cardiothoracic. We have had one baby at Capital & Coast with high caseweights of 65CWD. Electives are under budget YTD by $596k particularly for Capital & Coast and this is mostly due to elective Cardiothoracic being 57 CWD or $300k below budget. At this stage of the year results are likely to change as data is updated.

The graphs below show actual IDF CWD flows by month









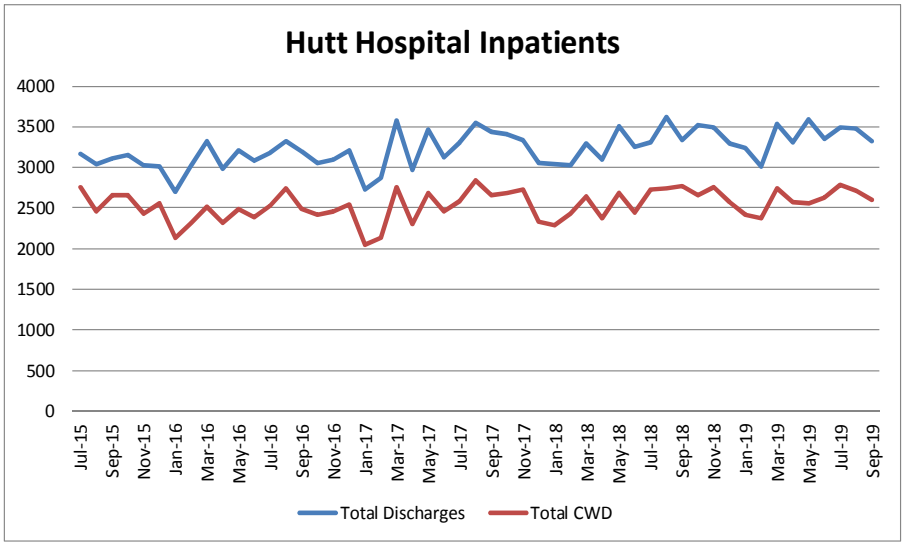
Hospital throughput

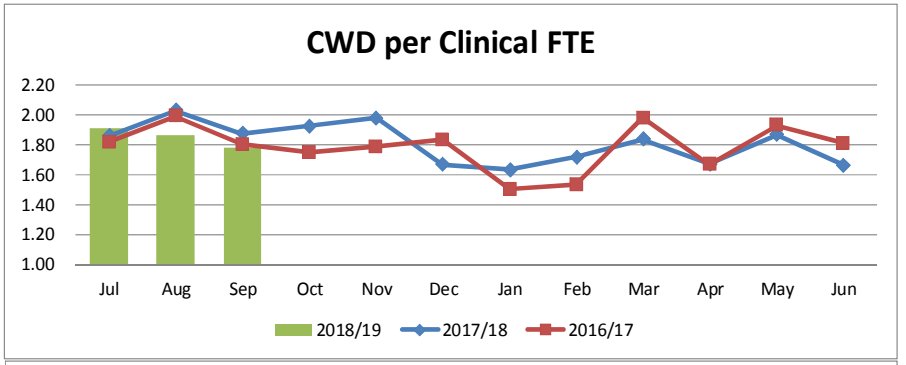
Month					Hutt Valley DHB Hospital Throughput YTD Sep-19	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,041	1,053	12	1,077	36	Surgical	3,142	3,202	60	3,386	244	12,425	12,797
1,832	1,756	(76)	1,860	28	Medical	5,830	5,328	(502)	5,645	(185)	20,730	19,506
453	422	(31)	393	(60)	Other	1,324	1,286	(38)	1,227	(97)	5,052	5,474
3,326	**3,230**	**(96)**	**3,330**	**4**	**Total**	**10,296**	**9,816**	**(480)**	**10,258**	**(38)**	**38,206**	**37,777**
					CWD							
1,128	1,164	36	1,227	99	Surgical	3,462	3,460	(2)	3,619	157	13,364	12,852
1,075	1,076	1	1,120	45	Medical	3,487	3,294	(193)	3,340	(147)	12,277	11,991
402	444	42	428	26	Other	1,158	1,306	148	1,278	120	5,053	4,698
2,605	**2,685**	**80**	**2,775**	**170**	**Total**	**8,107**	**8,060**	**(47)**	**8,237**	**130**	**30,695**	**29,540**
					Other							
4,166	4,040	(126)	4,084	(82)	Total ED Attendances	12,765	12,420	(345)	12,448	(317)	49,056	47,491
975	1,037	62	1,028	53	ED Admissions	3,041	3,263	222	3,177	136	12,187	11,847
742	769	27	786	44	Theatre Visits	2,265	2,321	56	2,454	189	9,047	9,271
121	123	2	126	5	Non- theatre Proc	392	348	(44)	368	(24)	1,452	1,891
7,497	7,269	(228)	7,048	(449)	Bed Days	23,018	22,137	(881)	21,697	(1,321)	82,109	85,515
4.34	4.30	(0.04)	4.29	(0.05)	ALOS Inpatient	4.39	4.30	(0.09)	4.37	(0.03)	4.30	4.29
2.10	2.03	(0.06)	2.13	0.03	ALOS Total	2.16	2.03	(0.13)	2.22	0.05	2.03	2.20
8.44%	8.02%	-0.42%	7.71%	-0.73%	Acute Readmission	8.44%	8.02%	-0.42%	7.96%	-0.48%	7.31%	7.36%

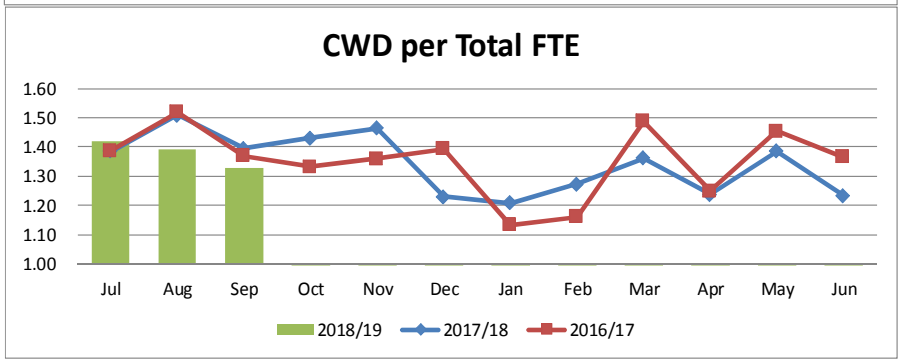
Note: Other inpatient includes mental health and maternity. Activity in this report includes ACC, overseas cases and privately funded cases.

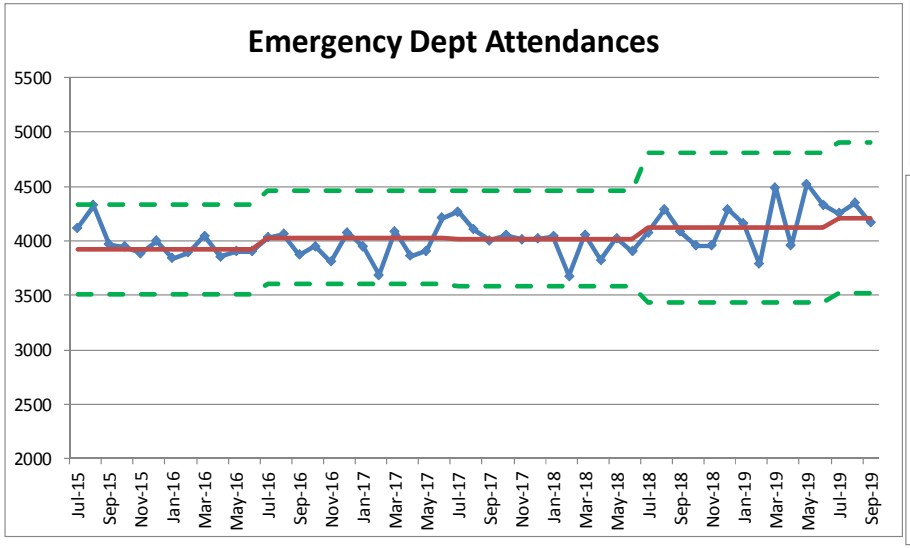
For the month of September, discharges from the hospital for Medical were higher than budget but slightly less than last year with more caseweights than budget and 4% more than the same time last year. Discharges for Surgical were similar to budget and lower than the previous year and caseweights lower than budget.

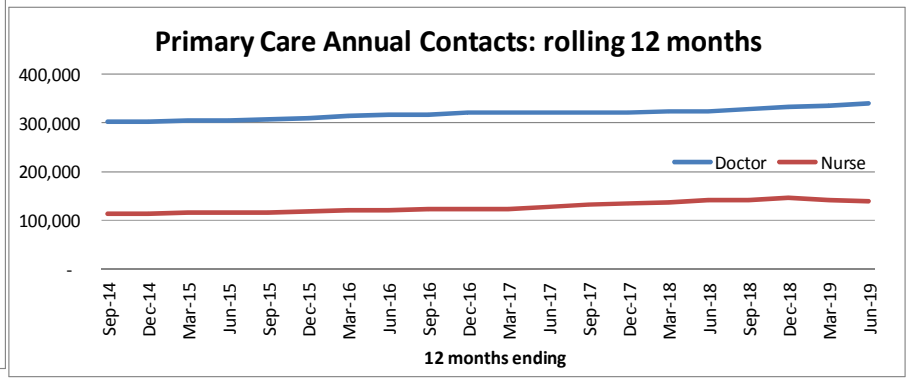
ED volumes for the month were 3% higher than budget and 3% higher than the same time last year. A lower proportion of patients were admitted from ED in September compared to last year. Theatre visits for September were lower than budget and last year. Non-Theatre procedures in September were close to budget but higher than budget year to date. Bed days were higher than budget in the month and 6% higher than September last year. ALOS was close to expected for September for inpatients but slightly higher overall for the year to date. The acute readmission rate was higher than budget for September and higher than the same time last year.


Hutt Hospital Inpatients
4000
3500
3000
2500
2000
1500
1000
500
0
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19
Total Discharges
Total CWD


CWD per Clinical FTE
2.20
2.00
1.80
1.60
1.40
1.20
1.00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2018/19
2017/18
2016/17


CWD per Total FTE
1.60
1.50
1.40
1.30
1.20
1.10
1.00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2018/19
2017/18
2016/17


Emergency Dept Attendances
5500
5000
4500
4000
3500
3000
2500
2000
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19


Primary Care Annual Contacts: rolling 12 months
400,000
300,000
200,000
100,000
-
Doctor
Nurse
Sep-14
Dec-14
Mar-15
Jun-15
Sep-15
Dec-15
Mar-16
Jun-16
Sep-16
Dec-16
Mar-17
Jun-17
Sep-17
Dec-17
Mar-18
Jun-18
Sep-18
Dec-18
Mar-19
Jun-19
12 months ending

Statement of Financial Position and Cash Flows

Financial Position as at 30 September 2019

$000s	Actual	Budget	Variance	Jun 19	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank - Non DHB Funds *	1,981	7,134	(5,152)	5,216	(3,235)	Payments from NHMG to DHB's paid earlier than budgeted
Accounts Receivable	29,823	27,970	1,853	27,095	2,728	
Stock	1,459	1,494	(35)	1,434	25	
Prepayments	1,445	868	578	727	718	
Total Current Assets	**34,709**	**37,465**	**(2,757)**	**34,473**	**236**	
Fixed Assets						
Fixed Assets	208,891	219,598	(10,707)	210,483	(1,592)	
Work in Progress	20,726	18,048	2,678	19,710	1,015	
Total Fixed Assets	**229,617**	**237,646**	**(8,030)**	**230,193**	**(577)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	Allied Laundry
Trust Funds Invested	1,459	1,426	33	1,409	50	Restricted trusts
Total Investments	**2,609**	**2,576**	**33**	**2,559**	**50**	
Total Assets	**266,935**	**277,687**	**(10,753)**	**267,225**	**(291)**	
Liabilities						
Current Liabilities						
Bank	2,588	3,402	814	1,433	(1,155)	Average bank balance in Sep-19 was $15.0m
Accounts Payable and Accruals	53,626	42,890	(10,736)	52,164	(1,462)	Higher than budgeted accrued expenses
Crown Loans and Other Loans	183	23	(160)	221	39	
Current Employee Provisions	24,365	24,193	(172)	24,190	(175)	
Total Current Liabilities	**83,942**	**70,495**	**(13,447)**	**78,009**	**(5,933)**	
Non Current Liabilities						
Other Loans	220	221	1	0	(220)	Finance leases
Long Term Employee Provisions	8,245	7,617	(628)	8,245	0	
Non DHB Liabilities	1,981	7,134	5,152	5,216	3,235	Payments from NHMG to DHB's paid earlier than budgeted
Trust Funds	1,459	1,442	(17)	1,409	(50)	
Total Non Current Liabilities	**11,905**	**16,414**	**4,508**	**14,870**	**2,965**	
Total Liabilities	**95,847**	**86,908**	**(8,939)**	**92,879**	**(2,968)**	
Net Assets	**171,088**	**190,779**	**(19,692)**	**174,346**	**(3,259)**	
Equity						
Crown Equity	124,123	123,916	207	124,123	0	
Revaluation Reserve	126,422	133,597	(7,175)	126,422	0	
Opening Retained Earnings	(76,199)	(64,442)	(11,757)	(56,323)	(19,876)	
Net Surplus / (Deficit)	(3,259)	(2,292)	(967)	(19,876)	16,617	
Total Equity	**171,088**	**190,779**	**(19,692)**	**174,347**	**(3,259)**	

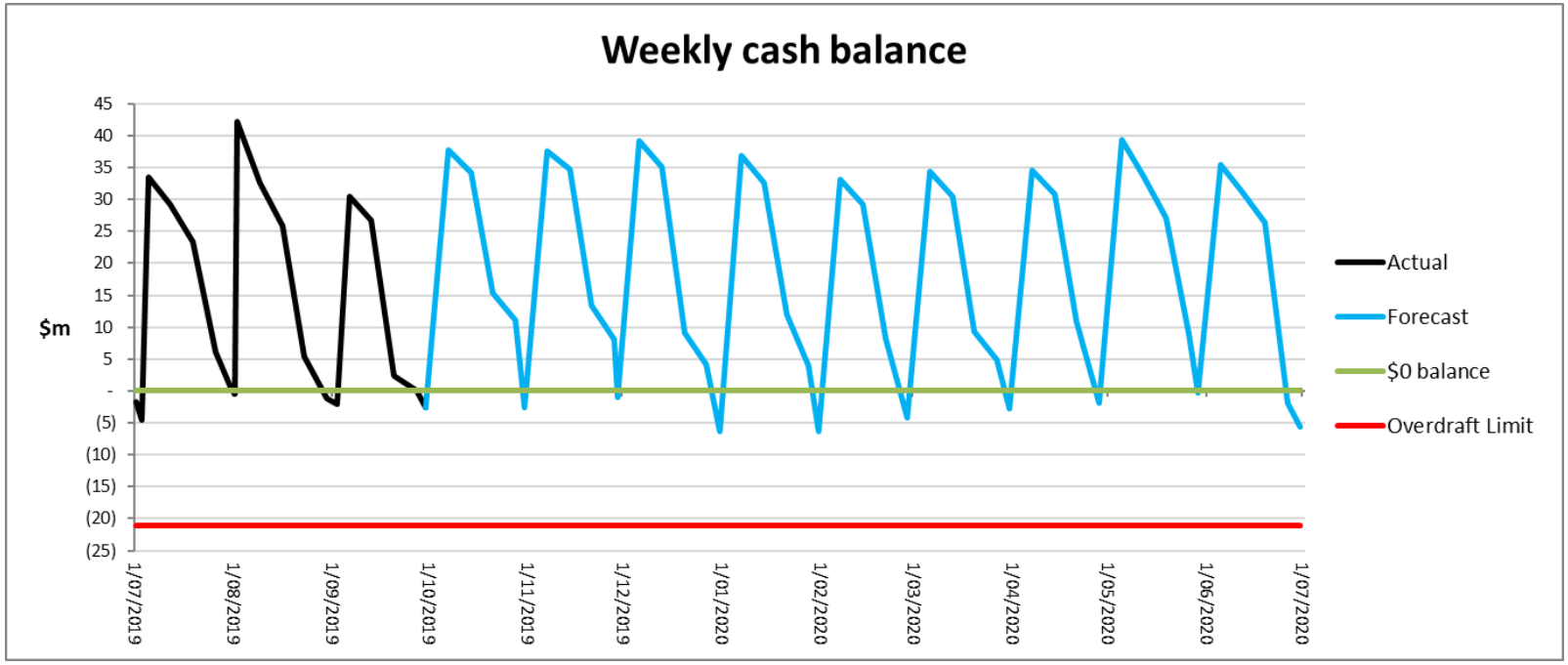
* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 30 September 2019

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	39,286	38,734	39,537	39,286	39,208	39,549	38,877	38,378	39,364	39,009	39,607	39,443
Receipts from Other DHBs (Including IDF)	8,191	8,284	7,981	8,928	8,928	8,927	8,928	8,928	8,928	8,928	8,928	8,928
Receipts from Other Government Sources	1,100	1,188	(134)	1,318	1,089	1,081	1,119	1,050	1,052	1,110	1,024	1,053
Other Revenue	1,472	553	(406)	418	392	380	380	380	380	380	380	385
Total Receipts	**50,049**	**48,759**	**46,978**	**49,951**	**49,617**	**49,937**	**49,305**	**48,737**	**49,724**	**49,427**	**49,939**	**49,809**
Payments for Personnel	(18,535)	(17,294)	(15,756)	(18,110)	(16,618)	(17,369)	(17,992)	(15,691)	(17,240)	(17,239)	(16,462)	(17,255)
Payments for Supplies (Excluding Capital Expenditure)	(1,524)	(6,314)	(6,549)	(4,670)	(4,460)	(4,143)	(4,441)	(4,614)	(3,929)	(4,429)	(4,418)	(4,032)
Capital Charge Paid	0	0	0	0	0	(6,360)	0	0	0	0	0	(6,360)
GST Movement	22	(297)	120	0	0	0	0	0	0	0	0	0
Payments to Other DHBs (Including IDF)	(8,416)	(8,221)	(7,778)	(8,419)	(8,434)	(8,434)	(8,434)	(8,434)	(8,434)	(8,434)	(8,434)	(8,434)
Payments to Providers	(18,044)	(18,060)	(17,755)	(17,961)	(17,970)	(18,225)	(17,726)	(17,189)	(17,925)	(17,818)	(18,346)	(18,319)
Total Payments	**(46,498)**	**(50,186)**	**(47,719)**	**(49,160)**	**(47,481)**	**(54,531)**	**(48,594)**	**(45,928)**	**(47,526)**	**(47,919)**	**(47,660)**	**(54,401)**
Net Cashflow from Operating Activities	**3,551**	**(1,427)**	**(741)**	**791**	**2,137**	**(4,594)**	**711**	**2,809**	**2,198**	**1,508**	**2,279**	**(4,592)**
Investing Activities												
Interest Receipts	26	22	16	46	46	46	46	46	46	46	46	46
Dividends	0	47	0	0	0	0	0	0	0	0	0	0
Total Receipts	**26**	**68**	**16**	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**
Capital Expenditure	(1,708)	(132)	(758)	(736)	(736)	(736)	(736)	(736)	(736)	(736)	(736)	(724)
Increase in Investments and Restricted & Trust Funds Assets	(75)	(82)	106	0	0	0	0	0	0	0	0	0
Total Payments	**(1,782)**	**(213)**	**(652)**	**(736)**	**(736)**	**(736)**	**(736)**	**(736)**	**(736)**	**(736)**	**(736)**	**(724)**
Net Cashflow from Investing Activities	**(1,756)**	**(145)**	**(635)**	**(690)**	**(690)**	**(690)**	**(690)**	**(690)**	**(690)**	**(690)**	**(690)**	**(678)**
Financing Activities												
Interest Paid on Finance Leases	(1)	(1)	(1)	(6)	(6)	(6)	(6)	(6)	(6)	(5)	(5)	(5)
Total Payments	**(1)**	**(1)**	**(1)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(1)**	**(1)**	**(1)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Total Cash In	50,075	48,827	46,995	49,996	49,663	49,982	49,350	48,783	49,770	49,473	49,985	49,855
Total Cash Out	(48,280)	(50,400)	(48,371)	(49,902)	(48,223)	(55,273)	(49,335)	(46,670)	(48,268)	(48,661)	(48,402)	(55,130)
Net Cashflow												
Opening Cash	(1,433)	362	(1,211)	(2,588)	(2,494)	(1,053)	(6,343)	(6,328)	(4,216)	(2,713)	(1,901)	(318)
Net Cash Movements	1,795	(1,573)	(1,376)	94	1,440	(5,290)	15	2,113	1,502	812	1,583	(5,275)
Closing Cash	**362**	**(1,211)**	**(2,588)**	**(2,494)**	**(1,053)**	**(6,343)**	**(6,328)**	**(4,216)**	**(2,713)**	**(1,901)**	**(318)**	**(5,592)**

Non DHB Funds - NHMG	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Opening Balance	5,216	1,933	1,424									
Net Movement	(3,283)	(509)	558									
Closing Balance	1,933	1,424	1,981									

Weekly Cash Flow – Actual to 30 September 2019



Note

- the overdraft facility shown in red is set at $21 million as at September 2019
- the lowest bank balance for the month of September was $2,599k overdrawn

Capital Expenditure – Actual to 30 September 2019

Project description	Budget rolled over from 2018/19	New budget for 2019/20	Total to spend F2019-20	Committed costs from prior year approved projects budget	Total maximum spend in 2019/20	Actual 2019/20 spend till date	Remaining to spend in 2019/20	Prior year costs	Estimated Costs in 2019/20	Estimated Costs in future years	Forecast Lifetime Project Costs at Completion
	($000)	($000)	($000)	($000)	($000)	($000)	($000)	($000)	($000)	($000)	($000)
Baseline											
Buildings and Plant	1,545	3,355	4,900	1,532	6,432	(484)	5,947	4,027	6,432	-	10,459
Clinical Equipment	215	3,500	3,715	957	4,672	(890)	3,782	1,518	4,672	-	6,190
Information Technology (Hardware)	100	650	750	372	1,122	(347)	775	1,599	1,122	-	2,721
Intangible Assets (Software)	932	625	1,557	868	2,424	(331)	2,093	2,433	2,424	-	4,858
Baseline Total	**2,792**	**8,130**	**10,922**	**3,728**	**14,650**	**(2,052)**	**12,598**	**9,577**	**14,650**	**-**	**24,227**
Strategic											
e-Medicines Management	310	-	310	-	310	-	310	-	310	-	310
Server Hardware	-	-	-	-	-	-	-	-	-	-	-
Digitising End-to-End Processes	78	-	78	288	366	(102)	263	648	366	-	1,014
Community Health Integration Platform	155	-	155	20	175	(15)	160	-	175	-	175
Mental Health Shared Electronic Record	150	-	150	(12)	138	-	138	40	138	-	178
Replacement Dental Imaging and Care system	25	175	200	9	209	(43)	166	26	209	-	235
Shared Cared - Record and Planning	100	-	100	4	104	-	104	34	104	-	138
Electronic In Patient Meal Ordering	-	-	-	-	-	-	-	-	-	-	-
Regional Clinical Portal (CTAS)	500	-	500	47	547	-	547	78	547	-	625
Mobile Application Development	125	250	375	51	426	(33)	393	149	426	-	575
Referrals, Bookings & Schedulling	399	341	740	215	955	(84)	871	34	955	-	989
Regional RIS Migration	330	-	330	422	752	-	752	8	752	-	760
Electronic Patient observations and Nursing D	-	-	-	-	-	-	-	-	-	-	-
Electronic In Patient Meal Ordering	-	300	300	36	336	(6)	330	3	336	-	339
Patient Check-ins and Kiosks	-	34	34	-	34	-	34	-	34	-	34
National Screening Solution	-	100	100	-	100	-	100	-	100	-	100
Community Dental Replacement	-	450	450	-	450	-	450	-	450	-	450
Anaesthesia Management System	-	25	25	-	25	-	25	-	25	-	25
Whiteboard & Patient Dashboards	-	200	200	81	281	(33)	248	103	281	-	384
Regional Public Health	-	150	150	-	150	-	150	-	150	-	150
NZ Post Letter Automation	-	50	50	3	53	(1)	52	19	53	-	72
Intergrated HRIS	-	100	100	-	100	-	100	-	100	-	100
Sterile Surgical Tracking (TDOCs)	-	150	150	-	150	-	150	-	150	-	150
Software Automation (Robots) Development	-	150	150	-	150	-	150	-	150	-	150
Upgrade FMIS	-	-	-	-	-	-	-		-	-	-
Clinical Event and Risk Detection (AI)	-	-	-	-	-	-	-		-	-	-
Clinical Document Scanning	-	150	150	-	150	-	150		150	-	150
Reporting, Analysis and Data Visualisation To	-	50	50	-	50	-	50		50	-	50
Telehealth Enablers	-	25	25	-	25	-	25		25	-	25
Digital Workplace	-	50	50	9	59	(15)	43		59	-	59
Kitchen Relocation	585	480	1,065	-	1,065	-	1,065		1,065	-	1,065
Old Ward 6 Repurpose	600	-	600	-	600	-	600		600	-	600
ED x-ray unit- Shimadzu	400	1,500	1,900	-	1,900	-	1,900		1,900	-	1,900
Philips trauma diagnost unit	300	-	300	-	300	-	300		300	-	300
C Vision IVS100 - Fluoroscopy fixed unit	-	-	-	467	467	(18)	450		467	-	467
Digital Mammography	-	-	-	39	39	-	39		39	-	39
General room 1, Toshiba X Ray Unit	90	-	90	210	300	-	300		300	-	300
Mobile breast screening Trailer Unit Strategic	600	-	600	-	600	-	600		600	-	600
Speech to Text Transcription	200	-	200	-	200	-	200	-	200	-	200
Corporate and People Enablers	22	100	122	-	122	-	122	-	122	-	122
	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-	-
Strategic Total	**4,969**	**4,830**	**9,799**	**1,889**	**11,688**	**(350)**	**11,338**	**1,140**	**11,688**	**-**	**12,829**
Total Capital (excluding Trust Funds)	**7,760**	**12,960**	**20,721**	**5,617**	**26,338**	**(2,402)**	**23,936**	**10,718**	**26,338**	**-**	**37,056**

Summary of Leases – as at 30 September 2019

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,149	13,787		1/11/2017	31/10/2020	Operating
Public Trust House Lower Hutt	Community Mental Health		21,887	262,643		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		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy		2,363	28,359		5/01/2019	31/12/2020	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
			50,685	**608,214**				
Car Park Leases								
CBD Towers Upper Hutt			542	6,500		8/06/2015	7/06/2021	Operating
Public Trust House Lower Hutt			1,603	19,240		1/09/2017	1/09/2023	Operating
St Peters (SPO)			270	3,240		Ongoing	Ongoing	Operating
			2,415	**28,980**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (115 Vehicles)			31,936	383,232		Ongoing	Ongoing	Operating
			31,936	**383,232**				
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
Theatre Equipment (FAR0135107)	All Leasing (paid quarterly in advance)	710,858	21,009	252,103	756,309	1/04/2017	1/04/2020	Finance
Theatre Equipment (FAR0135105)	All Leasing (paid quarterly in advance)	98,266	2,904	34,850	104,550	1/07/2017	1/07/2020	Finance
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		7,303	87,641	438,205	28/06/2017	28/06/2022	Operating
1 x Ultrasound (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	105,645	28/08/2017	28/07/2022	Operating
CT Scanner (Equigroup)	Toshiba Medical Systems		24,976	299,711	1,498,555	28/05/2017	28/05/2022	Operating
		1,102,312	**92,965**	**1,115,591**	**5,136,865**			
Total Leases			**178,001**	**2,136,017**				

Treasury - as at 30 September 2019

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$15,038	$20,287
Lowest balance for the month	($2,599)	($2,173)
Average interest rate	1.14%	1.40%
Net interest earned for the month	$14	$24

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	6	
Total value of transactions	$5,194	NZD
Largest transaction	$2,043	NZD

	No. of transactions	Equivalent NZD
AUD	6	$5,194
GBP	0	$0
USD	0	$0
Total	**6**	$5,194

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	$2,101	$395	$37	$23	$273	$36	$114	$1,224
Wairarapa District Health Board	$838	$281	$54	$11	$72	$0	$170	$251
Ministry of Health	$647	$488	$90	$22	($9)	($132)	$0	$187
Accident Compensation Corporation	$502	$498	($32)	($36)	$30	($24)	$29	$36
Ministry for Vulnerable Children, Oranga	$188	$43	$90	$0	$0	$0	$42	$13
Health Workforce NZ Limited	$120	$118	$0	$2	$0	$0	$0	$0
Non Resident	$54	$0	$0	$0	$9	$0	$0	$45
Ministry of Social Development	$46	$46	$0	$0	$0	$0	$0	$0
Hawkes Bay District Health Board	$40	$5	$0	$9	$9	$4	$0	$14
ESR Limited	$40	$40	$0	$0	$0	$0	$0	$0
Total Top 10 Debtors	**$4,575**	**$1,914**	**$238**	**$31**	**$383**	**($115)**	**$355**	**$1,769**

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Date 28 November 2019	**BOARD DISCUSSION**
Author	Chief Financial Officer — Michael McCarthy
Endorsed By	Chief Executive Capital & Coast and Hutt Valley DHBs — Fionnagh Dougan
Subject	**FINANCIAL AND OPERATIONAL PERFORMANCE REPORT – CAPITAL & COAST DHB**

RECOMMENDATIONS

It is **recommended** that the Concurrent Finance Risk and Audit Committee (FRAC):

(a) **Notes** that the DHB was $752k adverse for the month;

(b) **Notes** that the DHB YTD result was $3.2 million unfavourable to budget for September 2019;

(c) **Notes** that we are focused on delivering on our agreed savings strategies.

Financial Performance Result and Overview

Current Result

Overview

The overall DHB result for September 2019 is ($863k) unfavourable to budget and ($3.2m) YTD. The DHB deficit year to date is ($6.3m).

This variance in the accounts YTD has largely been driven by three factors:

- Personnel costs ($1 million including savings targets) The variance is only in outsourced staff;
- Treatment related costs ($1 million), this relates to blood costs, Pharmaceuticals and catheters;
- Non treatment related costs ($1.5 million), a combination of savings targets yet to be realised ($1.1 million) and existing integrated services contract (food & cleaning).

This has been partially offset by underspend in aged care claims.

Outsourcing costs were largely concentrated in Radiology, outsourced electives (timing), and outsourced Angio procedures.

Cash in the bank continues to be under pressure with actual $7.8m overdraft at the end of September. We expect that we will receive deficit support in June in line with our agreed deficit of $15.9 million, which will ease the situation

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The DHB has targeted a number of efficiency measures for the year ahead, which are largely being planned, some of these are yet to commence but are necessary to reach our deficit target of ($15.9m)

The future stability measures we are putting in place are not likely to deliver the quantity of savings required to deliver on the $15.9 million deficit. The expenditure on staffing is within budget and we are striving to manage other expenses, however we have a revenue stretch target in the current year that will be difficult to achieve. The current likely forecast based on the first three months performance and the measures currently in place is for a $21.9 million deficit. This could be further impacted if the current strike action is ongoing.

Our personnel budget, excluding outsourcing is currently on target, considerable increases in the last year are being managed carefully, and the majority of those not filled have been cancelled. All staff requests are being considered by the CEO, under the terms of the Minister's letter of Deficit support. As required in the letter all community contracts require the CEOs letter. The delegations for consultants and temporary staff over three months have also been elevated,

Nursing levels across the DHB, as you will see in the table on page 29 are at the highest ever since July 2018, despite us having significant turnover in the last two months.

In the hospital bed days continue to decline, whereas total bed days are increasing.

Year to date ED presentations for the first three months are slightly up whereas admissions are slightly down, but there was more activity last month. Surgical discharges are up by 1 percent on last year and complexity rose by a similar amount. Medical patients have also increased by a similar amount.

Leave balances continue to decline in line with the savings plan, and significant planning round bed closures for the labour weekend and Christmas periods are underway.

We have been advised that the Minister will be issuing a" Letter of Support" to the DHB in the next few days , which gives Board Members assurance in the Government's commitment to the Board being able to operate on a going concern basis.

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Financial Performance

Capital & Coast DHB Operating Variance - $000s	Provider Variance						
Monthly Variance for September 2019	SWC	MCC	QIPS	MHAID	Corporate & Other Exec	Reserves	Total
Devolved MoH Revenue	0	0	0	0	0	0	0
Non-Devolved MoH Revenue	6	46	0	50	(14)	0	88
Other Revenue	167	(335)	5	(37)	184	0	(16)
IDF Inflow	0	0	0	0	0	0	0
Inter DHB Provider Revenue	28	101	2	16	77	0	224
Internal revenue	(285)	103	0	(21)	106	(602)	(699)
Total Revenue	**(84)**	**(84)**	**7**	**8**	**353**	**(602)**	**(403)**
Personnel							
Medical	310	152	2	112	(31)	(327)	218
Nursing	220	82	(31)	108	66	(249)	197
Allied Health	22	21	16	16	(21)	(72)	(17)
Support	1	0	1	(0)	39	(15)	25
Management & Administration	30	(19)	0	(5)	205	24	235
Total Employee Cost	**584**	**236**	**(11)**	**231**	**258**	**(639)**	**658**
Outsourced Personnel							
Medical	12	(3)	(0)	(18)	0	0	(10)
Nursing	2	(1)	0	(16)	0	0	(15)
Allied Health	2	3	0	10	0	0	15
Support	0	0	0	0	(39)	0	(39)
Management & Administration	(6)	(8)	(2)	7	(198)	0	(206)
Total Outsourced Personnel Cost	**10**	**(9)**	**(2)**	**(17)**	**(237)**	**0**	**(255)**
Treatment related costs - Clinical Supp	82	(188)	(10)	3	(16)	0	(129)
Treatment related costs - Outsourced	(173)	14	0	(21)	(26)	0	(206)
Non Treatment Related Costs	(54)	(44)	63	(176)	(405)	(0)	(616)
IDF Outflow	0	0	0	0	0	0	0
Other External Provider Costs (SIP)	0	0	0	0	0	0	0
Interest Depreciation & Capital Charge	3	13	0	13	60	0	88
Total Other Expenditure	**(143)**	**(205)**	**53**	**(181)**	**(388)**	**(0)**	**(863)**
Total Expenditure	**451**	**22**	**40**	**33**	**(367)**	**(639)**	**(460)**
Net result	**368**	**(62)**	**46**	**41**	**(15)**	**(1,242)**	**(863)**

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Hospital Services

1. Shorter Stays in ED (SSIED)

The overall performance of ED admitted, and treated and discharged patients for the 2018/19 financial year is presented in table 1 below.

Table one ED performance 2018/19 and 2019/20

Performance	JUL	AUG	SEP
2018-19	88%	85%	85%
2019-20	78%	75%	75%

Breaches	JUL	AUG	SEP
2018-19	611	813	751
2019-20	1149	1315	1254

ED Volumes	JUL	AUG	SEP
2018-19	5,125	5,281	4,966
2019-20	5,285	5,284	4,940

Occupancy for adult beds at CCDHB remains high at over 94% which has a material impact on acute flow from ED. For this month a number of the additional winter beds have been flexed down to reflect the reduction in volumes where possible with the remainder of the beds due to be closed later this month. Average length of stay for acute services, planned and elective care remain low and relatively stable.

The Acute Demand and Bed Capacity Programme underway across the organisation aims to improve patient flow across both community and hospital services. The programme includes projects ranging from avoiding acute patient admissions to efficient hospital inpatient management to avoid delays in discharge. Projects include focus on long stay patients, enhanced multidisciplinary board rounding, reducing bed days in cancer services, reducing length of stay at Kenepuru to improve flow from Wellington hospital.

2. Planned Care

2.1 Inpatient Surgical Discharges/Minor Procedures

Our planned care funding schedule has been approved by MOH, however some DHB's are still awaiting approval which is impacting on regional reporting. Phasing of CCDHB volumes have not yet been processed by the Ministry and so YTD performance against case weights is not

available. As of 1 October the MOH is reporting that we have achieved 94.0% of planned care interventions, however this is very provisional because phasing has not been completed.

2.2 ESPI 2 Compliance

ESPI 2 relates **to patients waiting for first specialist assessment**. The maximum permitted waiting period is 120 days and compliance is calculated at month end.

CCDHB performance in ESPI 2 is shown in the table below. We regained our compliance status in August maintained that status in September and forecast to remain compliant in this measure.

Table two CCDHB performance in ESPI 2

ESPI 2 monitoring 18/19	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct*
Organisation wide	**-16**	**-40**	**-208**	**-72**	**-151**	**-136**	**-48**	**-49**	**-61**	0	-13	-14
Cardiology	-1	-1	-13	-18	-9	-6	0	0	-2	0	0	0
Cardiothoracic	0	0	0	0	0	0	0	0	0	0	0	0
Dermatology	0	-1	-48	0	-39	-39	-8	-28	-57	0	0	0
Endocrinology and Diabetic	0	0	0	0	0	-1	0	0	0	0	0	0
ENT	0	0	-1	0	-10	-1	-1	0	0	0	-4	0
Gastroenterology	0	0	-4	-1	0	0	0	0	0	0	0	0
General Medicine	0	0	0	0	-4	-3	0	0	-1	0	0	0
General Surgery	-2	0	-1	-1	0	-3	0	0	0	0	0	0
Gynaecology	-8	-11	-12	-1	-1	0	-3	0	0	0	0	0
Haematology	0	0	0	0	0	0	0	0	0	0	0	0
Neurology	0	0	-7	-14	0	-1	0	-1	0	0	-3	0
Neurosurgery	0	0	-1	-1	-1	-11	-8	0	0	0	0	0
Oncology	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmology	-3	-7	-5	0	-6	-6	-3	-4	0	0	-1	0
Orthopaedics	0	-2	-16	-18	-42	-26	-19	0	-1	0	-2	-5
Paediatric Medical	-1	-3	-5	-1	0	0	0	0	0	0	-1	-5
Paediatric Surgical	0	0	-1	0	0	0	0	0	0	0	0	0
Pain Management	0	0	0	0	0	0	0	0	0	0	0	0
Renal Medicine	0	0	0	0	0	0	0	0	0	0	0	0
Respiratory	0	0	-3	-2	-3	0	-2	0	0	0	0	0
Urology	-1	-1	-1	-14	-37	-36	-4	-16	0	0	-2	-4
Vascular Surgery	0	-14	-90	-1	0	-3	0	0	0	0	0	0

ESPI 2 will be Green if 0 patients, Yellow if > than 0 patients and < or equal to 10 patients, or < 0.39%, Red if 0.4% or higher. The max. number permitted at org level is approximately 27.

2.3 ESPI 5 Compliance

ESPI 5 relates to patients waiting for surgical treatment. The maximum waiting period is 120 days and compliance is calculated at month end.

CCDHB performance in ESPI 5 is shown in the table below. We have been noncompliant at an organisational level since December 2018. We are making slow progress in terms of regaining compliance, being impacted on by SMO vacancies and leave. Strike action being taken by Medical Imaging Technologists will result in deterioration of our September position due to restrictions on our scheduling of surgical patients.

Table three CCDHB Performance in ESPI 5

ESPI 5 monitoring 18/19	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct*
Organisation wide	**-23**	**-63**	**-137**	**-140**	**-146**	**-152**	**117**	**-107**	**-67**	**-59**	**-63**	**-82**
Cardiology	-7	-23	-65	-67	-60	-61	-51	-48	-22	-17	-12	-15
Cardiothoracic	-1	-2	0	-1	0	0	0	-1	-1	-5	-8	-12
Dental	0	0	0	0	0	0	0	0	0	0	0	0
ENT	0	0	0	-1	-3	-7	-1	0	-2	0	-3	-5
General Surgery	-4	-7	-14	-11	-9	-13	-7	-7	-13	-9	-10	-13
Gynaecology	-1	0	0	-1	0	-1	0	0	-2	-2	-2	-1
Neurosurgery	0	-3	-2	-7	-7	-10	-6	-10	-2	-1	-2	-5
Ophthalmology	-1	-8	-17	-15	-17	-11	-11	-10	-13	-5	-17	-21
Orthopaedics	-4	-8	-15	-20	-26	-25	-17	-13	-7	-9	-7	-6
Paediatric Surgical	0	-1	-2	-1	-2	-3	-3	-2	-1	-5	-1	0
Urology	-5	-9	-16	-9	-19	-19	-18	-15	-2	0	-1	-3
Vascular Surgery	0	-2	-6	-7	-3	-2	-3	-1	-2	-6	0	-1

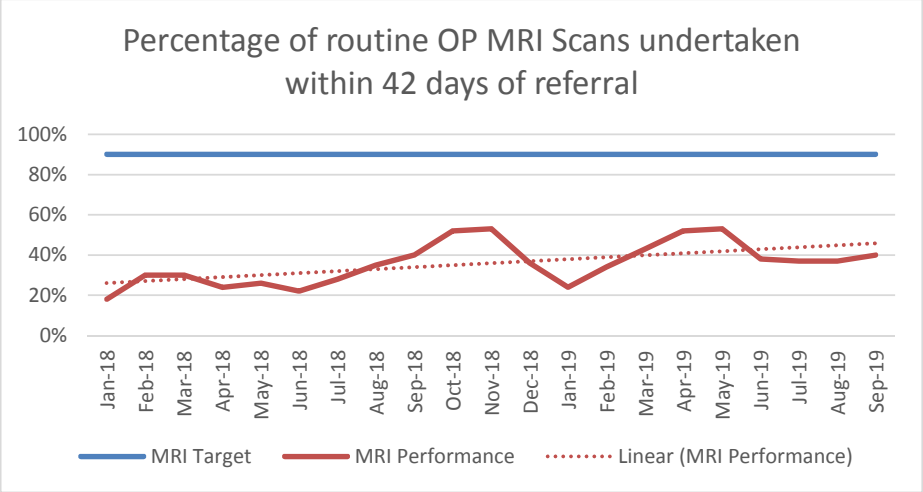
ESPI 5 will be Green if 0 patients, Yellow if > than 0 patients and < or equal to 10 patients or < 0.99%, Red if 1% or higher. The max number permitted at the org level is approximately 25.

2.4 MRI and CT Waiting Times

Performance against the CT and MRI MOH indicator for non-urgent referrals continues to be a challenge for the service, however both CT and MRI have remained relatively consistent. There is limited ability to match capacity and demand. The service is looking at opportunities to lift thresholds to manage demand and to ensure diagnostics are done closer to home for regional

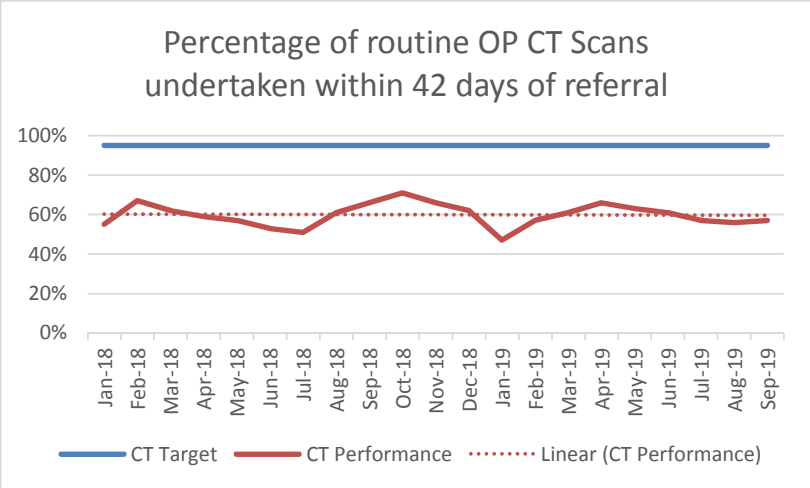
transfers. The current period of industrial action will further impact on waiting lists as planned activity will be significantly reduced.

Figure one MRI wait times



2.4.1 CT Waiting Times

Figure two CT wait times



2.5 Coronary Angiography Waiting Times

The proportion of patients waiting less than 90 days for angiography has slightly improved compared to last month yet remains below the target of 95%.

Table four Coronary Angiography Waiting Times

	2018 Sep	2018 Oct	2018 Nov	2018 Dec	2019 Jan	2019 Feb	2019 Mar	2019 Apr	2019 May	2019 Jun	2019 Jul	2019 Aug	2019 Sep
Waiting or catheterised in 90	193	180	173	173	162	157	159	138	134	131	134	123	93

days (3 months) or less													
Total number waiting or catheterised	229	229	226	233	249	266	252	224	215	195	186	161	117
% of Coronary Angiographies in 90 days (3 months) or less	84.3 %	78.6 %	76.5 %	74.2 %	65.1 %	59.0 %	63.1 %	61.6 %	62.3 %	67.2 %	72.0 %	76.4 %	79.5 %

The service continues to be non-complaint with the elective angiography target, driven by both demand and capacity (losing sessions to acute demand). Overall the wait list for angiography is reducing, and it is had been envisaged that the service would be compliant by the end of Quarter 2. The current period of industrial action will further impact on waiting lists as planned activity will be significantly reduced.

2.6 Acute Coronary Syndrome - key clinical quality improvement indicators

- 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')

- CCDHB result for August (most recent data that is available) was 88.9%. As a region we achieved target for August, 71.8% (117/163).
- Hawkes Bay, Wairarapa and Whanganui did not achieve the target (45.8%; 60%; 55.6%).
- A review of these events showed the main reason for non-compliance relates to access to beds at CCDHB
- The second measure relates to data quality, integrity – the target is that over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.

CCDHB result for August was 100%. As a region we achieved target for August, 98.2%.

Hawkes Bay did not achieve the target (91.7%).

2.7 Colonoscopy Waiting Times

CCDHB did not meet the Ministry of Health target for urgent colonoscopies (67%) and remains below target for non-urgent and surveillance colonoscopies achieving 66% and 38% respectively within 12 weeks against a target of 70%.

Figure three Percentage of patients receiving colonoscopy within required timeframes

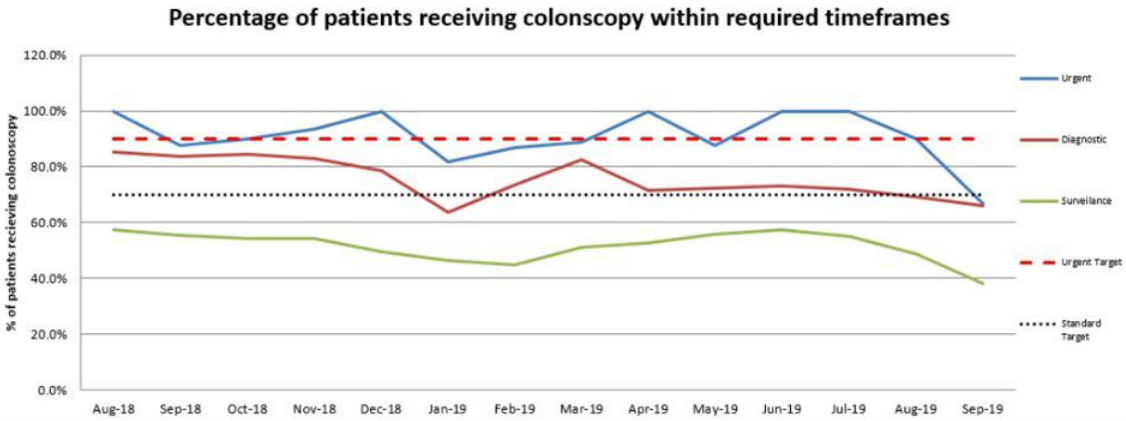
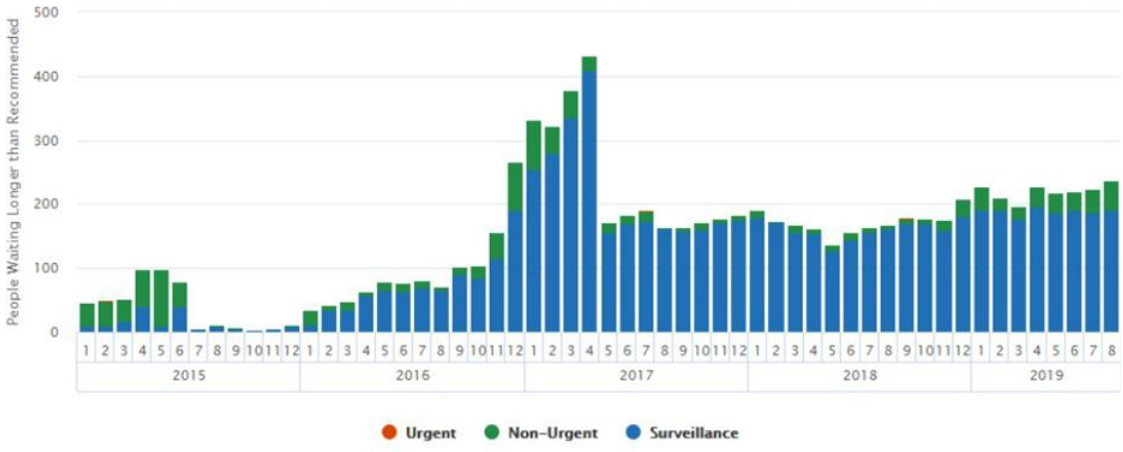


Figure four Numbers and those waiting beyond target waiting timeframes

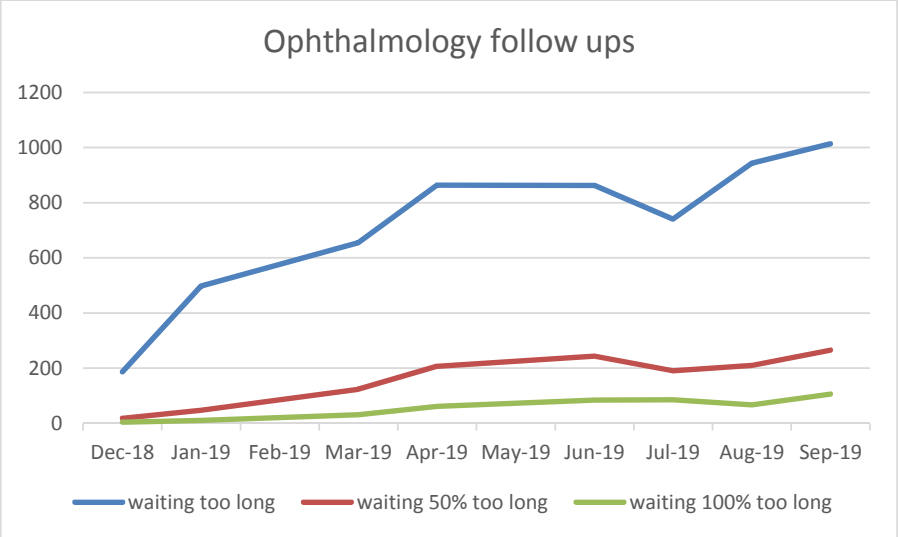


At the end of September there were 514 people on the colonoscopy waiting list. Of these, 247 patients had been waiting 'longer than recommended'. The Ministry have recently agreed to advance payment of the Bowel screening service fee ahead of joining the programme which will allow us to outsource and reduce the waiting list.

2.8 Ophthalmology treatment timeframes

All DHBs are required to report on the number of Ophthalmology patients who are not being assessed and treated within clinically indicated timeframes for follow up appointments, using the three categories on the graph below. Please note that patients waiting > 100% longer than clinically indicated are also counted in the group waiting >50% and the patients in those two groups are counted in the 'waiting too long' group. Follow up timeframe can be as short as 2 days for acute patients or as long as 2 years.

Figure five Ophthalmology treatment timeframes



A significant reduction in the backlog of follow-ups was seen in December 2018, however this has not been sustained due to the availability of specialists to run locum clinics.

The service has implemented many quality improvements over the last two years to manage capacity. Recruitment to the additional approved positions to support service delivery is ongoing with one fellow position and orthoptist still not appointed to.

2.9 Cardiac Surgery

In order to achieve the national target standardised intervention rate for cardiac surgery CCDHB is expected to provide 750 cardiac surgeries in 2019/20. CCDHB does not receive sufficient referrals from within the region to achieve this level of discharges and tends to provide around 510 discharges per annum. Figure seven below shows how we are tracking against current year plan and last year's actuals.

Figure six CCDHB cumulative weekly cardiac surgery

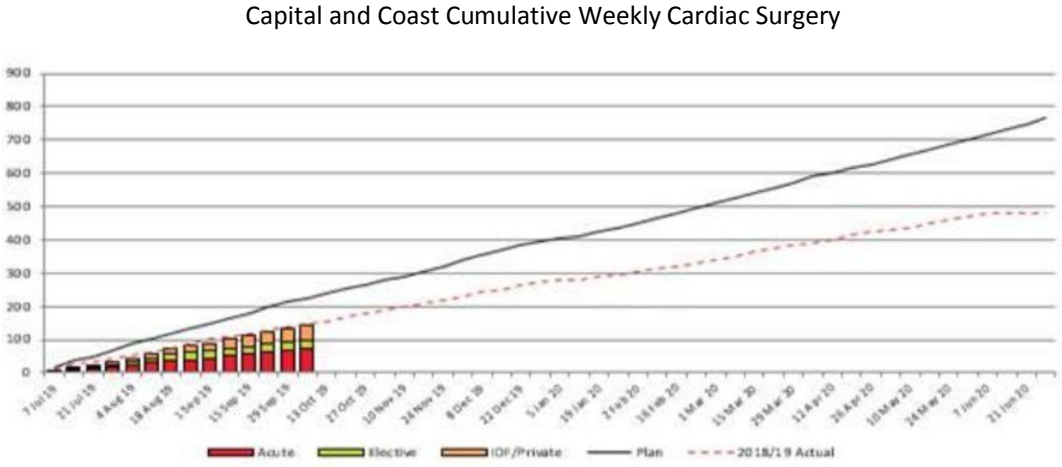
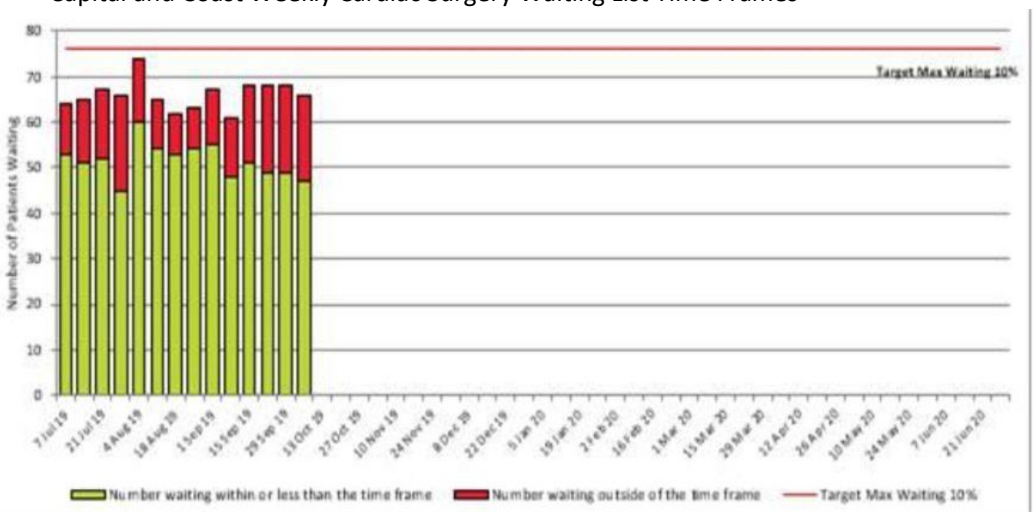


Figure seven below shows the cardiac surgery waitlist size and the number of patients waiting past their waitlist timeframes. The Ministry of Health calculates a maximum waiting list size, which is based on 10% of target throughput and requires variance reporting if we exceed that waitlist size. Although we are under the maximum waiting list size we do have a number of patients waiting outside the recommended waiting times.

The patients waiting outside the recommended treatment timeframe are band three patients (treatment required within 30 days) and band 4 patients (treatment required within 90 days). The patients tend to be the complex patients who require specific surgeons, two surgeons and all day operations.

Figure seven CCDHB weekly cardiac surgery waiting list timeframes

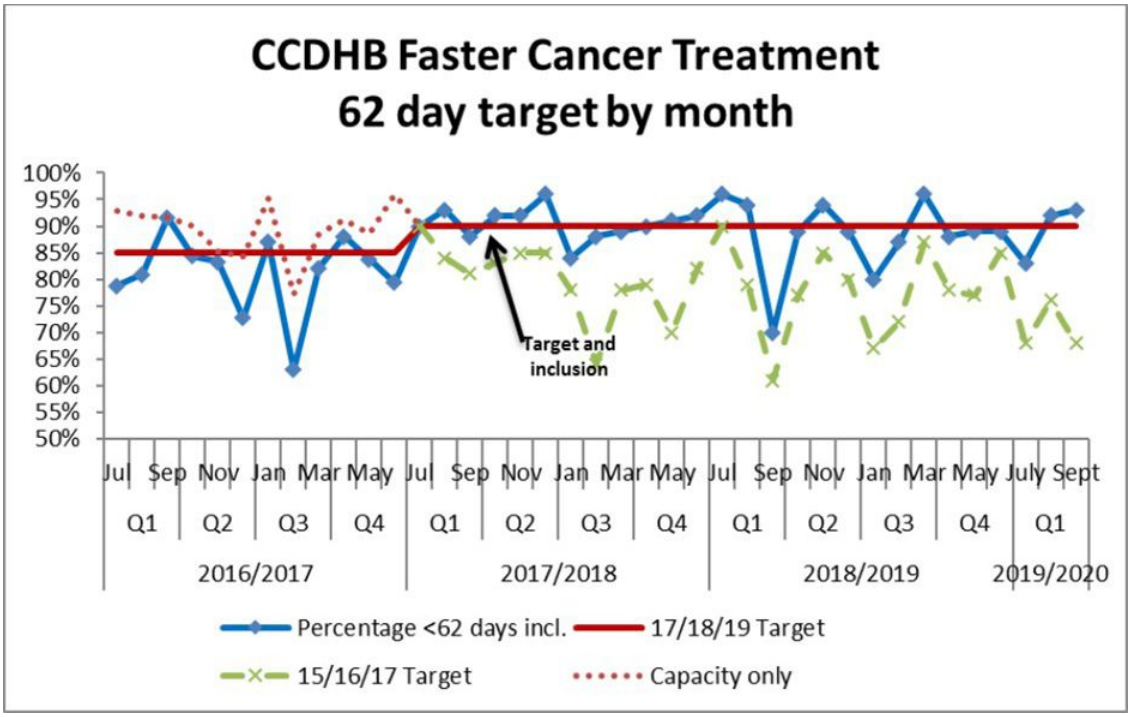


CCDHB is not meeting the target volume of patients for a variety of reasons. Available lists have not been able to be fully utilised because of surgeon availability and lack of ICU capacity.

2.10 Faster Cancer Treatment

CCDHB achieved 93% of urgent patients receiving treatment less than 62 days from referral against a target of 90% for September 2019. For the 31 day indicator, 91% of patients received their treatment within 31 days of a confirmed diagnosis in September 2019 compared to an 85% target.

Figure eight CCDHB Faster Cancer Treatment



3. Theatre Productivity

Two key measures of theatre productivity are session utilisation and list utilisation. Session utilisation refers to the utilisation of a session that is normally resourced. In terms of counting a session is either used or not used. The key drivers for lower than target utilisation continue to be SMO vacancies and leave and our inability to backfill sessions when surgeons are on leave. Wellington reached target with 95% utilisation of resourced sessions compared to 89% in August. Kenepuru at 71% showed a minor variance compared to 72% in August.

Table five Session Utilisation

Session Utilisation (Utilisation of resourced sessions

Hospital	Session Utilisation	Session Utilisation Target
Wellington	95%	95%
Kenepuru	71%	95%
Combined	95%	95%

The second key measure is list utilisation. List utilisation relates to the number of minutes that a list is utilised. Wellington list utilisation was 81% and just below target. Kenepuru showed an

improvement from previous month at 71% and remains lower than target. September was impacted by two MIT industrial actions which restricted the patients that could be booked on strike days. For the first period of industrial action and a number of patients were placed on standby and reinstated when the strike was lifted, however we were unable to fully utilise lists. The second strike period went ahead and had a significant impact. Both strike periods contributed to the lower than expected result for September.

Table six List Utilisation

List Utilisation (Utilisation of used Sessions)

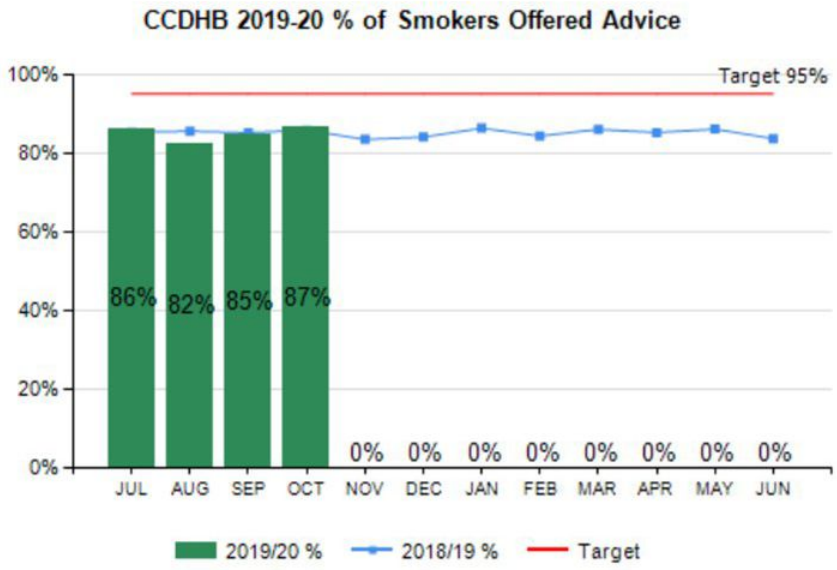
Hospital	List Utilisation	List Utilisation Target
Wellington	81%	85%
Kenepuru	71%	85%
Combined	79%	85%

4. Smoking Cessation

CCDHB achieved 85% of the 95% Ministry of Health target for providing smoking cessation advice to smokers in September 2019.

The DHB has a Tākiri Mai te Ata smoking cessation advisor visiting the hospital on a regular basis to bridge the gap between hospital stay and enrolment in cessation support services. This ensures patients can maintain nicotine replacement therapy and be supported to maintain Smoke free status on discharge.

Figure nine Advice for smokers given



Discharges

Publicly funded casemix discharges for the month of September 2019 have increased by 268

(5.0%) in comparison to the number of discharges recorded in September 2018. The increases were spread across a number of specialties with the increases most evident in Emergency Medicine (119 Acute), General Medicine (42 Acute), General Surgery (29 Acute) and Urology (11 Acute, 18 Elective). There were also a few decreases spread across a number of specialties with decreases most evident in Cardiology (42 Acute), ENT (8 Acute and 31 Elective), Orthopaedics (33 Elective) and Haematology (28 Acute).

The number of outsourced discharges in private facilities decreased from 142 in September 2018 to 111 in September 2018 (22% decrease).

Bed Utilisation and ED

The number of ED presentations is higher in September 2019 than the number recorded in the same month in the previous financial year. The emergency department in September 2019 has experienced a 2.2% increase (117) in the number of presentations compared to September 2018, this equated to a reduction of approx. 3.9 presentations per day

The utilisation of available of adult beds in core wards in September 2019 is 93.7% which is higher than the 93.6% rate recorded in September 2018. The number of available beds in 2019 is lower than in September 2018 with Ward 3 closed for 10 days and less additional beds opened at Kenepuru.

Elective theatre cases have decreased for the month of September 2019 by 1.8% (15 cases) when compared to September 2018. The decrease is spread across a number of specialties with increases evident in Orthopaedic (43) and ENT (19).

Case weights (CWDs) – Year-to-Date

Local acute CWDs are higher than previous financial year (121 CWDs) with an increase in discharges; a lower ALOS and a similar average CWD. The discharge increase is driven primarily by Emergency Medicine, General Medicine, Gynaecology and Ophthalmology. The CWD increase is driven primarily by Orthopaedics, Emergency Medicine, Respiratory, General Surgery, and Urology.

Local Elective CWDs are lower than the previous financial year by (48 CWDs) with a decrease in discharges; a decrease in ALOS and an increase average CWD. The discharge decrease is driven primarily by General Surgery and Orthopaedics. The CWD decrease is driven primarily by General Surgery and Orthopaedics.

IDF acute CWDs are higher (284 CWDs) than the previous financial year also with an increase in discharges a similar ALOS and a higher average CWD. The discharge increase is driven primarily by Emergency Medicine, Cardiothoracic and Neonatal. The CWD increase is driven primarily by Cardiothoracic Surgery, Neonatal and General Surgery.

IDF Elective CWDs are lower than the previous financial year (42 CWDs) with more discharges a similar ALOS and a lower average CWD. The discharge increase is driven primarily by Ophthalmology, Cardiology and Vascular Surgery. The CWD decrease is driven primarily by General Surgery and Cardiothoracic.

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Capital and Coast DHB: September 2019

HSS Inpatient Caseweight Activity

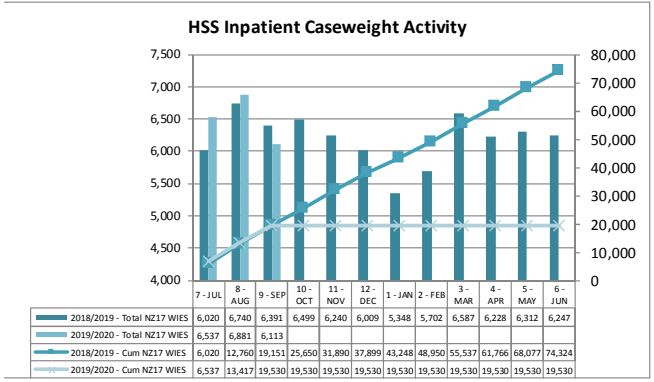
	2018/19	2019/20
YTD Totals	19,151	19,530
Change		379
% Change		2%

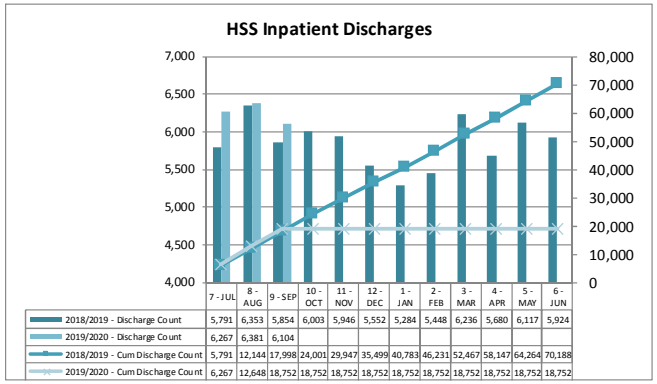
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2018/19	2019/20
YTD Totals	17,998	18,752
Change		754
% Change		4%

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



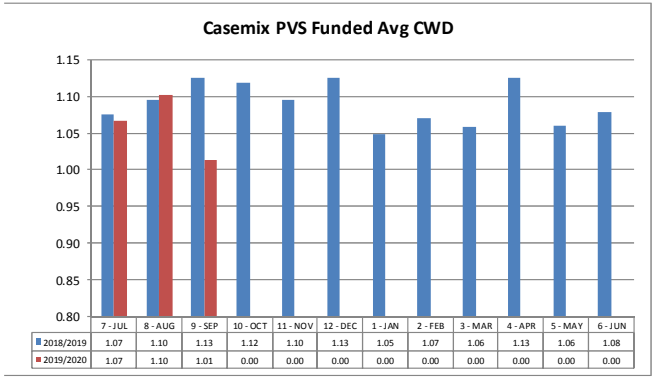


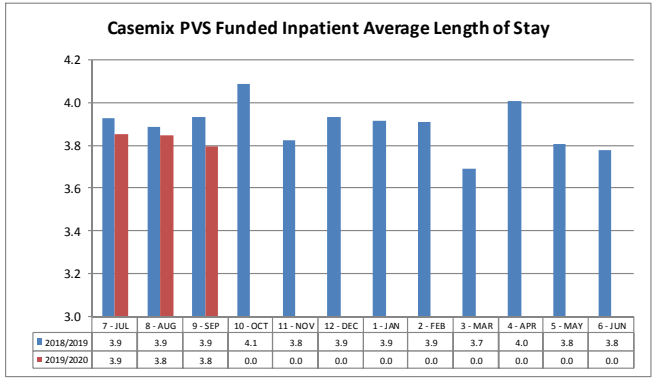
Casemix PVS Funded Avg CWD

	2018/19	2019/20
YTD Totals	1.09	1.06
Change		-0.03
% Change		-3%

Casemix PVS Funded Inpatient Average Length of Stay

	2018/19	2019/20
YTD Totals	3.89	3.83
Change		-0.06
% Change		-1.4%





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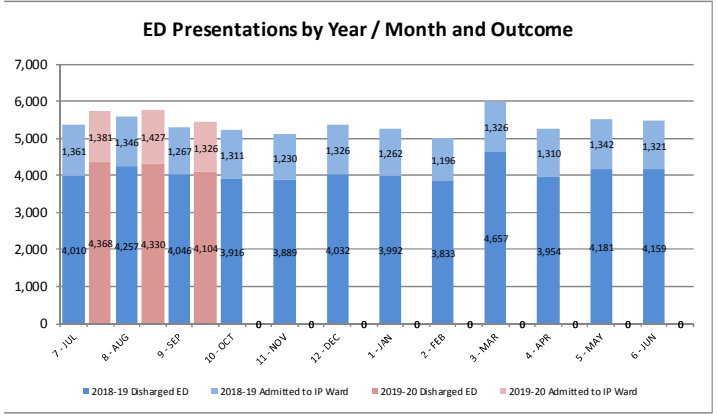
Capital and Coast DHB: September 2019

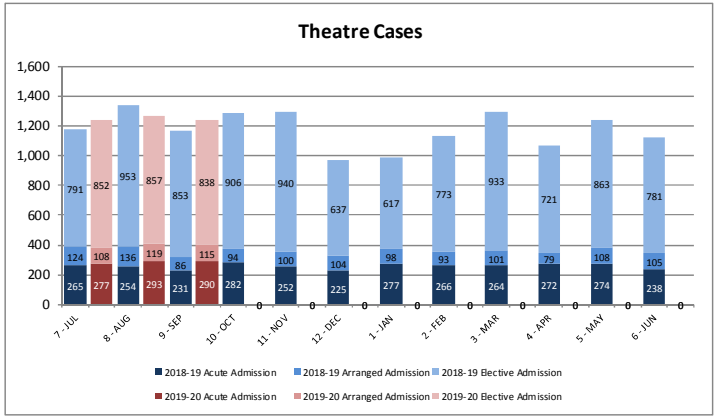
ED Presentations

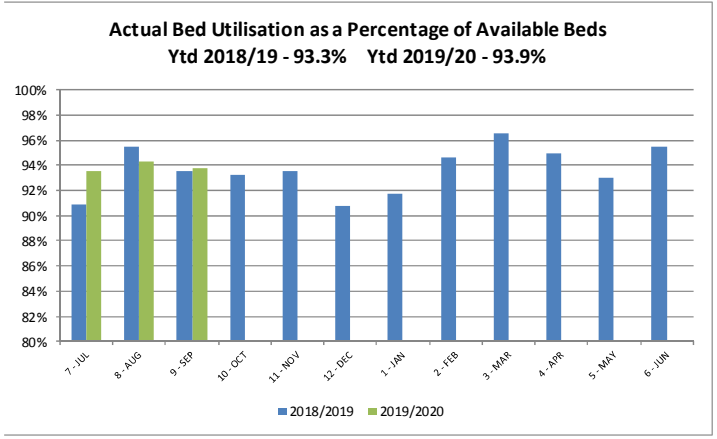
	2018/19	2019/20
YTD Totals	16,287	16,936
Change		649
% Change		4%

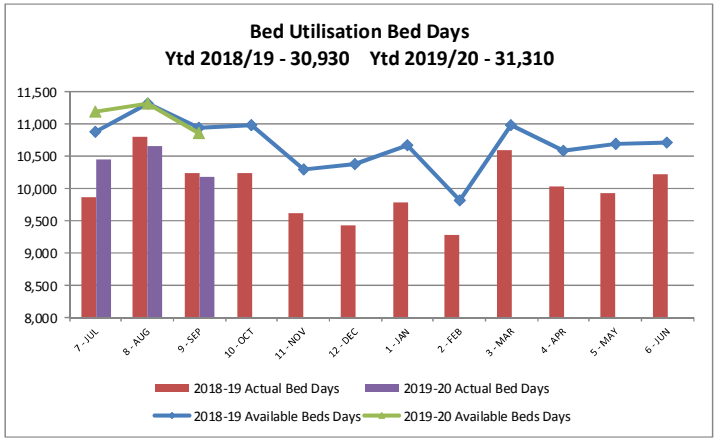
Theatre Cases

	2018/19	2019/20
YTD Totals	3,693	3,749
Change		56
% Change		2%









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IDF Revenue

The organisation is seeking to understand the full year impact of surgical inpatient and neonatal volumes against IDF and elective targets, and therefore we have yet to recognise this in our accounts for the YTD movement as indicated below (Note this table only includes inpatient activity and excludes PCT drugs).

DHB under delivered to	YTD Sep estimated inpatient wash-up
Hutt Valley	-1,484,523
Taranaki	-375,252
Wairarapa	-231,163
Hawkes Bay	-227,334
MidCentral	-201,422
Other under delivered (9 DHBS)	-510,069
Other over delivered (4 DHBS)	143,193
Whanganui	926,276
Total Undelivered inpatient IDF	**-1,960,294**

Capital & Coast District Health Board
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Month - September 2019					Capital & Coast DHB Operating Results - $000s	Year to Date					Annual	
			Variance						Variance			
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD September 2019	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Annual Budget	Last year
73,157	73,273	68,127	(116)	5,029	Devolved MoH Revenue	219,888	219,818	204,274	70	15,614	879,272	840,425
3,504	3,416	3,605	88	(102)	Non-Devolved MoH Revenue	10,410	10,339	10,924	71	(514)	41,265	43,826
3,257	3,312	3,751	(55)	(495)	Other Revenue	10,159	10,059	10,895	100	(736)	39,404	41,074
19,580	20,186	19,257	(606)	323	IDF Inflow	60,679	60,557	55,046	122	5,633	242,229	227,680
859	635	703	224	156	Inter DHB Provider Revenue	2,254	1,936	2,026	318	228	7,627	8,617
100,356	**100,821**	**95,444**	**(465)**	**4,912**	**Total Revenue**	**303,390**	**302,710**	**283,164**	**681**	**20,226**	**1,209,799**	**1,161,622**
					Personnel							
13,542	13,760	12,993	218	(549)	Medical	42,023	42,682	40,526	659	(1,497)	170,050	177,192
17,459	17,656	16,026	197	(1,434)	Nursing	53,523	52,172	48,426	(1,351)	(5,097)	217,226	223,578
4,846	4,829	4,488	(17)	(358)	Allied Health	15,310	15,178	14,407	(132)	(903)	62,609	63,265
792	818	622	25	(171)	Support	2,509	2,565	1,966	56	(543)	10,145	9,866
5,862	6,097	5,229	235	(633)	Management & Administration	18,391	19,158	16,293	767	(2,098)	78,165	70,157
42,502	**43,160**	**39,358**	**658**	**(3,144)**	**Total Employee Cost**	**131,756**	**131,756**	**121,618**	**(0)**	**(10,138)**	**538,194**	**544,059**
					Outsourced Personnel							
433	423	477	(10)	44	Medical	1,613	1,292	1,640	(321)	27	5,108	6,158
30	15	16	(15)	(14)	Nursing	60	47	55	(13)	(5)	183	215
109	124	174	15	65	Allied Health	373	380	540	7	167	1,488	1,770
43	4	19	(39)	(24)	Support	120	14	119	(107)	(2)	52	461
264	58	226	(206)	(38)	Management & Administration	799	178	558	(621)	(241)	693	2,660
880	**625**	**913**	**(255)**	**33**	**Total Outsourced Personnel Cost**	**2,965**	**1,910**	**2,911**	**(1,054)**	**(54)**	**7,524**	**11,265**
10,369	10,240	10,030	(129)	(338)	Treatment related costs - Clinical Supp	32,445	31,402	30,389	(1,043)	(2,056)	122,344	122,929
2,137	1,930	1,571	(206)	(566)	Treatment related costs - Outsourced	6,477	5,694	5,036	(784)	(1,441)	21,794	20,314
6,460	5,844	6,569	(616)	109	Non Treatment Related Costs	19,490	17,963	19,363	(1,526)	(126)	66,360	77,600
8,589	8,589	7,886	0	(703)	IDF Outflow	25,801	25,766	23,763	(35)	(2,038)	103,064	98,083
24,921	25,094	23,817	173	(1,104)	Other External Provider Costs (SIP)	75,487	75,783	71,858	296	(3,630)	304,138	288,682
5,102	5,191	5,057	88	(46)	Interest Depreciation & Capital Charge	15,318	15,609	14,974	291	(344)	62,281	66,224
57,578	**56,887**	**54,930**	**(690)**	**(2,648)**	**Total Other Expenditure**	**175,019**	**172,217**	**165,383**	**(2,801)**	**(9,636)**	**679,981**	**673,831**
100,959	**100,672**	**95,201**	**(287)**	**(5,758)**	**Total Expenditure**	**309,739**	**305,883**	**289,912**	**(3,856)**	**(19,828)**	**1,225,699**	**1,229,155**
(603)	**149**	**243**	**(752)**	**(847)**	**Net result**	**(6,349)**	**(3,174)**	**(6,747)**	**(3,175)**	**398**	**(15,900)**	**(67,533)**
(3,512)	(3,623)	1,495	111	(5,008)	Funder	(4,392)	(5,786)	(1,118)	1,394	(3,274)	(0)	19,170
(81)	(144)	46	63	(127)	Governance	(55)	2	224	(57)	(279)	0	524
2,990	3,916	(1,298)	(926)	4,288	Provider	(1,901)	2,611	(5,853)	(4,512)	3,952	(15,900)	(87,227)
(603)	**149**	**243**	**(752)**	**(847)**	**Net result**	**(6,349)**	**(3,174)**	**(6,748)**	**(3,175)**	**399**	**(15,900)**	**(67,533)**

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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Aug -19	Month : September 2019				Variance			Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	September 2018	At June 2019	Actual vs Budget	Actual vs September 2018	Notes	YTD September 2019
33	34	33	22	33	1	12	1	Bank
0	0	0	3,477	0	0	(3,477)	1	Bank NZHP
11,346	11,686	10,754	10,255	10,754	932	1,431	1	Trust funds
64,104	53,640	51,217	51,606	51,217	2,423	2,034	2	Accounts receivable
9,120	8,832	9,046	8,780	9,046	(214)	52		Inventory/Stock
5,565	6,216	4,197	5,655	4,197	2,018	561		Prepayments
90,168	**80,407**	**75,247**	**79,795**	**75,247**	**5,160**	**613**		**Total current assets**
537,360	534,551	551,731	553,128	543,825	(17,180)	(18,576)		Fixed assets
13,323	13,774	13,774	9,859	11,626	0	3,915		Work in Progress - CRISP
35,376	42,272	28,424	27,889	32,572	13,848	14,383		Work in progress
586,059	**590,597**	**593,929**	**590,876**	**588,023**	**(3,332)**	**(279)**	3	**Total fixed assets**
(253)	0	0	5,448	0	0	(5,448)		Investments in New Zealand Health Partnership
1,150	1,150	1,150	1,150	1,150	(1)	0		Investment in Allied Laundry
897	**1,150**	**1,150**	**6,598**	**1,150**	**(1)**	**(5,448)**		**Total investments**
677,124	**672,154**	**670,326**	**677,268**	**664,420**	**1,828**	**(5,114)**		**Total Assets**
19,553	7,806	9,429	0	2,704	1,623	(7,806)		Bank overdraft HBL
65,549	67,474	67,115	69,687	64,760	(359)	2,213	4	Accounts payable, Accruals and provisions
0	0	55	166	55	55	166	7	Loans - Current portion
4,126	6,315	0	6,173	0	(6,315)	(142)	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
57,849	59,141	56,248	26,496	56,248	(2,893)	(32,644)	5	Current Employee Provisions
52,949	52,613	53,276	48,849	53,276	663	(3,764)	5	Accrued Employee Leave
10,280	12,421	21,041	10,051	21,041	8,620	(2,371)	5	Accrued Employee salary & Wages
210,899	**206,364**	**207,758**	**162,015**	**198,677**	**1,394**	**(44,348)**		**Total current liabilities**
0	0	0	55	0	0	55		Crown loans
77	78	80	10,313	72	1	10,235		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,297	6,297	6,353	5,642	6,353	56	(655)		Long-term employee provisions
6,979	**6,980**	**7,037**	**16,615**	**7,029**	**57**	**9,635**		**Total non-current liabilities**
217,877	**213,344**	**214,795**	**178,631**	**205,707**	**1,452**	**(34,713)**		**Total Liabilities**
459,246	**458,810**	**455,531**	**498,638**	**458,713**	**3,279**	**(39,827)**		**Net Assets**
792,059	792,226	785,356	764,402	778,200	6,870	27,824		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
0	0	0	0	0	0	0		Capital Injection
136,294	136,294	136,711	136,813	147,359	(417)	(519)		Reserves
(469,107)	(469,710)	(466,537)	(402,577)	(463,363)	(3,174)	(67,133)		Retained earnings
459,246	**458,810**	**455,531**	**498,637**	**458,713**	**3,279**	**(39,827)**		**Total Equity**

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

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Month - September 2019					Capital & Coast DHB Hospital Throughput	Year to Date						Annual	
			Variance						Variance				
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD September 2019	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	% variance	Annual Budget	Last year
					Discharges								
1,915	1,933	1,862		(53)	Surgical	5,838	5,987	5,646		(192)	-3.40%		22,346
2,742	2,429	2,562		(180)	Medical	8,419	7,429	7,701		(718)	-9.32%		30,299
1,004	1,033	966		(38)	Other	3,106	3,233	3,138		32	1.02%		10,651
5,661		**5,390**		**(271)**	**Total**	**17,363**	**16,649**	**16,485**		**(878)**	**-5.33%**	**0**	**63,296**
					CWD	WIES 19*		WIES 19*					
2,818	2,954	2,906	137	88	Surgical	8,928	9,120	8,759	192	(169)	-1.93%	34,906	33,976
2,067	2,083	2,150	17	83	Medical	6,574	6,369	6,460	(205)	(113)	-1.75%	24,605	25,283
848	922	1,014	74	165	Other	2,919	2,874	2,909	(45)	(10)	-0.35%	10,893	10,834
5,733	**5,960**	**6,070**	**227**	**337**	**Total**	**18,421**	**18,363**	**18,128**	**(58)**	**(292)**	**-1.61%**	**70,404**	**70,093**
					Other								
5,430		5,313		(117)	ED Presentations	16,936		16,287		(649)	-3.98%		64,524
3,507		3,390		(117)	ED Non-Admitted	10,987		10,334		(653)	-6.32%		41,428
1,923		1,923		0	ED Admissions	5,949		5,953		4	0.07%		23,096
1,243		1,170		(73)	Theatre Throughput	3,749		3,693		(56)	-1.52%		14,096
13,039		12,986		(53)	Bed Days on discharge	40,503		39,547		(956)	-2.42%		153,245
3.79		3.94		0.15	ALOS Inpatient	3.83		3.92		0.09	2.21%		3.89
2.30		2.41		0.11	ALOS Including Day Patients	2.33		2.40		0.07	0.03		2.38

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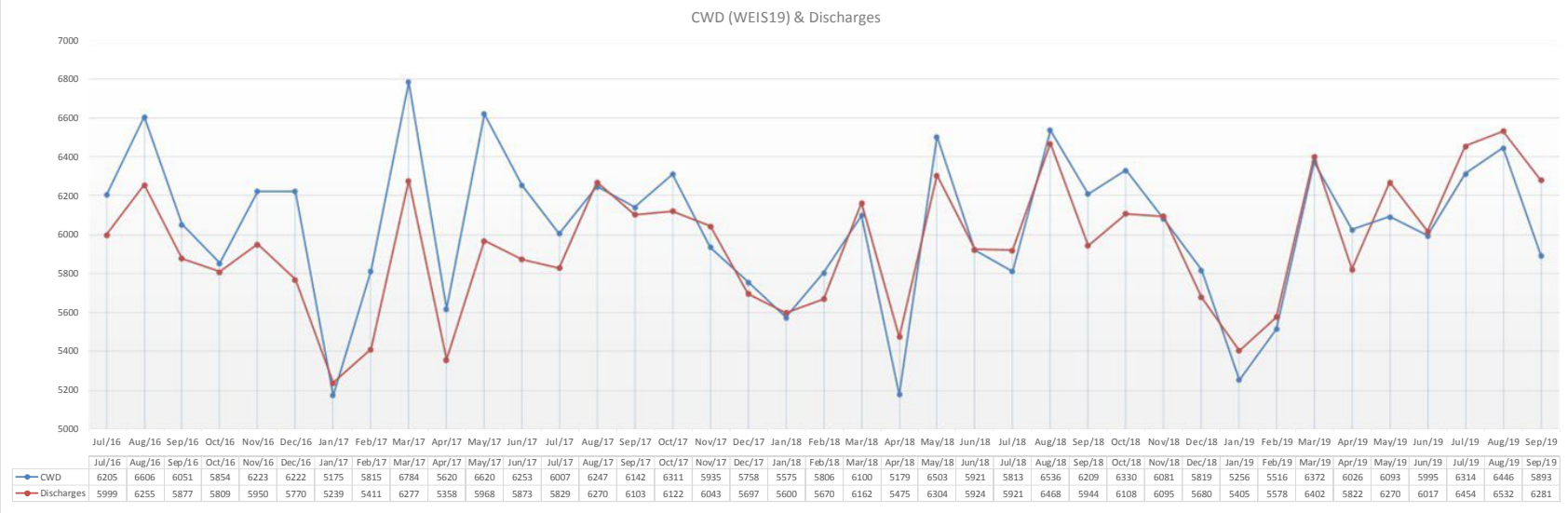
Additional Personnel Information:

The Ministry representation of 'Accrued FTE' is not yet available



	Jul/16	Aug/16	Sep/16	Oct/16	Nov/16	Dec/16	Jan/17	Feb/17	Mar/17	Apr/17	May/17	Jun/17	Jul/17	Aug/17	Sep/17	Oct/17	Nov/17	Dec/17	Jan/18	Feb/18	Mar/18	Apr/18	May/18	Jun/18	Jul/18	Aug/18	Sep/18	Oct/18	Nov/18	Dec/18	Jan/19	Feb/19	Mar/19	Apr/19	May/19	Jun/19	Jul/19	Aug/19	Sep/19
CWD	6205	6606	6051	5854	6223	6222	5175	5815	6784	5620	6620	6253	6007	6247	6142	6311	5935	5758	5575	5806	6100	5179	6503	5921	5813	6536	6209	6330	6081	5819	5256	5516	6372	6026	6093	5995	6314	6446	5893
Discharges	5999	6255	5877	5809	5950	5770	5239	5411	6277	5358	5968	5873	5829	6270	6103	6122	6043	5697	5600	5670	6162	5475	6304	5924	5921	6468	5944	6108	6095	5680	5405	5578	6402	5822	6270	6017	6454	6532	6281

Discharges and Case weights for In-house Activity (Including ACC & Non-residents): July 16 – Sep 19

The above data is then compared to Worked FTE for all Personnel in the payroll system to provide a reflection of productive effort required.

Note that Worked FTE is a subcomponent of Paid FTE (being Working and Non-Working hours), to provide a close relationship between the hours of work 'on the shop floor' and the case weights or discharges completed.

It is for this reason also that we exclude outsourced activity within these measures.

Capital & Coast District Health Board
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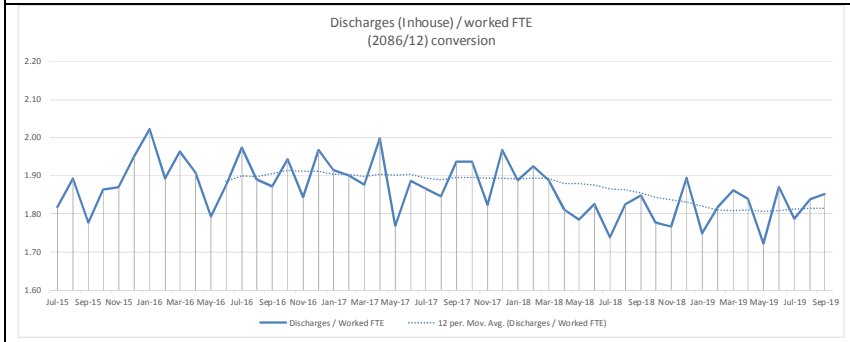
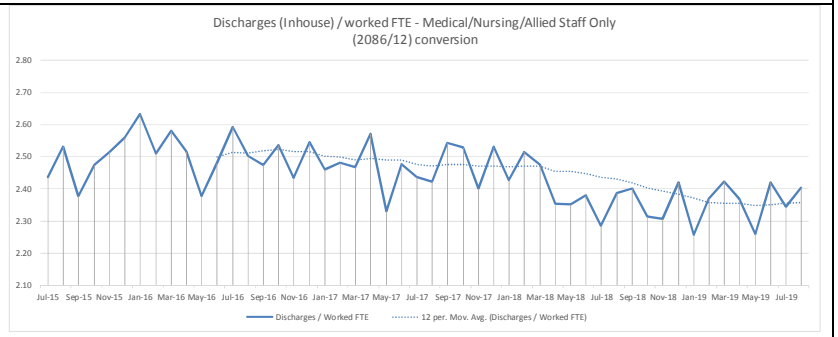
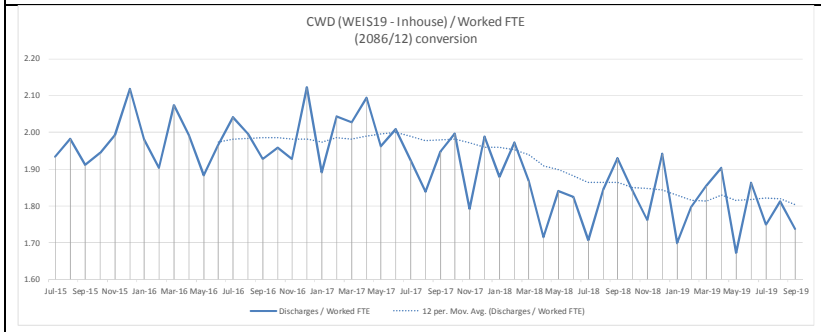
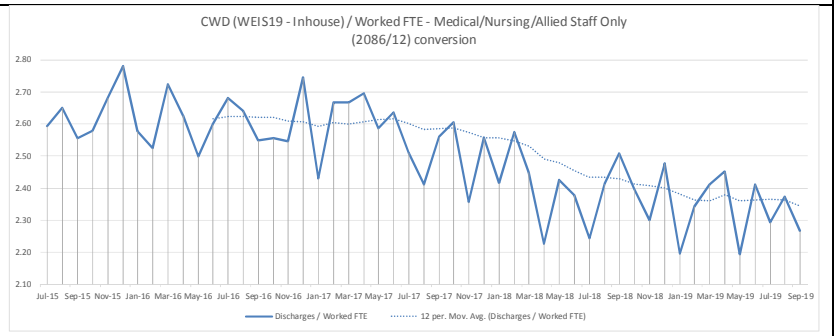
All Staff	*The below data represents the same information, except divided by Clinical Staff rather than total staff*
Discharges to Worked FTE	*Discharges to Worked FTE – Clinical:* Note the scale change
	
Caseweights to Worked FTE	*Caseweights to Worked FTE - Clinical*
	

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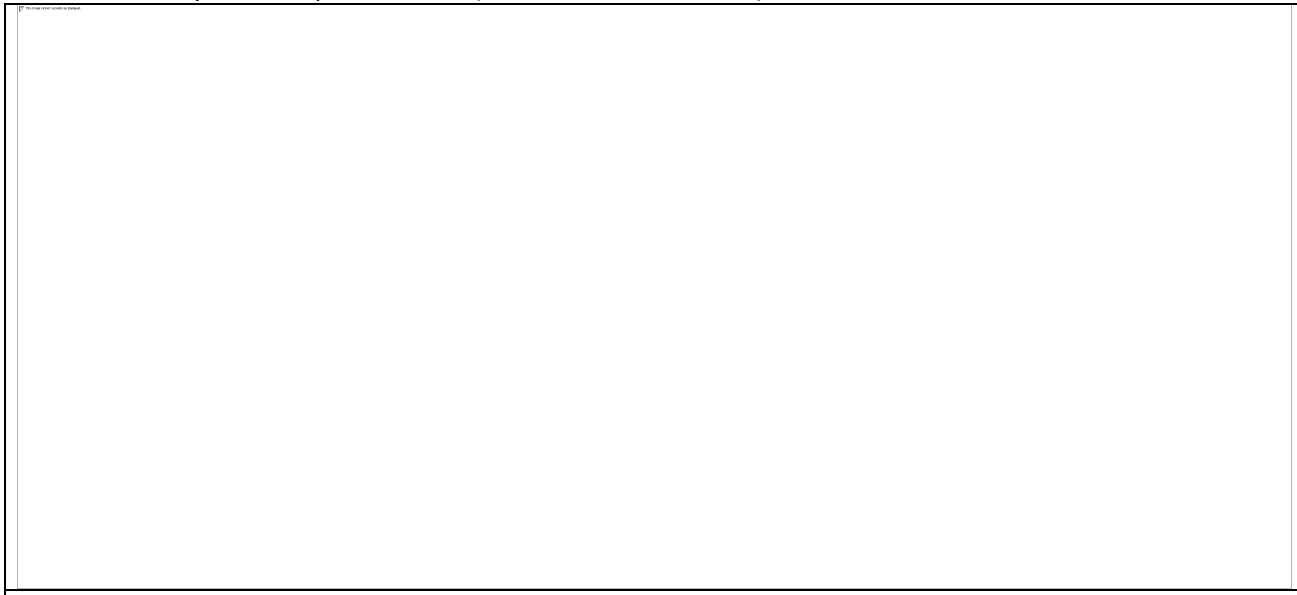
FTE Measures: July 2016 – September 2019 (Personnel not outsourced)

<table>
<tr><td>  </td><td rowspan="2">Budgeted FTE is comparable to Paid FTE, and provides a Volume Variance to budget (excluding leave balances increasing)

Establishment FTE is comparable to Contracted FTE, and provides vacancies. We have developed a live way of representing vacant roles for the coming financial year.

This graph does not take into consideration ‘Accrued FTE’ which is effectively the same as Paid FTE with the incorporation of leave balance movement.

However, we use FTE measures direct from Payroll to establish trends, i.e. when the payment was for, irrespective of when it was banked into an employee’s bank account, especially in the alignment of MECA increases.</td></tr>
<tr><td>Quick Definitions
• Light blue (bottom line) represents Contracted FTE i.e. standard hours for a week per contract
• Yellow line represents Paid FTE, this represents the hours paid each week
• Purple top line represents Budgets excluding savings and vacancy targets,
• Grey line is budgeted FTE with the effect of vacancy and savings targets
• Red line is the establishment FTE from start of year i.e. The FTE of what am I allowed to hire to</td></tr>
</table>

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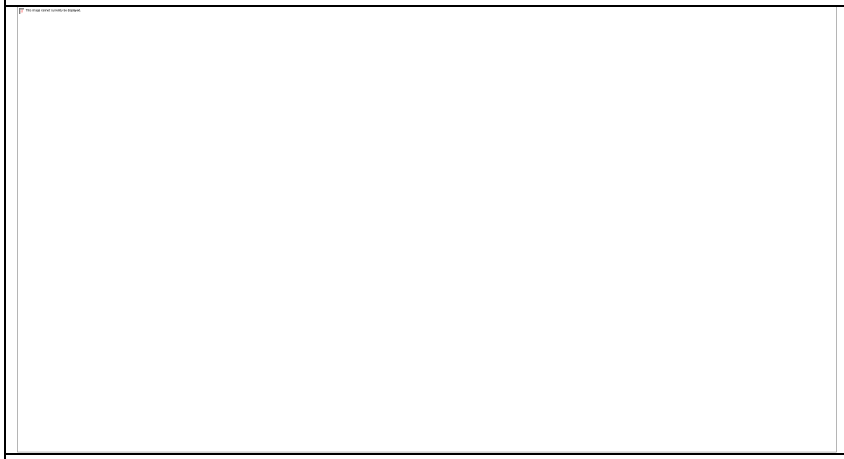
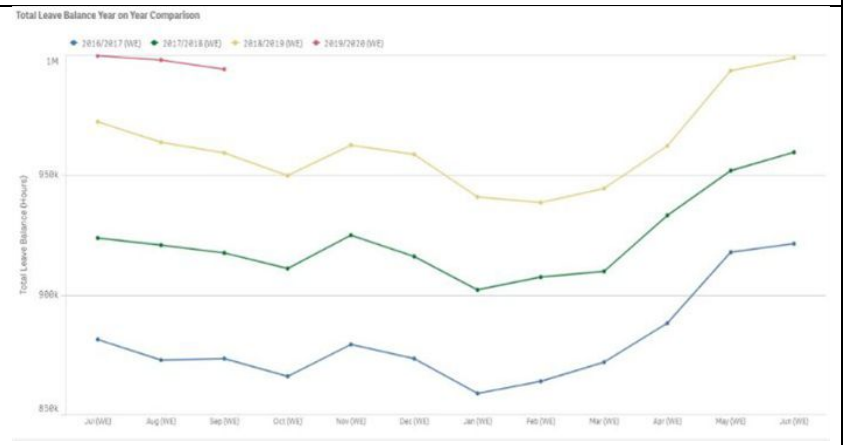
Paid FTE table (Yellow line) for the 2018/19 Year continuing into the current year

Category	2018/2019-Jul (WE)	2018/2019-Aug (WE)	2018/2019-Sep (WE)	2018/2019-Oct (WE)	2018/2019-Nov (WE)	2018/2019-Dec (WE)	2018/2019-Jan (WE)	2018/2019-Feb (WE)	2018/2019-Mar (WE)	2018/2019-Apr (WE)	2018/2019-May (WE)	2018/2019-Jun (WE)	2019/2020-Jul (WE)	2019/2020-Aug (WE)	2019/2020-Sep (WE)
Medical Personnel	923.93	931.67	937.35	945.99	943.37	1,051.52	923.19	906.57	931.88	933.65	901.83	965.45	919.63	926.00	941.00
Nursing Personnel	2,310.65	2,357.90	2,364.01	2,394.64	2,370.89	2,356.44	2,393.73	2,434.23	2,417.25	2,440.37	2,446.44	2,447.27	2,448.01	2,437.00	2,450.00
Allied Health Personnel	720.80	717.10	717.92	728.69	729.72	734.06	722.47	729.17	724.55	727.50	725.98	736.97	733.32	726.00	722.00
Support Personnel	142.98	144.01	139.22	142.97	144.22	148.43	145.08	149.94	145.75	148.27	145.01	147.51	146.32	152.00	150.00
Management/Administration Personnel	891.50	888.50	895.60	890.45	873.85	886.37	886.88	897.07	884.27	890.71	896.11	896.11	903.19	909.00	914.00
Total	**4,989.85**	**5,039.19**	**5,054.09**	**5,102.74**	**5,062.04**	**5,176.83**	**5,071.35**	**5,116.98**	**5,103.70**	**5,140.49**	**5,115.37**	**5,193.31**	**5,150.47**	**5,150.00**	**5,177.00**

Sick leave: Paid sick leave as a % of Paid FTE	*Total Leave Balances:* Utilising Payslip leave balances: Annual leave, Lieu (Alternative Holidays), Lilo (In lieu of Overtime), Long service, etc
	
Overtime: Overtime hours as a % of Paid FTE	*Average Leave Balance per Headcount (note not FTE): A*s above

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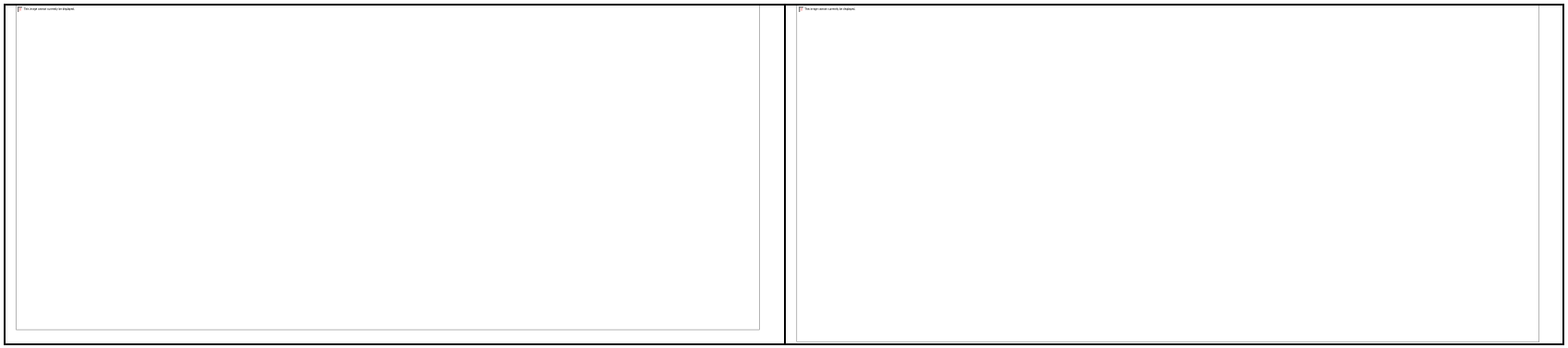

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Hospital Budget Variance

The variance within the hospital is ($92k) YTD.

Positive variances in personnel costs $1.5m YTD due to SMO vacancies predominantly in SWC are offset by;

- Clinical supplies ($1m) mostly in MCC due to PCT drugs (some offset by revenue), other drugs and savings targets not achieved
- outsourced services ($606k)
- Non treatment related costs due to efficiency targets ($427k).

Corporate & Other Exec (Corporate Services, Clinical Support, Executive Office, SIP)

Revenue was favourable as increased special funds revenue. Personal costs including outsourced roles were favourable in Executive areas for the month $7k and across all areas ($230k) YTD. Non treatment related costs are overspent ($405k) for the month and ($1m) YTD. This was due to significant spend on general services (spotless) (relates to ETU SECA cost escalation) and savings targets of $607k not achieved.

Mental Health

Revenue YTD is significantly favourable to budget $524k largely as a result of MSD, NIDCA contracts and forensic courts assessments with consequent costs Personnel cost were favourable to budget $231k for the month and unfavourable ($81k) YTD, increase mainly in Nursing. Increase in overtime, high occupancy in the inpatients units, allowance. Includes a personnel savings target of ($2.1M). Outsourced services unfavourable due to Increase in outsourced clinical services and personnel offset by increase in revenue (courts assessments) and savings from Medical personnel.

SIP (Community Funding)

The variance for the month is positive at $111k and $1.4m YTD as a result of aged care claims.

Reserves

($3.8m) adverse, the reserves directorate contains budgets for the MECA settlements which when finalised are transferred to directorates and additional organisation savings targets. The MECA components are on budget YTD. The savings target budgets are also transferred out as savings identified. The ($3.8m) YTD variance represents the unallocated savings targets YTD.

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The ($3.8m) is split ($2m) of personnel costs that are yet to be offset by services, (this equates to approximately 72 FTE) and ($1.8m) revenue provision for surgical patients.

Balance Sheet and Cash flow

The DHB's overall cash position will improve over the next quarter following quarterly Electives funding from the Ministry. However, cash will drop sharply into overdraft in late January 2020 due to Capital Charge and three payrolls falling due that month.

Deficit support will be needed in 2020, to help manage the large expected overdrafts. Current projections do not include extraordinary cash flows such as Holidays Act settlements which may occur during the year. Current projections do not include one-off extraordinary cash flows where amount and timing are uncertain, such as may occur if there are Holidays Act settlements during the year.

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	BOARD INFORMATION
	Date: 28 November 2019
Authors	General Manager Human Resources and Organisational Development, HVDHB - Fiona Allen Acting Executive Director People and Capability, CCDHB - Stewart Collinson
Endorsed By	Chief Executive, Hutt Valley and Capital & Coast District Health Boards - Fionnagh Dougan
Subject	**2DHB PEOPLE AND CAPABILITY REPORT**

RECOMMENDATIONS

It is recommended that the Boards:

a) **NOTE** the content of the report in regard to the progress being made by HVDHB and CCDHB against the key Regional priorities

APPENDICES (SEE RESOURCE CENTRE)

- Appendix 1 - Living Our Values Programme (HVDHB)
- Appendix 2 - Building a values Led Culture Session Pilot (HVDHB)
- Appendix 3 - Mauri Ora staff wellbeing programme (HVDHB)
- Appendix 4 – Wellbeing Framework and Principles (CCDHB)
- Appendix 5 – Mental Health Awareness Week – 23 to 29 September (HVDHB)
- Appendix 6 - Soifua Moui Lelei Wellness Day (HVDHB)
- Appendix 7 - Shared Values 2019 Manaakitanga Team Poster (CCDHB & MHAIDS)
- Appendix 8 - Shared Values 2019: What does Manaakitanga look like? (CCDHB & MHAIDS)
- Appendix 9 - What does Manaakitanga look like? (CCDHB & MHAIDS)

1. PURPOSE

This report provides the Boards with an update in relation to People and Capability-related activity and outcomes across Hutt Valley and Capital & Coast DHBs. An overview of progress against the Central Region work programme.

2. CENTRAL REGION HUMAN RESOURCES (HR) PRIORITIES

2.1 Priorities

In early May 2019 the Central Region leads reviewed and confirmed their previously agreed regional priorities for the next 12 months. These are:

- Leadership and Talent Mapping;
- Engagement Surveys;
- Values / Culture / Behaviours / Bullying Approaches;

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- People Strategy Frameworks & Development;
- Capability Programme / Framework;
- Dashboard / Data Analysis;
- Holidays Act Compliance / Payroll improvement processes;
- Wellbeing;
- Doing the Basics brilliantly;
- Health & Safety.

Each of the Central Region's DHBs is undertaking work in regard to these priorities and will share learnings and opportunities.

The table below provides a summary of the progress to date in terms of impact for Hutt Valley and Capital & Coast DHBs.

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2.2 Progress against Central Region HR priorities – as at November 2019

Priority Area	HVDHB	CCDHB
Māori Workforce Development	A commitment has been made that all Māori job applicants who demonstrate the core skill requirements in their written application, will progress to interview. Existing recruitment polices and processes are currently being reviewed and updated. Once finalised briefing sessions / training for hiring managers will be developed and implemented.	
Leadership and Talent Mapping • To ensure a consistent approach that is aligned to the SSC Leadership Success profile (LSP) and best practice • Develop strong and committed leaders for the future across the region who contribute to a talent pool enabling sharing and transferability of skills and staff • Create a strong succession pipeline for our DHBs	**Talent Mapping –** The initial report has been produced and a calibration session with the HVDHB ELT is being arranged. This meeting will be facilitated by Kate Coley, Chair of the Central Region GMs HR group (and from Hawkes Bay DHB). There is an option to develop a Central Region Career Board pilot – this is yet to be discussed with the Executive team. **Leadership Development** – Development of a senior leadership programme for the HVDHB executive and senior leaders has been deferred while development outcomes and organisational needs are being reassessed. This work will be resumed early 2020. In the meantime, a management development offering providing core skills based training and learning opportunities for managers continues to be developed; and a management of change programme is being developed in conjunction with CCDHB.	**Talent Mapping** – As a result of the talent mapping process undertaken in 2018/19 a report on the development needs of T2 and T3 leaders including options for development and actions to be taken has been completed. The report will be discussed with the Chief Executive in the first instance and then discussed with individuals and feedback sought. There is an option to develop a Central Region Career Board pilot – this is yet to be discussed with the Executive teams. **Leadership Development** – In 2019 the Emerging Leaders and Frontline Leadership Programme continue. The Frontline Leadership programme continues to be offered across the health system and across Hutt Valley and CCDHB. With the findings of the Clinical Leader Review being considered for adoption the Clinical Leadership Programme is being designed. The offering has a mix of both internal and external offerings. A pilot programme of Leadership Sound Bites for CNMs and CMMs has been successfully piloted and as a result is being offered to other leader groups. The Sound Bites are delivered twice and remote access for satellite sites is being improved. Topics will cover organisational leadership priorities. A management of change programme is being developed in conjunction with Hutt Valley.
Engagement Surveys • Developing an engaged workforce	Work continues to explore possible options for engagement monitoring, both in terms of survey options, but also in terms of developing a more strategic approach to engagement. We are exploring potential survey options (e.g. Qualtrics) and have connected with DHBs across New Zealand regarding their experience. We are currently exploring the possibility of a joined up approach to monitoring of both patient experience and staff experience. This has potential efficiency and cost saving implications and would	

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<table>
<tr><th>Priority Area</th><th>HVDHB</th><th>CCDHB</th></tr>
<tr><td></td><td colspan="2">create a single system for all to navigate – increasing usability. We anticipate that this conversation will develop further as part of the development of the 2DHB Quality and Safety Framework.</td></tr>
<tr><td rowspan="2">Values / Culture / Behaviours / Bullying approaches
Building an organisation culture and values that ensures the delivery of continuously improving high quality, safe and compassionate care
Embedding organisational values
Encouraging positive behaviours and addressing unacceptable behaviours (including bullying)</td><td colspan="2">Values/Culture/Behaviours

Each DHB has values programmes in progress, both of which are designed to enable shared exploration in 2020. We have met together to start to develop a process to support this exploration.</td></tr>
<tr><td>Living Our Values Everyday Programme

Values refresh / values in te reo – as part of the work to shape the top level of our values into a narrative using te reo, we have refreshed the look of the values koru.

The koru is based on the shape of an unfurling fern frond. Its circular curved shape conveys the idea of perpetual movement, and its inward coil suggests a return to the point of origin. The koru therefore symbolises the way in which life both changes and stays the same. When all our values koru are woven together, they are a visual representation of our waka and the journey we are all on together. See appendix 1 for examples of the new values collateral.

Building a values-led culture – We recently piloted a one hour session to support the creation of a values-led culture with the Perioperative team. There was around 100 staff in attendance from a wide range of roles.

The session has been designed to be facilitated by our People Leaders and includes activities that enables teams to:
Know our values and behaviours
Demonstrate how our values are brought to life every day to create and values led culture and positive team environment, and
Know the importance of showing appreciation to each other.</td><td>Shared Values 2019

CCDHB’s Executive Leadership Team has been working to explore the emerging themes from the staff workshops and input. Three values have emerged and we are currently in consultation phase to test these with groups of staff, to fine tune the descriptors and develop a picture of the behaviours which align/don’t align with them. Work is also underway to identify the key organisational areas of focus for embedding values.

Speaking up for Safety (SUFS)

We have now reached 80% of staff trained in Speaking up for Safety and the training component has moved into BAU.

Team SUFS, which focuses on the role of safety leadership in teams and the importance of the wider system supporting our frontline team, has now been piloted and is being further refined.</td></tr>
</table>

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Priority Area	HVDHB	CCDHB
	Positive feedback was received from the team, who has now agreed that as part of their monthly education sessions they will set aside time to focus on each of the values – see appendix 2 for some examples of the session's work outputs. A formal review of the pilot session has been conducted and the resultant feedback has been incorporated into the resources resulting in a more focused and streamlined session guide. Next steps involve planning and organising to run the session with other teams including the Operations Centre, GSG / Orthopaedics / Outpatients. **Speaking up Safely** – As part of our work to design our approach to tackling inappropriate and bullying behaviour we are working alongside CCDHB and WrDHB to review the 'Workplace Bullying, Harassment Discrimination Prevention Policy'. The supporting 'Speaking up Safely' framework and suite of resources will be finalised and introduced as part of the new policy. **BUILD / ABC** – BUILD and the ABC of Appreciation were introduced with our refreshed values and these models are now being further embedded into everyday life at the DHB: • Feedback session which covered both ABC of Appreciation and the BUILD model was incorporated and ran as part of the pilot of the Emerging Leaders Programme in September. **Staff appreciation –** framework introduced which uses our core values to underpin how we reward and recognise our people: • ***Values Postcards*** – being used by all staff as a way of informally showing appreciation to each other. The physical cards have proved extremely popular, and an online eCard has also been introduced to support our focus on sustainability and reducing paper wastage.	

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Priority Area	HVDHB	CCDHB
	• ***Bi-monthly 'Te tohu o ngā uara – living our values awards'*** – first set of awards were presented to recipients at the last Senior Leadership Group meeting in October and communicated via the staff intranet. The December awards will be presented as part of the CE Update being run in early December. It's been pleasing to see a wide range of staff being nominated each time.	
	Workplace Bullying, Harassment, Discrimination and Victimisation Policy Review (3DHB) A collaborative review of this policy is currently underway across the 3DHBs, including Human Resources, Health & Safety, legal, managers, staff and unions in the development of the new policy. A Terms of Reference for the review has been developed and a co-design process is underway. The principles for the review include: simplicity, clarity, alignment with national and sector guidance, and alignment and linkages with DHB associated policies, guidelines, programme and processes (e.g. values, Speaking up). To date, a Terms of Reference has been circulated with key stakeholders and union organisers; meetings with union organisers have been conducted; and a workshop is planned for early December where a draft policy will be developed with the input of HR Managers / Advisors, Employment Relations, Health & Safety, Managers and Professional Leads.	
People Strategy Frameworks & Development • Workforce Strategy • People and Capability Strategy	**Development of a 2 DHB Strategic Approach to People, Culture & Capability** During September our two directorates (Hutt Valley and Capital & Coast DHB) came together to develop a 2DHB strategic approach to People, Culture and Capability. The strategy is in development and provides a strong base for the two services to work together to create a place where people are excited to come to work, able to do their best work and proud to say they work. We identified a joint purpose of enabling our organisation to have the people, culture and capability to support achievement of the quadruple aim of better health outcomes, improved patient experience, improved staff experience and lower cost of care.	
Capability Programme / Framework • Equity Framework	The Central Region CEs have committed to DHBs implementing the Central Region *Equity Framework*. The Framework has a capability section that is focussed on two goals: Increasing equity capacity in DHBs and increasing staff capability and focus on equity actions. Work is underway to develop an action plan to identify actions underway and planned by the DHBs to achieve these two goals. Hutt Valley DHB and CCDHB are contributing to a Central Region Workforce Development Hub Workshop which seeks to collate and learn from the work being undertaken in each of the central region DHBs. This will inform the preliminary plans that are currently forming.	
Dashboard / Data Analysis • Developing a Central Region Dashboard of HR metrics	The Central Region GMs HR have had preliminary discussions on the benefits and possible format of a Central Region Workforce dashboard. Development of a work programme is underway). The Central Region HR Dashboard for the last quarter was not available at the time of writing. This report will be summarised in the next People & Capability update.	

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<table>
<tr><th>Priority Area</th><th>HVDHB</th><th>CCDHB</th></tr>
<tr><td>Holidays Act compliance – nationally agreed interpretation and application of the Holidays Act</td><td colspan="2">A national approach to the implementation of the 20 DHB Holidays Act Compliance Project and assessment against the baseline (interpretations) has been agreed between the 20 DHBs, NZ Blood Service, CTU unions and MBIE. Implementation will be staged over four tranches, with the Auckland metro DHBs and Northland DHB making up the first tranche, and HVDHB and CCDHB scheduled to be part of tranche three, commencing their baseline assessment in January 2020. A national Programme Director, sponsored by the 20DHB CEs forum has been appointed to lead the work programme at a national level.

Planning has already commenced at HVDHB, CCDHB and WrDHB for the project. While HVDHB and CCDHB have different payroll systems, there are economies to be achieved by working collaboratively, e.g. a single project manager for the DHBs can be appointed and there is potential to share project resources. In addition, the collaborative approach across the DHBs will better enable knowledge sharing and a consistent approach to review phase, and alignment of remediation and rectification activities.</td></tr>
<tr><td rowspan="2">Employee Wellbeing
• Support the health and wellbeing of our staff
• Providing a healthy and safe workplace for staff
• Ensure that family violence support programme for staff is implemented and socialised.</td><td colspan="2">2019 Quality Awards Winner
Belinda Davis, our Organisation Development Advisor at Hutt received a quality award for Excellence in the Workplace. This recognises Belinda’s great work in developing and implementing our wellbeing programme, embedding the values, working with our Maori and Pacific staff and a number of other activities associated with these.

Mental Health Awareness Week (23-29 September) provided a great focal point for promotion of wellbeing across our DHBs. MHAIDS led the communications for the week and a wide range of wellbeing activities were available for staff (e.g. walking for wellbeing, yoga/pilates, mindfulness).</td></tr>
<tr><td>#Mauri Ora Staff Wellbeing Programme - (WorkWell Programme)

Work is progressing well to deliver the agreed wellbeing initiatives that form our 12 month action plan:

• WorkWell Bronze Accreditation – HVDHB has been successful in attaining Bronze accreditation from WorkWell / Toi Te Ora. See appendix 3 for WorkWell accreditation report excerpts and logo.
• Mental Health Awareness Week 23 to 29 September – to support staff with exploring their way to wellbeing, a range of free activities were run during the week e.g. mihimihi/pepeha workshops, nurturing you workshops, healthy snacks workshops, mindful movement and yoga. To also reward our clinical ward based staff, a massage therapist was available on site giving free 10 minute chair massages. See appendix 5 for photos from the week.</td><td>Speaking up for Support
Our Wellbeing Framework is now completed and is available on our intranet for staff feedback. Please see appendix 4.
The purpose of the framework is to guide us in creating and continually improving a healthy and safe workplace where our people can thrive, including:

• Identify and eliminate hazards in the workplace that pose a risk of harm to the wellbeing of our people
• Assess and control risks associated with hazards that cannot be eliminated
• Implement structures and practices that support and promote health, safety and wellbeing in the workplace
• Foster a culture that promotes health, safety and wellbeing in the workplace</td></tr>
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Priority Area	HVDHB	CCDHB
	• **Soifua Moui Lelei Wellness Day –** to encourage our Domestic Services staff to look after their wellbeing and offer an opportunity especially dedicated to them, a wellness day was run in October. In partnership with nursing students from Whitireia, staff received a basic wellness check and with community health partners on site, were also able to find out more about the healthy lifestyle programmes on offer to support them and their fanau / whanau. The day was such a resounding success for both HVDHB, Whitireia and our community partners, the next one has already been scheduled in 2020! See appendix 6 for quotes and photos from the day. • **Upcoming initiatives –** work is underway to run a financial health session on 12th December. Feedback from Domestic Services staff from the recent wellbeing day indicated they wanted information around financial wellbeing and budgeting and will be given priority in relation to attending; however, we plan on opening this up across the DHB as many staff would benefit from this. We have a resin picnic table and seats which has been generously donated to Mauri Ora. These will be installed beside the Kōwhai tree which was planted outside Pilmuir House as a commitment to staff wellbeing. To support our partnership with the Sustainability Group and offering staff an eBike Buying Scheme, we are making the bike storage facility behind ED secure (just awaiting on the work being completed) Planning is also underway in relation to organising a session aimed at people leaders and leading mental health in the workplace. We anticipate that this will be completed in the first quarter of 2020.	

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Priority Area	HVDHB	CCDHB
Doing the Basics brilliantly - Excellent people processes; Skilled and capable managers	**Managing Leave** – HVDHB maintains a strong focus on leave management. Improvements to the leave management, planning and reporting will be investigated alongside the Holidays Act remediation project. **Induction** - An initiative to improve the experience a new employee when joining the DHB is underway: • The kete of knowledge will be gifted to all new staff providing them with important organisational information so they quickly assimilate into the DHB. The aim is to pilot the booklet with new employees who attend the next Pōwhiri / Strategic Overview on 25th November. • A Manager Checklist will ensure new employees are supported by having all the tools needed to start their job, are able to start building connections in their own team and across the DHB, and that their experience is consistent with our values. • Work is underway to provide new graduates who begin at Hutt Valley DHB with more wellbeing related information when they commence: o Shift work and sleep – how to structure sleep to ensure you get back to a regular routine o Shift work and eating well – what to eat and when on shift work o Financial wellbeing – offer of a free financial health check (achieving financial goals, how to reduce debt, kiwisaver etc.) o Keeping mentally healthy - some tips to help them stay mentally healthy, how to cope with stress, emotions of the job, EAP etc. This pack will be issued to new graduates who begin in January 2020.	**Managing Leave** – CCDHB continues to maintain a strong focus on effective leave management. This includes: • A particular focus on the leave profiles of SMO's in the Payroll system prior to the end of this financial year. This project is still in the planning stage. • The identification of leave leakage across all roster staff, excluding SOM's. The issue has been addressed growing forward, with a new auditing tool/process. It is estimated it will save in excess of $1 million in the current year, and a further $1 million from the previous 2 years. • Reducing overall leave is being addressed by allowing staff to go into deficit by 5 days (more for some MECAs) This has commenced. • A promotional campaign is encouraging staff to take breaks to support a rested and safe workforce. • Implementation of the Qlik Sense reporting tool is allowing for more accessible HR information. A webpage mash-up of key HR metrics, including Leave, means Leave management information is more available to and accessible for Qlik users across CCDHB. • Improvements to the Leave Management capabilities of the Payroll system, by upgrading to leave manager module. • As noted above, work continues on improving our Recruitment processes and approach, on-boarding new employees and assessing the capabilities of our HR systems. **Recruitment** The delegation for all recruitment has been withdrawn to the CEO, general nursing positions being reviewed daily, and other positions weekly. Vacancies are being prioritised according to their contribution to patient and staff safety, as a first priority. The budget includes an expectation that the vacancy rate will be equal to last year's actuals.

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Priority Area	HVDHB	CCDHB
Health & Safety • Effective and embedded health and safety practices within the DHB • A health and safety culture that supports a safe healthy workplace and employee wellbeing	At HVDHB the Workplace Health and Safety Manager vacancy is still unfilled however a Senior Health and Safety Advisor appointed in August is acting in the role. The function is now under review as part of the move to a 2DHB model. The DHB operates the ACC Accredited Employer Programme which dropped from Tertiary to Primary level as an outcome of recent ACC Audit – key areas for improvement were Fire preparedness and Worker participation and both are currently under action. Work is continuing in the areas of Manual/Patient Handling and Hazardous Substances, and our Occupational Nursing function increased staff vaccination numbers this year to 77%. A draft Lone Worker / Community Worker Safety policy will be released for consultation in November and other policies are under development. Recent refresh Health and Safety training for managers, and Health and Safety Representatives (HSRs) was well attended and 15 new HSRs have also been elected and trained to Level 1. A focus for the next few months will be to increase health and safety communication across the DHB and to more fully engage with managers and HSRs. HVDHB, along with Hawkes Bay and Auckland DHBs received Innovation in Health and Safety Award at the Safest Place to Work Awards held in Auckland on 14 November. The innovative award is for businesses who have demonstrated truly outstanding innovative practices that fundamentally shift the safety dial in a way that improves the outcomes for themselves, their workers and community. The 3 DHB's are working in partnership with Safe 365 and ACC in growing H&S capability with our contractors and service providers. The work is being funded through an ACC "Workplace Injury Prevention Grant".	At CCDHB the Health and Safety function reports to the GM, Corporate Services. A separate CCDHB Health & Safety report has been provided to the joint Board meeting.

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Appendix 1 – Living our values programme

Refreshed values logos:

Refreshed values collateral:

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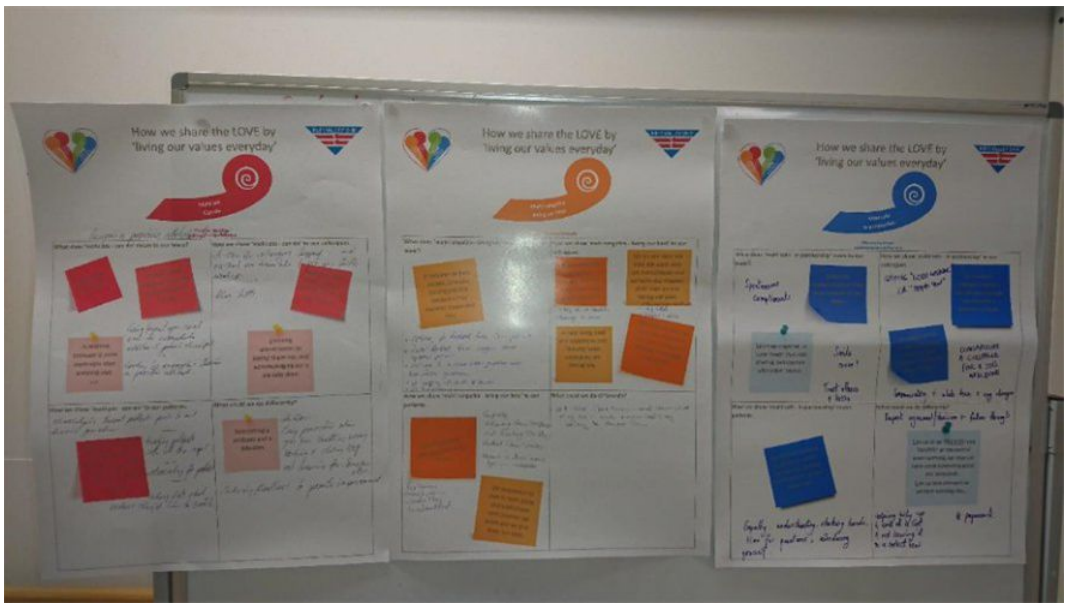
Appendix 2 - Building a values led culture session pilot



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Appendix 3 – Mauri Ora staff wellbeing programme

WorkWell Bronze Standard Accreditation Assessment Report comments and accreditation logo:

Workplace:	Hutt Valley District Health Board
WorkWell Leader:	Belinda Davis
WorkWell Advisor:	Natasha Barlow-Kasibante
WorkWell Assessor:	Dave Wood
Portfolio submission date:	11 July 2019
On-site assessment date:	30 August 2019
Assessment completion date:	1 October 2019

Outcome:	Achieved

"The assessor was impressed with the quality of evidence provided for the Bronze online portfolio. The amount of evidence in relation to the communication steps and the quality of their unique Mauri Ora action and evaluation plan was impressive. Combined with the observations and interviews from the site visit, it is clear that the Hutt Valley DHB is implementing a WorkWell Bronze Standard workplace wellbeing programme.

The assessor would like to acknowledge the obvious dedication and enthusiasm of the working group, and in particular, the wellbeing the leader. It was clear through the comments received within the interview process, that the wellbeing leader has been a key component to the success of this programme.

The assessor would also like to acknowledge the commitment of Hutt Valley DHB to intentionally target the harder to reach staff members and those with the greater health and wellbeing needs. In terms of addressing health inequities, a goal of Toi Te Ora Public Health and the WorkWell programme, it's pleasing to see the Hutt Valley DHB prioritise this in their Mauri Ora programme."

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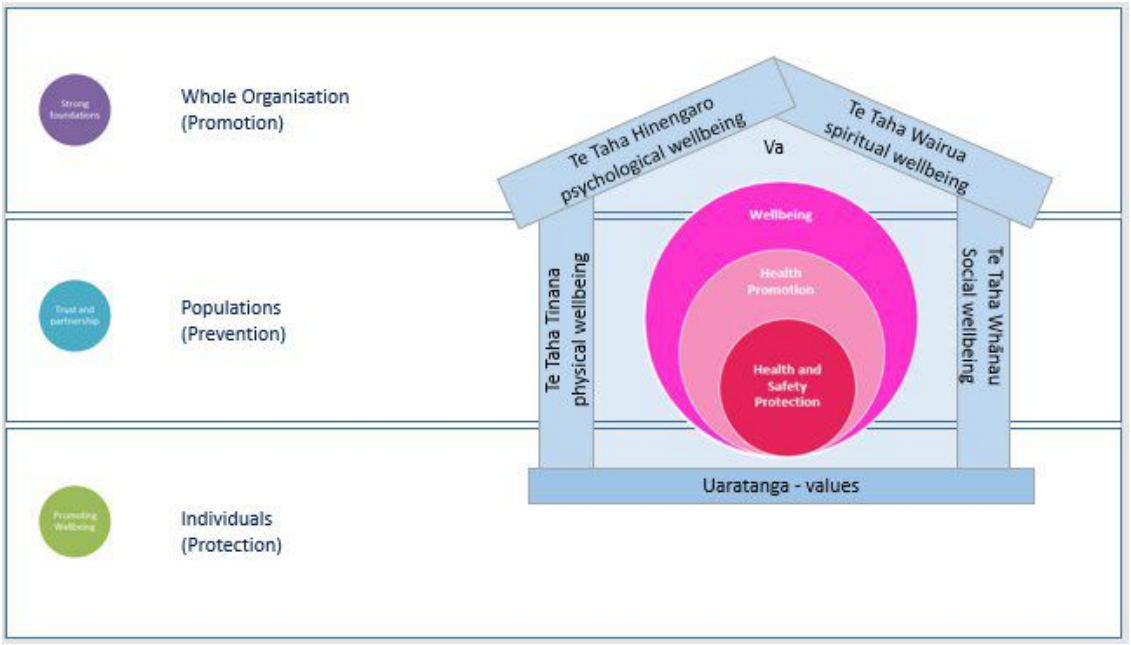
Appendix 4 - Wellbeing Framework and Principles - CCDHB



PRINCIPLES

People who work here, can thrive here

We bring our whole selves to work

We celebrate and honour diversity

Health, Wellbeing and Safety are part of one whole

We are all responsible for creating a safe and supportive workplace

We support better health outcomes for all

Principle 1: People who work here, can thrive here

Our goal is, in addition to hazards management, to be able to proactively support and promote health and wellbeing. That when harm occurs, we have resilient teams and people, with systems, processes and resources to support them.

Principle 2: We bring our whole selves to work

Incorporating Te Whare Tapa Wha as core to the wellbeing framework, reminds us that we bring our whole selves to work. Wellbeing, includes physical, psychological, spiritual and social wellbeing, at work and in life outside of work. Individual wellbeing reflects both of these contexts and our aim is to increase understanding of health and wellbeing.

Principle 3: We celebrate and honour diversity

The foundation of values in our wellbeing framework, recognises the strength that comes from a diversity of perspectives, experience and identity. A key intention of our wellbeing approach is to build a culture of identity, pride, connectedness and belonging. We aim to foster inclusive work environments where differences in what people bring, are valued.

Principle 4: Health, Wellbeing and Safety are part of one whole

The pink circles in our wellbeing framework (derived from the Worksafe model) represent the principle that health, safety and wellbeing are part of one whole and support and influence each other. If the wellbeing of the organisation is robust; with a strong sense of purpose and high levels of belonging and engagement, resilience will be enhanced and the risk of harm reduced. Strong organisational wellbeing, supports populations to live healthy lives, with prevention of poorer health and wellbeing outcomes as the result. A robust and resilient workforce are more able to monitor, anticipate and proactively ensure health and safety protections are effective, reducing risk of harm. A robust and resilient organisation will be able to respond effectively when harm occurs.

Principle 5: We are all responsible for creating a safe and supportive workplace

We are all part of a community, a complex interactive system in which we both impact the wellbeing of others and which impacts our own wellbeing. We have a responsibility as an organisation to address behaviours which impact negatively on the health and wellbeing of our people. Unwarranted behaviours include violence and aggression, discrimination, racism and bias. Individuals have a responsibility for their own health and wellbeing and for the impact of their behaviours on the wellbeing of others within our work community. The Pacifica concept of le va, refers to the space between, not the space that separates but the space that connects, that holds separate entities and things together in unity[1].

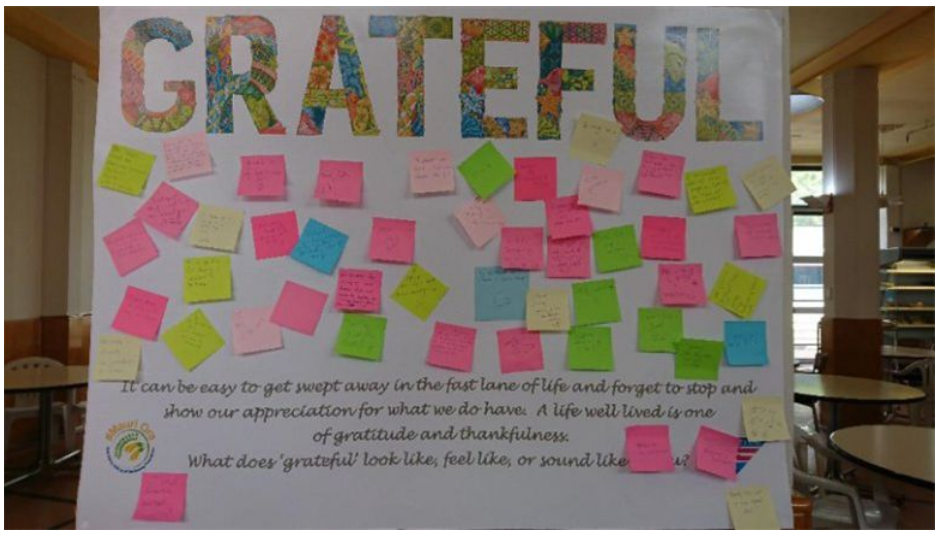
Principle 6: We support better health outcomes for all

We have considered our work community as a microcosm of NZ society, with our workforce of 6000+, and have considered public health data regarding health and wellbeing outcomes for different groups within. Our framework therefore reflects a layer of activity focussed on the whole organisation, a layer of activity which focusses on priority populations and a layer which focusses on individual wellbeing. The three segments of the framework (whole organisation, populations, individual) recognise and reflect this. Our organisation plays a critical role in facilitating access to health and wellbeing information and resources for our people.

[1] Albert Wendt. “Our va with others defines us”. Inside Out: Literature, cultural Politics and Identity in the New Pacific. (1999).

PUBLIC

Appendix 5 - Mental Health Awareness Week 23 to 29 September



PUBLIC

Appendix 6 - Soifua Moui Lelei Wellness Day

Quote from Debbie Jennings, Manager Domestic & Support Services:

"It was a fantastic opportunity for 2nd year nursing students to be able to educate and complete basic health checks for our domestic staff. Despite some staff being nervous; being able to pop upstairs with their peers as support made it such a positive experience. The day was a great success and staff can't wait for the chance to do it again."

Quotes from second year nursing students from Whitireia:

"A highlight of the day was getting to experience doing blood pressure on our older generation and helping them to understand what all the numbers mean to them. Also getting a better understanding of English words we use to describe something and using the Samoan equivalent to help better explain it. It was an overall great experience!"

"I really enjoyed taking part and particularly enjoyed meeting new people especially when I was offering advice on improving their health, it actually felt like I was making a difference."

Community Health Partners in attendance: HVDHB Occupational Health, Melon health, Sport Wellington, BreastScreen Aotearoa and the Cervical Screening Programme, the Bowel Screening Programme and Tākiri Mai Te Ata Regional Stop Smoking Service.

PUBLIC

Appendix 7 - Shared Values 2019 Manaakitanga Team Poster (CCDHB and MHAIDS)

PUBLIC

Appendix 8 - Shared Values 2019: What does Manaakitanga look like? (CCDHB and MHAIDS). Developed from over 100 team posters.

PUBLIC

Appendix 9 - Shared Values 2019: What does Manaakitanga look like? (CCDHB and MHAIDS). Developed from posters in patient waiting areas and a review of recent patient compliments.

PUBLIC

HUTT VALLEY DHB	BOARD DISCUSSION
	Date: 28 November 2019

Authors	Director Māori Health - Kerry Dougall
Endorsed by	Chief Executive - Fionnagh Dougan
Reviewed/approved by	The Executive Leadership Team
Subject	TE PAE AMORANGI – INCREASING MĀORI WORKFORCE UPDATE

RECOMMENDATIONS

It is recommended that the Board:

a) **NOTES** the work underway through Te Pae Aronga Tuatahi – Increasing Māori workforce across the system;

b) **NOTES** the 20 DHB CE's endorsement of Te Tumu Whakarae's position statement on increasing Māori participation in the workforce and the approved six targets to support the position statement and increase Māori participation in the workforce;

c) **NOTES** the development of a funding plan for the implementation of Te Pae Amorangi.

APPENDICES

1. Kia Ora Hauora Hutt Valley DHB Statistics – August 2019
2. Email regarding 20 DHB CEs endorsed Te Tumu Whakarae's position statement on increasing Māori participation in the workforce
3. Māori representation within DHB employed workforces as at 30 June 2019.

1. PURPOSE

The purpose of this paper is to provide the Board with an update on Māori Workforce

Ko te Amorangi ki mua, ko te hāpai ō ki muri
The leaders in the front, the workers behind

2. STRATEGIC WORK PROGRAMME

2.1 Te Pae Aronga Tuatahi – Increasing our Māori Workforce Across the System

2.1.1 Hutt Valley DHB collaborates with YOUth Inspire

Former Lower Hutt Mayor Ray Wallace championed YOUth Inspire. This nationwide Mayors' Taskforce for Jobs initiative is committed to building a brighter future for all young people in Aotearoa. Their focus is to ensure all young people under 25 are engaged in meaningful education, training or employment.

On Wednesday 4 September the Hutt Valley DHB's Māori Workforce Coordinator hosted 36 rangatahi that are currently taking part in the YOUth Inspire Programme. The purpose of the session was to

inspire rangatahi to pursue a career in Health. A mix of DHB employees and placement students were on hand to share their stories and their journeys into a career in health.

A number of the rangatahi will follow up the session with four weeks work experience at the hospital. This session was the first of what will be an annual event and next year we plan to include hospital tours.

2.1.2 Whakapumautia te Aroha, Hutt Valley DHB's Māori mentoring programme

Whakapumautia te Aroha is a programme being developed by Māori for Māori to invest, grow and develop our Māori workforce.

Whakapumautia te Aroha is based on the ancient practice of Tuakana-teina mentoring relationship. This traditional practice connects the learners and teachers as one, and creates a reciprocal learning space;

- Kanohi ki te kanohi is an effective method for developing trust, learning and teaching;
- Whānaungatanga is vital to create strong relationships, based on respect, reciprocity and trust

The intention of the programme is to grow the Māori workforce across all areas, with a focus on Māori leadership and development.

We plan to launch a pilot programme in February 2020, and have already had expressions of interest from potential tuakana who will koha their time and energy to this.

2.1.3 Creating a Board level governance seat for Rangatahi Māori to be exposed to and participate in governance

A paper outlining the proposed approach has been presented and endorsed by the HVDHB Executive Leadership Team.

The key benefits of creating a Board level governance seat for Rangatahi Māori are:

- To grow interest in health governance with Rangatahi Māori
- To enable and encourage increased Māori participation in decision-making at a governance level
- Inclusion of Māori members on government boards has many benefits for New Zealand, Māori and the board members themselves

- Enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities and development as a people, is a key thread of He Korowai Oranga.

We now seek endorsement from the board to progress this to the next stage and to have a rangatahi in this role for the first board meeting of 2020.

2.1.4 Increasing our Maori Workforce through policy

Māori and Pacific workforce development and recruitment is a National priority for all District Health Boards.

Our Māori Workforce Development Coordinator has drafted the following policies which have now been handed over to Human Resources to finalise and implement:

- Māori Workforce recruitment Policy
- Progression of eligible Māori and Pacific applicants to interview policy.

The Māori Workforce Recruitment Policy seeks to improve the way we recruit by making the process culturally appropriate. The policy will ensure that all Hutt Valley DHB advertisements are designed to attract Māori applicants and will include an organisation diversity statement, a Māori welcome, a whakatauki and a DHB kowhaiwhai.

The Progression of eligible Māori and Pacific applicants to interview policy will see all Māori and Pacific candidates who meet the criteria for the role applied for automatically shortlisted for an interview along with any other candidates who meet the position criteria.

2.1.5 Rangatahi Pipelines into Health

We are in the process of creating a working group to focus on developing a pipeline programme which will be delivered in targeted schools with high Māori populations. The working group will explore current successful models across the DHB region to draw from their learnings.

The intention will be to work with identified rangatahi from years seven through too years thirteen.

The programme will include a focus on building individual goal plans to focus on;

- NCEA credits
- Building science and maths knowledge
- Mentoring and leadership
- Exposure to the wide range of health careers.

2.1.6 Annual Work Exposure Days for Rangatahi Māori

On 20 May College students from throughout the Wellington and Hutt Valley region, took part in a Work Exposure Day at Wellington regional hospital, a programme that aims to show students what it is like to have a career in health.

The day is a collaboration between the district health board and Kia Ora Hauora, a Maori health workforce programme. Our Hutt Valley DHB Maori Workforce Development Coordinator attended and took along a group of rangatahi from Te Ara Whanui Kura Kaupapa.

The invitation was extended to secondary school Maori classes with 85 students, in years 9, 10 and 11, taking part. The students rotated around different workshops designed to show them what life as a health professional would be like. They ranged from midwifery to physio-therapy, through to a simulated surgery where students took the roles of nurses and an anaesthesiologist.

The day was hugely successful and will be an annual event from 2020.

3. INVESTMENT PLAN FOR IMPLEMENTATION

A well-trained and sustainable health workforce is a fundamental building block of a strong health system. As a DHB we know we must do better to deliver on our objective to reduce and eliminate inequity, particularly for Māori. Te Pae Amorangi – Hutt Valley DHB Māori health Strategy will help us focus our efforts and inform our decision making to accelerate improvements in Māori health outcomes.

Te Pae Amorangi explicitly builds off the principles for decision-making provided in *Our Vision for Change*, these principles are a critical driver of the financial and non-financial performance of the DHB. We know that how we deliver health services has a big impact on health outcomes and so we will look at how we invest, how we work in partnership with and across our communities, and how we engage across the sector.

For the next nine years we will focus our efforts and investments on five key focus areas:

- Workforce
- Organisational Development and Cultural Safety
- Commissioning
- Mental Health and Addictions; and
- First Thousand Days.

By addressing these focus areas we will challenge the 'status quo' and long standing 'cultural norms' of our organisation that no longer support us to achieve our goals.

The Director of Māori Health is currently working on the development of an investment plan for the implementation of Te Pae Amorangi. The investment plan will include the need for Hutt Valley DHB to reinvest it's current expenditure to enable the delivery of Te Pae Amorangi, and will include a focus on investment in:

- Leadership Training and development for the DHB's Maori Workforce
- Support for Whakapumautia te Aroha, Hutt Valley DHB's Māori mentoring programme
- Governance training and meeting attendance fees for rangatahi Maori board governance seats.

Kia Ora Hauora
Supporting Māori into Health

HUTT VALLEY DHB STATISTICS | AUGUST 2019

NATIONAL DATA

3,189

TOTAL MĀORI REGISTERED ON THE KIA ORA HAUORA THE DATABASE

TOTAL # TERTIARY STUDENTS
1,685

TOTAL # SECONDARY STUDENTS
805

GENDER: 81% 2,597 | 18% 577

AGE:

UNDER 25	26-40YRS	41+YRS	NOT STATED
56% 1,779	21% 657	9% 281	15% 472

CURRENT STATUS:

EMPLOYED IN HEALTH SECTOR	15%
EMPLOYED IN OTHER SECTOR	4%
SECONDARY STUDENT	25%
TERTIARY STUDENT	53%
TBC	3%

* DATA AS OF 1 AUGUST 2019

HUTT VALLEY DISTRICT HEALTH BOARD DATA

57

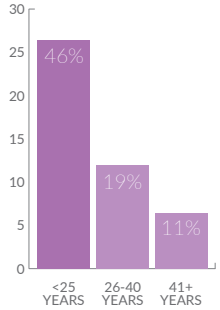
TOTAL ON THE DATABASE

GENDER:
FEMALE 79% (45) MALE 21% (12)

CURRENT STATUS

EMPLOYED IN HEALTH SECTOR	14% 8
EMPLOYED IN OTHER SECTOR	9% 5
SECONDARY STUDENT	21% 12
TERTIARY STUDENT	56% 32

AGE: NOT STATED: 14



SECONDARY STUDENTS: 12

YEAR LEVEL	YR9	YR10	YR11	YR12	YR13
TOTAL	1	1	0	0	10

TERTIARY STUDENTS: 32

1ST YR	2ND YR	3RD YR	4TH YR	5+ YR
9	8	6	5	4

KOH TERTIARY DHB ENGAGEMENT SURVEY DATA

TOTAL # OF TERTIARY STUDENTS WHO ENGAGED IN OUR DISTRICT HEALTH BOARD SURVEY
499

TOTAL # IN DHB SURVEY WHO SELECTED HUTT VALLEY DHB AS THEIR 1ST CHOICE FUTURE EMPLOYER
6

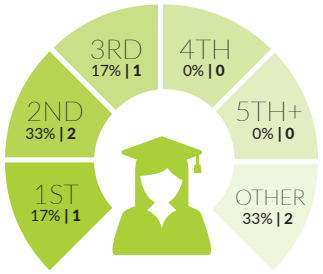
AREA(S) OF STUDY:

NURSING	COUNSELLING	PHARMACY	OTHER
1	1	1	1

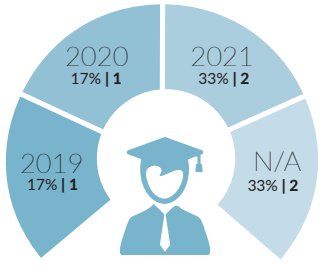
PLACE OF STUDY:

OTAGO UNI.	WHITIREIA	WELTEC	WINTEC
1	1	1	1

MOST HELPFUL SUPPORT SERVICES UPON GRADUATION:



WHAT YEAR OF STUDY ARE YOU CURRENTLY IN?



WHAT YEAR DO YOU EXPECT TO GRADUATE?

1 HAS GRADUATED, 1 IS LOOKING FOR CORRECT STUDY PATHWAY TOWARDS COUNSELLING

REASONS FOR WANTING TO WORK AT HUTT VALLEY DHB/AREA:

- Local
- Family, friends and my partner live there.
- I currently live in the Hutt Valley region.
- Working with familiar people in the Hutt Valley as I grew up here
- Close to home and am familiar with the environment etc
- Close to home, to whanau.
- A friendly team environment, where everyone is supportive.
- Travel time. Cost
- Effective communication
- Cultural Consideration
- Mutual Respect
- the people (good dynamic) being able to practice in a maori kaupapa way.
- Environment, Customer Service, Work Ethic
- Team work

From: Kirsten Holley <Kirsten.Holley@tas.health.nz>
Sent: Tuesday, 1 October 2019 1:05 PM
To: O365.DHB - CEOs <DHB-CEOs@tas.health.nz>; O365.DHB - CMOs <DHB-CMOs@tas.health.nz>; O365.DHB - COOs <DHB-COOs@tas.health.nz>; O365.DHB - GMs Human Resources <DHB-GMsHumanResources@tas.health.nz>; O365.DHB - Directors of Allied Health <DHB-DirectorsofAlliedHealth@tas.health.nz>; O365.DHB - Lead DoNs <DHB-LeadDoNs@tas.health.nz>; O365.DHB - Lead DoNs <DHB-LeadDoNs@tas.health.nz>; O365.DLIST.DHB-GMs Maori <DLIST.DHB-GMsMaori@tas.health.nz>; O365.DLIST.DHB-GMsPlanningandFunding@TAS <DHB-GMsPlanningandFunding@tas.health.nz>
Cc: O365.DHB - COOs EA <DHB_COOs_EA@tas.health.nz>; O365.DHB - CFO EAs <DHB-CFOEAs@tas.health.nz>; O365.DHBSS - Workforce Team <DHBSS.WorkforceTeam@tas.health.nz>; O365.DLIST.DHBWorkforceStrategyGroup.TAS <DLIST.DHBWorkforceStrategyGroup.TAS@tas.health.nz>; Anna Clark <Anna.Clark@health.govt.nz>; O365.DHB - Chairs <DHB-Chairs@tas.health.nz>; john.whaanga@health.govt.nz
Subject: All DHBs – ACTION REQUEST #58- Increasing Māori participation in the DHB employed workforce

All DHBs- ACTION REQUEST #58- Increasing Māori Participation in the DHB employed workforce

TO: DHB - CEOs, DHB - DAHs, DHB - DONs, DHB - CMOs, DHB - COOs, DHB - GMs Planning and Funding, DHB - GMsHR, GMs - Māori

CC: DHB - Chairs
Anna Clark
John Whaanga
Workforce Team
Workforce Strategy Group

From: Helen Mason, Chair - Workforce Strategy Group and Riki Nia Nia, Chair - Te Tumu Whakarae

Kia ora koutou

Earlier this year, the 20 DHB CEs endorsed Te Tumu Whakarae's position statement on increasing Māori participation in the workforce, and in May 2019 approved six targets to support the position statement and increase Māori participation in the workforce. We now need to capture, track and report on progress against the targets. This is a key piece of work for the Workforce Strategy Group in partnership with Te Tumu Whakarae.

We are pleased to share with you the attached infographic that provides a current overview of the Māori representation within the DHB employed workforce as at 30 June 2019. This has been created by TAS using the Health Workforce Information

Programme (HWIP) data and the infographic was endorsed by the Workforce Strategy Group to help inform the following targets. It provides a benchmark/point-in-time to then monitor progress. Targets four and five are qualitative measures and are not able to be measured via HWIP. We will seek information from DHBs via an All DHBs request and will provide an update once this information has been collated.

All DHBs will actively grow their Māori workforce to achieve a Māori workforce that reflects the proportionality for their Māori population.
Target One – Each DHB will have 0% of employees who have their ethnicity recorded in their employee profile as "unknown" by 30 June 2020 – report quarterly
Target Two – Each DHB will employ a Māori workforce that reflects the Māori population proportionality for their region by 2030 – report annually.
Target Three - Each DHB will employ a Māori workforce with occupational groupings that reflect the Māori population proportionality for their region by 2040 – report annually.

TAS will work with the DHBs to help improve the data reported on ethnicity, providing those records that have been reported to the national collection with an 'unknown' ethnicity to the respective DHB. The DHBs can then check their internal HR records and if required ask staff to update their records. TAS and the DHB GMsHR have agreed that the only true 'unknown' ethnicity code is 95555 – refused to answer. This will be the only code accepted into the national collection from the end of the year.

All DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whānau.
Target Four - All DHB staff (clinical and non-clinical) who have contact with patients and whānau, Board members and those in people management or leadership roles will demonstrate participation in cultural competence training by 2022 - report staff and Board member participation in cultural competence training as a percentage of these groups over the last 3 years by 30 June 2020 then monitor annually.

3. All DHBs will measure and report on the recruitment and retention of Māori staff in clinical and non-clinical occupations.
Target Five – In each DHB 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview - report by October 2019, then monitor quarterly.
Target Six- In each DHB, turnover for Māori staff will be no greater than the DHB turnover for all staff - report quarterly.

Action: All DHBs should review their information and discuss strategies to increase their proportionality across all workforce groups.

For further information on this work, or the infographic, please contact Brenda Hall (Brenda.Hall@tas.health.nz) or Amanda Newton (Amanda.Newton@tas.health.nz) at TAS.

Ngā mihi nui

Helen Mason
Chair, Workforce Strategy Group

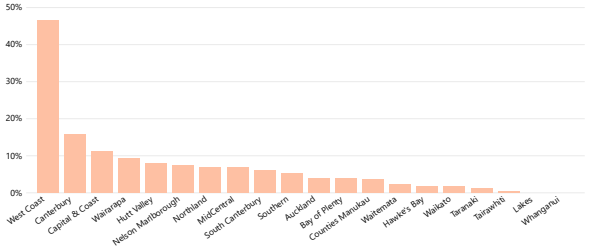
Riki Nia Nia
Chair, Te Tumu Whakarae

Māori representation within DHB employed workforces as at 30 June 2019

(Informing the Te Tumu Whakarae position statement and Workforce Strategy Group targets)

TAS Kahui tuitui tangata

Target one - Proportion of DHB employed staff whose ethnicity is reported as 'Unknown'

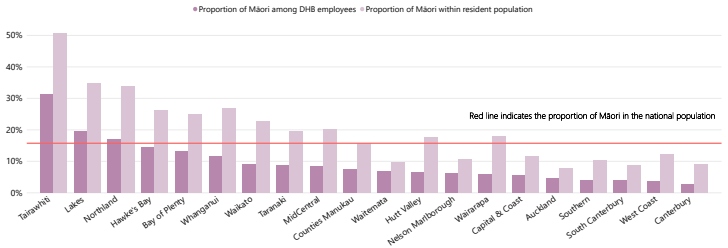


Although the proportion of DHB employees whose ethnicity is reported as 'Unknown' has been trending down in recent years, it still accounts for a sizeable number of employees.

While we are unable to determine what proportion of these 'unknowns' are likely to be Māori, the high proportions at some DHBs will impact on tracking any increase in representation, i.e. some increases may be made simply by improved reporting on existing staff rather than actual changes in representation.

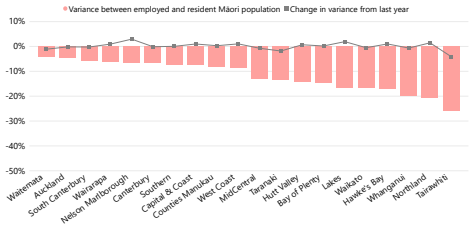
In terms of Māori representation in the workforce, all the DHBs have a lower proportion of people reported as Māori in their workforce than in their estimated resident populations.

Target two - Proportion of DHB employed staff identified as Māori

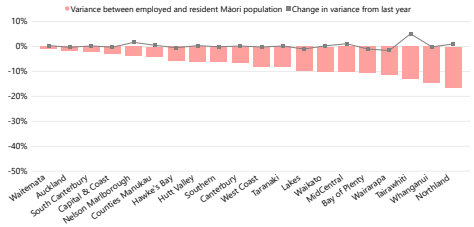


Target three - Differences between reported proportions of Māori within HWIP occupation groups and estimated proportions of Māori within resident population (including change from the same period 12 months ago)

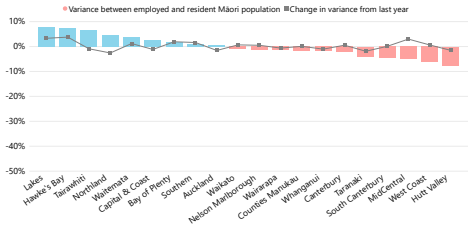
Variance between proportion of Māori employed in Allied and Scientific roles and resident population



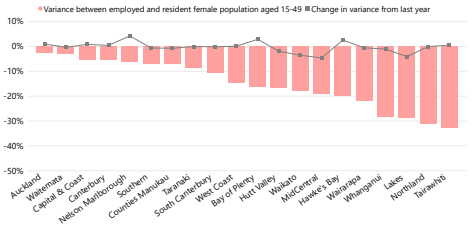
Variance between proportion of Māori employed in Corporate and Other roles and resident population



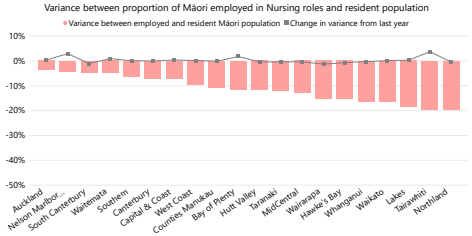
Variance between proportion of Māori employed in Care and Support roles and resident population



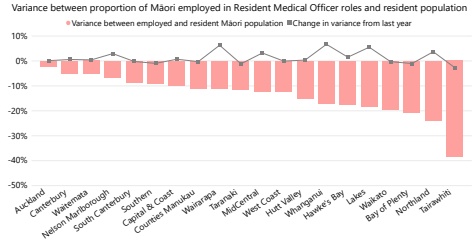
Variance between proportion of Māori employed in Midwifery roles and female population aged 15-49



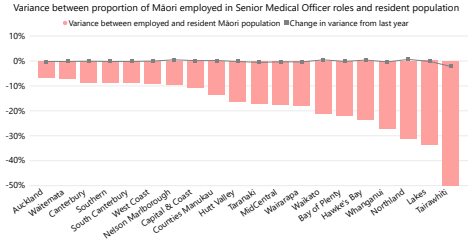
Variance between proportion of Māori employed in Nursing roles and resident population



Variance between proportion of Māori employed in Resident Medical Officer roles and resident population



Variance between proportion of Māori employed in Senior Medical Officer roles and resident population



Across all occupation groups, except Care and Support, the proportion of staff in DHBs identified as Māori is lower than the estimated proportion of Māori within their resident populations.

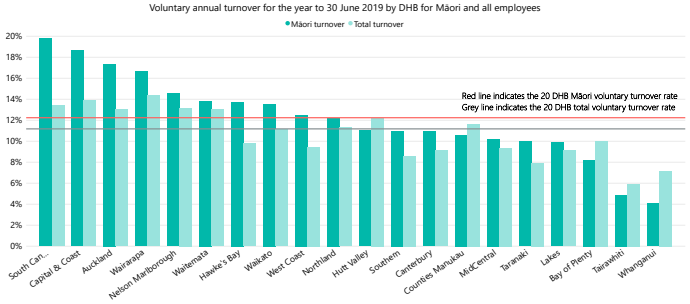
The occupation groups with the largest Māori under-representation were Senior Medical Officers and Midwifery. However, the overall low numbers of these occupations in some DHBs may be part of the reason behind the large variances.

Overall, Auckland and Waitemata tended to have a smaller variance between the proportion of Māori in the workforce compared to the resident population.

For the majority of DHBs, the change in Māori representation compared to June 2018 has been small, especially for Senior Medical Officers. There have been some larger increases in the representation of Resident Medical Officers for some DHBs, but some of this change may be transitory due to the mobile nature of this workforce.

Target six - Comparison of annual voluntary turnover for Māori staff relative to all DHB employed staff

Voluntary annual turnover for the year to 30 June 2019 by DHB for Māori and all employees

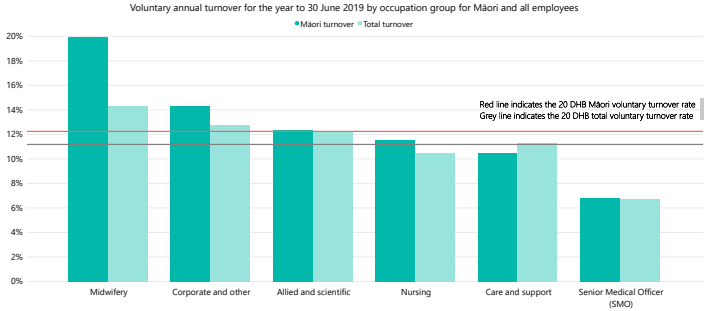


For most of the DHBs, voluntary annual turnover rates for Māori are higher than the rates for all employees. In some instances, this can be driven by the low number of Māori employees, especially in smaller DHBs.

Five DHBs have Māori turnover rates lower than the total turnover: Bay of Plenty, Counties Manukau, Hutt Valley, Tairāwhiti and Whanganui.

When we look at turnover by occupation group, there is no significant difference between Māori employees and all employees, except for Midwifery. However, this may be linked to the low number of Māori working as midwives.

Voluntary annual turnover for the year to 30 June 2019 by occupation group for Māori and all employees



Data extracted from the HWIP database on 12 September 2019. Data reflects people employed by the 20 DHBs as at 30 June 2019. Data excludes casuals, contractors, those on parental leave or on leave without pay. Resident population projections for DHBs have been supplied by Stats NZ. Voluntary turnover calculations exclude Resident Medical Officers (RMOs), people employed on a fixed term, as well as people who ceased employment due to restructure/redundancy, dismissal, death or for health reasons.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DISCUSSION**
	Date: 28 November 2019
Author	Executive Director Corporate Service — Thomas Davis
Endorsed	Chief Executive – Fionnagh Dougan
Subject	**NEW CHILDREN'S HOSPITAL PROGRAM OF WORKS STATUS REPORT**

RECOMMENDATIONS

The Portfolio Board recommends the Board:

(a) **Notes** there have been 2 minor, non-personal harm incidents, since the last report.

(b) **Notes** that McKee Fehl are forecasting Project Handover on 14th April 2021 @ 12.10.2019

(c) **Notes** that the CCDHB internal FM & clinical teams & CCDHB external consultants are continuing to assist with input, for the Benefactors team in working towards 100% Detail Design.

(d) **Notes** that a design sign off package & sign off document for the CE's approval, is progressing

(e) **Notes** that FF&E is in final stages of review with clinical teams

(f) **Notes** that the Electrical Services parcel of work, is entering the procurement stage

(g) **Notes** Grace Neill – L3 Reconfiguration - Naylor Love construction work has commenced.

(h) **Notes** WRH – WBCC, Building Consent has been lodged with Council. Subcontract tender underway.

APPENDIX

1. Site Photos.

1. INTRODUCTION

1.1 Purpose

The purpose of the paper is to inform the CCDHB PCG of the progress with the new Children's Hospital Program of Works. The CCDHB new Children's Hospital Program of Works (projects) includes:

- New Children's Hospital (NCH) project (undertaken by the Benefactor)
- Subprojects – enabling projects;
  - Engineering Services (Procurement stage)
  - Furniture Fittings & Equipment (FF&E)
  - WRH L3 Link & WRH WBCC Reconfiguration
  - Car parking (temporary locations)
  - Civil Diversion works (now complete)
  - Demolition works (now complete)

2. UPDATE

2.1 Health & Safety

There have been two minor incidents during Oct 2019.

34) Crane Load Requests
There was a verbal disagreement between the crane operator and a sub-contractor waiting for his load to be lifted
35) Concrete Pump cleanout
Whilst cleaning a concrete pump, over spray slurry had landed on Margret Steward House – this was cleaned up.

SiteSafe audits continue with McKee Fehl Construction (MFC) achieving a score of 95.5% for October. Each month MFC are issued with Actions/Correction notices that need to be addressed and that evidence to be returned to the CCDHB Project Team by SiteSafe, prior to the next SiteSafe visit.

2.2 Benefactor progress

The Benefactor's builder, McKee Fehl Constructors (MFC), are progressing with the installation of the structural steel. Offsite manufacturing & procurement continues. Updated site photos attached.

Site Works completed during October 2019 includes;
Primary structural steel frame from grids A to F erected.

- Columns up to and including grid E concrete filled
- Perimeter scaffolding erected up to grid D.
- Zone A (grids A-C / 1-5) poured up to level 4 & comflor installed on same gridlines on roof
- Zone B (grids C-E / 1-5) slabs poured up to level 2 and comflor installed starting on level 3

Site Works planned for November includes but not limited too;
Structural Steel primary frame erection

- Pour roof level Zone A slab
- Commence install of comflor to Level 3 Zone B
- Temporary propping and formwork install following comflor
- Primary structural steel frame up to Grid G complete
- 5x columns on grid F to be concrete filled

Other Benefactor activities completed or continuing, include;

- Sub-contractor procurement is progressing
- Materials procurement is ongoing

The following, possible impacts, are continuing to be monitored;

- Noise from concrete pours & steel erection
- Dust & debris.
- Traffic from concrete pours and large steel deliveries

Controls to be implemented in respect to possible impacts;

- Construction Noise & Vibration Management Plan in place for the project
- Materials to be secured in case of high winds and ground to be kept damp in dry weather to mitigate windblown dust.
- Traffic management plans to be in place for any oversize loads coming to site. Major concrete pours to be coordinated around peak traffic times
- Scrim (mesh fabric) is installed on scaffolding and open fences to reduce or prevent where possible, material/dust migration

2.3 Design

New Children's Hospital project.

CE sign off – Documentation is being prepared with set of Room Layout Sheets (RLS) ready for CE sign off. These are the architectural room designs that have been approved by clinical staff, The Health Planner (THP) as per earlier delegation and that have been countered signed by the Architect. These will be the control design set that all references will fall back to.

In addition, certain other design elements (services, civils, Link Bridge) will be treated in a similar manner as they reach a detail design stage.

Outstanding designs;
During the last few months, focus by the Benefactors team has been focussed on the development of documents for Wellington Council, resource & building consent submissions and subsequent RFI queries by council. This has taken the focus off designs CCDHB had been wanting to review.

Link bridge detailed design is not expected to be completed until January 2020. This has been further delayed due to delays in geotechnical investigations required in the memorial garden for the link bridge foundations. The delay is due to the potential contamination of this area from previous site works.

Furniture, Fixings & Equipment (FF&E)

The FF&E manager continues to work through deliverables such as;

- FF&E Risks
- Procurement management Plan
- FF&E Budget tracking

In addition, the FF&E manager is working with the Clinical Services team, Wellington Hospital Foundation and McKee Fehl on FF&E queries

Building Engineering Services (supply of services from WRH to NCH)

The Building Engineering Services works includes the design, construction, connection and integration of engineering services from the WRH to the NCH via either the link bridge or locations deemed the optimum supply location.

Procurement will be in two stages; 1) Power Supply & 2) other services (as noted below)

Electrical Supply design;

- A Procurement Plan has been approved for release on GETS week commencing 12 November.
    - The power is to come from L6 WRH down to the basement carpark, switch room where Aurecon will continue the design to the CCDHB demarcation point in the new Childrens Hospital's being the NCH MSB.

Building Services; (Other Services)

- Aurecon's design on CCDHBs behalf includes;
    - The services that need to be taken across to the NCH includes; Security, Fire Systems control, Medgas, comms & water.
    - The Benefactors team are providing these specs which will be included in the GETS, 2nd package.

2.4 WRH L3 Link & WRH WBCC Reconfiguration

New, Blood & cancer office space – Grace Neill Building level 3 (GNB)

- Naylor Love Construction work ongoing – walls and first fix building services started.

- Consultant and construction contracts are being prepared for signing.
- Furniture and IT – detailed scope being reviewed

Wellington Regional Hospital Building Level 3 Link and WBCC Day Ward Reconfigurations (WRH)

- Building Consent lodged.
- Subcontract tender underway. The end date has been extended to mid-November to allow more thorough queries and responses to be included. Indicative pricing will be received 15 November with the full pricing submission received in late November. At that point we will have a clearer picture of the overall budget and any further actions required.
- The full, WRH L3 Link & WRH WBCC Reconfiguration Status Report #21 is attached.

2.5 Timeline programme

Below is a high-level capture of the Program of Works per project timeline & approx. percentage of works completed

Task	Target Completion Date	% Complete on site (31.09.2019)	Comment
Demolition Works Project	02/05/2019	100%	Closed
Civil Diversions	16/08/2018	100%	Practical completion date
Internal Reconfiguration works within Regional Hospital	01/03/2021	10%	GNB Demo complete Construction commenced
Building Services Works Project (WRH), Design Stage	01/05/2020	60%	Procurement paper completed Aurecon design completed Tender for GETS to commence mid Dec
FF&E, Identification of equipment & evaluation of costs	30/06/2019	100%	Next stage to be reporting in this table is; the Development - lists of items to be procured by CCDHB & the process of procurement
Children's Hospital Construction phase: Primary steel, superstructure	14/04/2021	60%	Reflects the percentage of work completed for structural steel erection, only. Practical Completion, as well as handover, is targeted for mid-April 2021 See Milestone programme below
New Children's Hospital Project – Soft fitout	8/03/2021	0%	Commencement of Time allocation allowance for the CCDHB to complete the final fitout / installation of FF&E and all training & Commission where required

New Children's Hospital,

Site progress photos

31.10.2019

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

24.10.2019

31.10.2019

10.10.2019

17.10.2019

02.09.2019

30.09.2019

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa; HUTT VALLEY DHB; Capital & Coast District Health Board Ūpoko ki te Uru Hauora	**BOARD DISCUSSION** **Date**: 28 November 2019
Author	Chief Digital Officer, 3DHB ICT — Tracy Voice
Reviewed/approved by	HVDHB Executive Leadership Team CCDHB Executive Leadership Team
Endorsed by	Chief Executive, CCDHB & HVDHB — Fionnagh Dougan
Subject	**3DHB DIGITAL ICT QUARTERLY UPDATE - NOVEMBER 2019**

RECOMMENDATION

It is **recommended** that the Boards:

(a) **Notes** that a number of performance areas have been downgraded as the CDO has made her assessment of the current operating environment.

1. PURPOSE

This report provides the Boards with an overview of Information, Communications and Technology (ICT) performance and key local, regional and national projects for this quarter.

2. OVERVIEW OF ICT PERFORMANCE – SINCE LAST QUARTELRY UPDATE

2.1 Key performance areas

Key		
	🟢	Effective performance to support the requirements of the DHB
	🟡	Potential degradation in performance; effective mitigation strategies in place
	🔴	Performance has deteriorated; DHB is adversely impacted, or mitigations are not adequate

Performance Area	Status	Comment
Service Management & Customer Satisfaction		
	🟡	1. There was a total of 14 priority one incidents were raised during the three months from August through to October, average time to resolve these tickets was just over 3 ½ hours. 2. 71% of the tickets were resolved within the service goal of two hours. 3. A total of 6,083 incidents were raised for CCDHB and HVDHB (4,537 and 1,546 respectfully) 69% of these tickets have been closed. 4. Incidents raised and closed during this period took an average of 9½ days to close. 5. In addition to the incidents, the service desk received 11,467 requests for service (new software or hardware, password resets etc.)

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Performance Area	Status	Comment
		3DHB ICT continue to experience a high backlog of calls within the Service Desk and broader team. CDO has sought approval to appoint additional headcount for its Service Desk in order to reduce this backlog while teams focus on aged calls. The high calls are a symptom of our legacy environment.
Systems availability		
		During this reporting period: • 'Category one' system availability during the period of this report was 99.62 percent against a target of 99.90 percent; • The average availability over the last 12 months was 99.14 percent.
Security & Privacy		
		During the reporting period: • Virus/malware protection was kept up to date on a regular 15 to 30 minute update schedule. • ICT encountered a major phishing incident in August which was isolated quickly. ICT's Cyber Security Incident response plan was invoked and executed to mitigate any further risk. In October ICT conducted a DHB wide phishing test to ascertain levels of cyber security awareness across the organisations. Of the 12184 emails sent, 1152 users opened the link and a further 171 people entered their credentials. This result was poorer than expected and indicates to the DHB that additional, possibly mandatory cybersecurity training should be delivered to all DHB staff. 3DHB ICT is continuing to strengthen its environment by regularly installing software updates and taking other steps to protect ICT systems (refer to sections 4.1 and 4.2 below) ICT remains vigilant and ensures a high level of staff awareness. It is working closely with other DHBs and Ministry of Health. The CDO is working at a Regional level to discuss security capability and what can been shared across the DHBs. The 3DHB environment is lacking security capability for example: Chief Security Information Officer, Security Manager whom will work closely at a security assurance function. Cyber security is a risk for our DHBs.
Data protection and systems recovery		
		All planned data backups were completed successfully during the reporting period. 3DHB ICT continues to implement resilience improvements, and disaster recovery platforms and processes. The hardware hosting the backup system for applications and data will be replaced. The CDO is concerned of the current Data Centre configuration with Primary and Secondary data centres being hosted in the Wellington Region. This is

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<table>
<tr><th>Performance Area</th><th>Status</th><th>Comment</th></tr>
<tr><td></td><td></td><td>not an ideal position as most organisations have their core infrastructure based in completely separate regional locations. Further investigation will happen in this space. In the interim a business continuity plan for all sites is currently being drafted. A discovery phase is currently underway around our backup infrastructure, aiming to look at different service models to address both backups and resilience.</td></tr>
<tr><td colspan="3">Quality and maintenance of infrastructure and applications</td></tr>
<tr><td></td><td> </td><td>The CDO has done an initial assessment looking at our current systems portfolio from a 3DHB perspective. The table below which has been categorised into CAT1 (critical to enabling the DHBs to provide a high standard of clinical and patient care) and CAT 2 (important to enabling the DHBs to provide a high standard of clinical and patient care). Of the 861 systems we only have 16 which are shared across the 3DHBs.
<table>
<tr><th></th><th>Cat 1</th><th>3DHBs</th><th>Cat 2</th><th>3DHBs</th><th>Other</th><th>Total</th></tr>
<tr><td>Clinical Systems</td><td>41</td><td>5</td><td>28</td><td>3</td><td></td><td></td></tr>
<tr><td>Corporate Systems</td><td>14</td><td>1</td><td>21</td><td>1</td><td></td><td></td></tr>
<tr><td>Infrastructure Systems</td><td>10</td><td>6</td><td>4</td><td>0</td><td></td><td></td></tr>
<tr><td>Total</td><td>65</td><td></td><td>53</td><td></td><td>743</td><td>861</td></tr>
</table>
Further analysis work is underway rating the health of these systems.

A proposal to establish a 3DHB ICT Governance Group is being recommended and will be socialised to the ELTs in November 2019 to help govern this environment.</td></tr>
<tr><td colspan="3">Ability to implement projects in a timely and efficient way</td></tr>
<tr><td></td><td> </td><td>Most projects are progressing to plan. ICT is operating at maximum capacity. It is expected the governance model will assist with prioritisation of activity going forward.</td></tr>
<tr><td colspan="3">Quality, capacity and stability of ICT staffing</td></tr>
<tr><td></td><td> </td><td>The ICT team is at full capacity, the current work plan carries over from the 18/19 financial year plus what is planned for the 19/20 financial year. This sits outside the standard core services e.g. helpdesk, problem resolution and maintenance.

Our permanent FTE count is 142 (106 CC, 22.3 HV, 7.5 WA with 12 vacancies). At present we have 38 contractors (mix of Sole Traders and Suppliers) working on projects.

We have not unified the team as one 3DHB ICT. Therefore have three entities to gain insights to manage the environment. Further work will be conducted with our people and capability teams, CFOs on what can be achieved to unify the team. ELTs and Boards approval will be required to proceed.

The majority of our work actually relates to mitigating risk by ensuring our infrastructure remains current and secure, helpdesk calls are captured and</td></tr>
</table>

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Performance Area	Status	Comment
		problems resolved. The teams are stretched in just delivering our core services. Alternative sourcing models could complement the team. The remainder of the team focus is on initiatives that invoke change or efficiencies of which the majority are contractors. We have not analysed the capacity needed to support such an environment. In Q3 the CDO will work with the team to define an appropriate operating model that addresses the right capability needed. This may consider alternative sourcing models and capability to assist so we can move quickly. The majority of our current capability is at a technical infrastructure level. It is worth noting that many internal ICT teams have moved away from this in-house capability to sourcing services e.g. IT Managed Services (inclusive of Helpdesk, Desktop Services, Data Centre management etc.) through the All of Government panels. These teams now focus on creating the right digital experiences for their workforce and customers (e.g. IRD, MPI, MSD, AirNZ etc). The CDO has introduced the 'skills framework for the Information Age' (global framework which the NZ government has adopted) to assist with identifying the right skills needed for the 3DHB ICT team to meet expectations at a 3DHB, regional, national and MOH level. There are a number of capability gaps e.g. Portfolio management, Data and Information management, Service Design and User Experience, Enterprise and Application Architecture, Security. Further analysis on remuneration is needed as we have discrepancies based on the market and locations.
ICT governance and planning		
		A proposal to establish a 3DHB ICT Governance Group is being recommended and will be socialised to the ELTs in November 2019.
Digital and Data Strategy		
		At the start of November a new Strategy Planning and Architecture manager joined the 3DHB ICT team. Until then, in the absence of having the right capability on the ground the ELTs have sponsored the CDO to engage an external consultancy group (through the All of Government panel) to assist crafting a digital and data strategy plus action plan. This is likely to involve external research within the Health Sector (inclusive of the Health and Disability System Review) and others, working within the 3DHBs understanding our working persona's (clinical and corporate), aligning with our strategic plans and defining an action plan so we can be deliberate about our future decisions with regard to digital and data. The consultancy group selected is Tenzing Consulting. It is anticipated that workshops will be held in the New Year with ELTs, Boards and Staff.
Operating budget		

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Performance Area	Status	Comment
		The Year-to-date (YTD) ICT Opex budget is tracking close to plan. We will review the forecast to the end of the year and adjust where necessary to meet our budget at year end. At CCDHB – the current YTD to 31 October 2019 is $6.4k over budget. At HVDHB – Operating Expenditure (excluding Depreciation) YTD was ($58k) unfavourable to budget. This was mostly due to timing differences.
Key risks		
		They current key risks that ICT management are focussed on are outlined below. All areas have mitigations and / or actions in place to reduce or eliminate the risk. • Staff Capacity and Capability – there is considerable pressure on the team to meet the demands driven by the 3DHBs, the sub-region, the region, the Ministry, the Government Chief Digital Officer, and the Treasury. ICT's challenge is to respond to competing priorities, many beyond the DHBs' control. CDO is now working on the operating model to right size the team which will require investment; • Systems complexity – considerable amount of legacy technical debt remains in our environment. Stronger governance is now under action. • Systems resilience – having data centres located in one region is not an ideal position, investigation into alternative regional sites is imperative. • 3DHB ICT is moving services offshore (in the cloud). The CDO questions whether the ELTs and Boards have signed off the potential risk in an alternative jurisdiction with regard to data. A paper is circulating with ELTs at present and will be submitted in February to discuss this risk appetite; • Security – Process gaps in systems access and information security. Threats to the security of patient and DHB information caused by a variety of sources including malware, hacking, lost or stolen DHB devices, and unapproved access to systems resulting in patient and DHB information privacy being compromised, and reputational damage for the DHB. This is an area of constant threat and will require continued investment. A workshop is being held in November to review all the ICT risks.

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3. KEY ICT PROJECTS AND OTHER ACTIVITIES

3.1 Current Projects

Key	
🟢	Project is within budget, scope and on schedule
🟡	Project has deviated from plan but should recover. No impact to critical path or major milestones.
🔴	Project has fallen significantly behind schedule or is significantly over budget and/or scope has changed. Requires Management intervention.

3.1.1 2DHB and 3DHB projects

Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
3DHB Citrix Upgrade 2018	🟢	Tracking to plan	**Expected Project Completion:** Now 8 Nov 2019 **% Completed:** 95 % **Status**: Good	**Approved/Actuals** CCDHB PROD $494,450 Actual Spend to Date:$452,388 HVDHB PROD $364,550 Actual Spend to Date: 332,024 CCDHB DR $461,450 Actual Spend to Date: $448,466 HVDHB DR $303,050 Actual Spend to Date: $297,087
3DHB Exchange Online - Cloud Based Email	🟢	Progress towards Piloting solution is delayed due to enduring we deliver a quality pilot experience which has been hampered by technical issues.	**Expected Project Completion**: Feb 2020 **% Completed**: 55% Status: Delayed	Awaiting Business Case approval for WrDHB. Project tracking to budget. $78,397 spent to date
3DHB Storage Upgrade Project	🟡	New SAN hardware installed and configured. Migration of data well underway WRDHB SAN commission in Oct.	**Expected Project Completion**: 20 Dec 2019 **% Complete:** 80 **Status:** behind schedule. Resourcing constraints have impacted this project. Looking to reset timeline	Budget Approved: CC Prod-$494,450.00 CC DR-$461,146.00 HV Prod-$374,550.00 HV DR-$303,050..00 Actual Spend: CC Prod-$452,388.00

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
				CC DR- $448,466.00 HV Prod-$254,110.62 HV DR-$297,087.36 Status: On Track
3DHB WAN Upgrade		Project Assessment and planning phase - going to plan	Project in Assessment and Planning Phase - 15% of the way through the project.	Budget: $200,000 Actual: Status:
3DHB Windows 10		The Windows 7 to Windows 10 upgrade is ongoing slowly following significant disruption and delay caused by key project staff departing in August/September 2018 and the project manager departing in March 2019. 85% of devices have been upgraded with the last 15% being the more complex to move off Window 7 In summary: Approx. device count over 3DHB -2246 Approx. Devices upgraded over 3DHB - 1931 Approx. Devices left to Upgrade over 3 DHB - 317	**Expected Project Completion:** December 2019 **Status:** The project will not be completed until December 2019 due to the loss of key resources in August 2018 and February 2019.	Budget / Actuals Core Win10 Upgrade CCDHB: 473,800 / 473,800 HVDHB: 200,000 / 200,000 App Remediation, including IE upgrade CCDHB: 165,575 / 164, 885 HVDHB: 180,550/ 103,000 Budget has been consumed from CCDHB with around 70k still available from Hutt's remediation (IE11) budget. A Project Variation Request to CCDHB has been prepared and submitted to CCDHB Corporate Services Director for approval to secure funding to secure resources to complete the project by the end of the calendar year.

3.1.2 HVDHB Projects

Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
HVDHB Allied Health Mobile App (AHAC)		AHAC 1.7 released 16/10 enabling completion of the roll out. Team is working on release 1.8 with two additional enhancements (NHI search) and (Unmet needs). The Mobility Apps team will disband as of 18/11 and AHAC support	**Project Deadline:** November 2019 **% Complete:** 100% **Status:** Deployment of AHAC mobile app 100%., release of Desktop AHAC app (100%), release	HVDHB Approved Budget: $108,208 $23,840 (variation 80 x iPhone 7s) Total approved HVDHB budget$132,407

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		shifts to the 3DHB ICT Applications team. A full handover to the Application team to be done.	of Admin app (100%), release of Service Desk app (100%)	CCDHB Approved Budget: $124,346 Actuals: HVDHB: $ 97,557 CCDHB: $123,550 AHAC costs split 70/30 CCDHB/HVDHB
HVDHB Care Capacity Demand - Variance Response Management		Sixteen of the seventeen Dashboard installations are complete. The final Dashboard to be completed is waiting completion for TWA. The Mobile application alert development is progressing. Awaiting Building Services expenses for TV Installations.	**Expected Project Completion**: November 2019 **% Complete:** 95% Status: In-progress Start - 4th March 2019	Budget: $96,628 IT Resource Budget: $49,100 Actual Spend To Date: $74,702 Status: In-progress
HVDHB Community Health Services Workflow Management		Work on this initiative has just about finished as the budget is exhausted. Silhouette Star training was undertaken in September, and the new laptop/camera for use in clinics and associated laptops have been purchased and are being set up. A business case to enhance Trident has been drafted and is making its way through the approval chain.	**Expected Project Completion:** October 2019 **Status**: Completed once Silhouette devices handed over to DN service. Trident enhancements will be a different project.	**Budget Approved:** $90,974.23 **Actual Spend To Date:** $90,285.14 **Status:** Funding from the innovation fund has been exhausted. Silhouette setup will be funded separately. If Trident is enhanced there will be CAPEX funding for ICT resources available in that project.
HVDHB Dental Digital Imaging		The go live is underway and the scanners and monitors have been rolled out to the Naenae Hub and 1 van. The rollout is currently expected to be completed on schedule.	**Project Deadline:** 15 November 2019. Project completed 18 October 2019. **% Completed:** 100% Status: Closeout in progress.	**Budget Approved**: $136,400 **Actual Spend to Date**: $111,054.25 There is a positive variance of $25,345.75 **Status**: Actual expenditure includes the PVR expenditure for the desktop backfill for deployment. The additional allocation for desktop backfill was not required in the end.
HVDHB Electronic Whiteboards		Tracking well using scrum with 2 week sprints. **Whiteboards in production:** Antibiotic Allergy, Delivery Suite Allied Health view, ED Allied Health view, Personal Care, SCBU Allied Health view **Enhancements in production:** Implementation of: Frailty Indicator, frequent attendees flag, Red2Green functionality for Medical ward, frequent attendees flag,	**Expected Project Completion:** Iterative weekly Go Lives, two week sprints. **% Completed:** N/A **Status:** Execution	**Budget:** $184,008 **Actual Spend to Date:** $136,854.99 **Status:** Tracking to budget

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		radiology appointments column, whiteboard auto login functionality, BAU removal tool, update radiology results display, close button to SMT pop up, re order of whiteboard menus in Concerto, alphabetical ward sort, increase of comment column size Requested changes, updates and fixes to the following whiteboards: ACC, Acute Theatre, Allied Health, Birthing Suite, CCU, Children's Ward, ED, Gen Surgery, GSG, Gynae, ICU, MAPU, Maternity, Medical Ward, OPRS, Orthopaedic, Personal Care, Plastics, SCBU, Surgical Admissions, Theatre, TWA **Other:** Feasibility and requirement gathering sessions, feedback and benefit sessions, Mobility FHIR server, TrendCare, WebPAS and RIS upgrade testing and support, BAU monitoring, bug fixes, maintenance and support of all whiteboards.		
HVDHB Inpatient Electronic Meal Ordering - Design		Gathering information for strategic direction decision. Exemption to go to closed tender with three vendors from the RFI was approved on 4th November.	**Project Deadline:** December **% Complete:** 30% **Status:** In-progress	**Budget Approved:** $38,600 I**T Resource Budget:** $38,600 **Actual Spend To Date: $**12,690.00 **Status:** In-progress
HVDHB Scanning 2018		Scanning for Medical Inpatient events commenced on 19th September. There have been some issues following go-live, but these are now starting to settle. Closure activities will be carried out over the next 2 weeks.	**Expected Project Completion:** Closure expected in October. **% Completed:** 95 **Status:** On Track	Budget: $275,081.00 Actual to date: $221,524.00 Status: On budget. PVR001 was approved on 6/6 to reallocate the budget and fund the ICT resource component out of the ICT Innovation fun. Note: The current budget will get the first document type into production, further funding will then be required.
HVDHB Scope Solutions - Phase 1		Formal approval additional funding for the delay to development of the robot is still being obtained by the Business Sponsor. However, the slight budget variance and the full budget for the robot development will now almost cover the estimated amount - but it does not provide any contingency.	**Project Deadline:** End of November. IT Project finished 8 November. **% Completed:** 95% **Status:** The business will complete the rollout of the final services.	**Budget**: $318,894 **Actual spend to date**: $316,442 **Status**: Expenditure is expected to provide a small positive variance.

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		The roll out across the business is going well. The IT Project Team will stand down on 8 November at the end of the first week of the Plastics Go Live. The Change Management team and the system administrator will roll out the remaining 4 specialties. The closeout report/PIR is in the process of being written.		
HVDHB Security Remediation		The team are working operationally to implement the agreed MS cyber security remediation plan, which also works to address many of the documented audit vulnerabilities	**Expected Project Completion:**: 30 March 2020 **% Complete:** 45% **Status:** Implementation	**Budget Approved**: $126,773 **Actual spend to date**: $77,076 **Status:** On budget The project has additional $264,110 CCDHB funding of which $110,918 has been spent to date. No project funding was approved by Wairarapa DHB.
HVDHB TDocs Upgrade		HV capex approved 17 October. Architectural Design is underway. Mitigation strategy being sought for major data loss, migration issue experienced at other DHBs.	**Expected Project Completion:** 31 January 2020 + PIR **% Complete:** 5% **Status:** In -progress	**Budget**: $152,617 **IT Resource Budget:** $16,150.00 **Actual Spend To Date:**$3,240.00 **Status:** In-progress

3.1.3 CCDHB Projects

Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
CCDHB Allied Health Mobile App (AHAC)		AHAC 1.7 released 16/10 enabling completion of the roll out. Team is working on release 1.8 with two additional enhancements (NHI search) and (Unmet needs). The Mobility Apps team will disband as of 18/11 and AHAC support shifts	**Project Deadline:** November **% Complete:** 100% **Status:** Deployment of AHAC mobile app 100%., release of Desktop AHAC app (100%), release	This project has spent its budget and hours spent on this project by the project team is being offset against other ICT projects with unspent monies (as agreed with Manager, Projects). Total approved / Actual Spend

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		to the 3DHB ICT Applications team. A full handover to the Applications team to be done.	of Admin app (100%), release of Service Desk app (100%)	HVDHB: $132,407 ($108,208 + $23,840 (variation for 80 x iPhone 7s))/ $97,557 CCDHB: $124,346 / $123,550 AHAC costs split 70/30 CCDHB/HVDHB
CCDHB Appointment Information Management System (AIMS)		Planning underway, with ToR in final draft and demo of HVDHB AIMS booked with key staff in MHAIDS and the PAS booking centre	Development work to be scoped by ICT developer on his return from leave on 18 November	Budget: $160,188.00 Actual Spend to Date: $1,440.00 Status: Tracking to budget.
CCDHB Aria v15 Upgrade & Linac replacement		Update 30 October 2019: CCDHB Project team have had an initial meeting with Varian to discuss how to approach the project. The ICT CDO has asked for an architect to evaluate the Aria cloud offering, which is being progressed. This is currently halting progress on other work as it will affect the	Discovery phase underway timings looking like June 2020	Overall Budget: $5,720,000 ICT Budget: $350,000 Status on budget
CCDHB Cath Lab System Replacement (Synapse)		Updated 4 Nov 2019: Integration Testing underway. De-scoped initial delivery in November ratified which doesn't include haemodynamic integration	Project Initial Go Live: 27 November 2019 (Unintegrated Minimal Viable Product to replace Xcelera) **% Complete:** 70% **Status:** Implementation	Budget: $806,000 Actual Spend:$437,535 Status: On Budget
CCDHB Contact Directory (Hyperfish)		Project stalled due to change of technology / architecture decisions.	**Expected Project Completion:** TBC **% Completed:** 50% **Status:** Nine weeks behind schedule	Budget: CCDHB $113,685 (Approved) Actual: $21,342 HVDHB $56,842 WrDHB $18,948
CCDHB Contract Management System Implementation		Corporate workflow - testing completed. Hayley from Procurement is starting to upload contracts. Still to resolve securing contracts and variation processes. SIP team has more complex workflow. Workshop to map the process completed, reviewed and signed off. Currently with IL team to provide a quote to implement. Additional Active Directory groups required to secure contracts by teams.	**Expected Project Completion:** October 2019 **% Complete:** 70% **Status**: Behind schedule	Budget: $ 155,000 Actual Spend: $100K Status: Under-Budget

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		Question being discussed at present is whether 3 approvers is sufficient. This is parked until the system has been used. PIA signed off. Security Assessment is yet to be scheduled. NEXT MILESTONE: Complete the corporate security setup and continue with the deployment.		
CCDHB Haemodynamic Replacement (Synapse)		Updated 5 Nov 2019: PO completed but contract/SAE yet to be signed. Timeline to be confirmed once contract signed and commitments obtained by vendor (Siemens) and by Synapse vendor for integration activities.	Project Initial Go Live: 2 December 2019 **% Complete:** 5% **Status:** Planning	Budget: $427,035 Actual Spend:$0 Status: On Budget
CCDHB Intranet Upgrade		Go live for new Intranet was 1 November. Feedback has been positive. Some enquiries about content i.e. where to find information on the new Intranet and missing links/pages. Content update will be continuous. Privacy and Security assessment for project completed.	**Expected Project Completion:** Jan 2020 **% Complete:** 95% **Status:** On track (after re-baseline)	Budget: $ 202,000 Actual Spend: $183K Status: Under-Budget
CCDHB Intune MDM		CCDHB rollout near complete and HVDHB rollout to commenced	**Expected Project Completion:** 31 March 2020 **% Completed:** 55% **Status:** Deployment	Budget Approved: $388,080 Actual spend to date: $168,801 Status: On budget The project has an additional 194,040 funding from HVDHB, of which 91,107 has been spent to date. No project funding has been provided by Wairarapa DHB.
CCDHB Lab e-Ordering Implementation	ON HOLD	01 November 19:·A decision has been made by the 3DHB Chief Digital Officer to place the	**Expected Project Completion**: late 2020	Budget: $449,343 Actual spend to date: $79,047.84

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		project on hold. This is approved by the Steering Group. The 3DHB ICT core infrastructure requires improvements to provide strategic interoperability capability. The project needs to wait until the capability is available to deliver the preferred solution. There are multiple parties involved in completing this work with planning, design still to be completed. Time to complete is to be determined. HealthScope have replaced their Eclair forms developer. 3DHB has provided requirements for forms content. Sysmex have provided an estimated cost to complete the forms development. The steering group approved that completion of this work within the project budget.	**% Complete:** 20 **Status:** On time	Status: On budget
CCDHB MOSAIQ Implementation (IOMS)		Updated 29 October 2019: The project continues to be impacted by technical issues with MOSAIQ, in particular an error affecting the login window. Progress has been made with the integrations however and the feed of lab results is now live, as is the document export feed. If the login window issue can be resolved in the near term we will still be able to go live in November as originally intended.	**Expected Project Completion:** Phase 1 ends in November 2019 **Status:** ICT work for phase 1 to be complete by this date. Phase 2 work for ICT will be undertaken from February 2020.	Updated 29 October 2019 Budget: $1,261,045 Actual Spend: $544,159 Commitments: $601,208 Estimates: $104,335 Forecast total spend: $1,249,701 Status: An invoice for $417,000 due to be paid to Elekta has been held pending resolution of issues affecting the project timescales by the supplier.
CCDHB Netscaler Replacement		01 November 19: NetScaler design in final draft ready for sign-off. Phase 1 Wellington build started Friday 4th October. Slight delay waiting for delivery of additional network connectors, expected delivery 6 November.	**Expected Project Completion:** May 2020 **% Complete:** 20 **Status:** On Time	Budget: $328k Actual Spend: $204,233.04 ($177,528.32)* Status: On Budget *less Wairarapa $26,704.72
CCDHB NICU Monitors		01 November 19: Initiation started. Requesting resources. Go-live Date of 16 March. Need to commit ICT availability and capacity to meet this date.	**Expected Project Completion:** June 2020 **% Complete:** 0 **Status:** On Time	Budget: $50k (ICT budget only) Actual Spend: $480.00 Status: On Budget
CCDHB PACS Reporting		01 November 19: Initiation started. Requesting resources. Go-live Date of 16 March. Need to commit ICT availability and capacity to meet this date.	**Expected Project Completion:** November 2019 **% Complete:** 80% **Status:** On track (after re-baseline)	Budget: $ 60,000 Actual Spend: $0K Status: Under-Budget

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		- Philips are focused on the development/integration work. CCDHB team are working on setting up the devices for testing. - Currently CCDHB has 27 licenses which is insufficient. To purchase another 10 licenses it will cost $10K. Information shared with Radiology for their consideration. Enquiry made with Philips to see if temporary licenses can be issued until CCDHB is on boarded - NEXT MILESTONE: Training and Testing (September/Oct 2019)		
CCDHB Robot Referrals		Completed Sprints 1 through 6 Started Sprint 7 External Referral process including exception reporting is now operational within production environment. 27/09/19 - the external referral upload automation is now processing referrals from all the 30 services in scope of this project. The automation is able to not only process the happy path but also Hutt referral forwarding, below 16 years old patient processing, updating of referral notes and is able to make use of the Practice and GP cross reference mapping files. Project will need additional funding in order to meet business critical requirements 2/11 - Project has exceeded allocated budget	**Expected Project Completion:** 15/10/2019 **% Complete:** 95% as at 2/10/19 **Status:** In progress	Approved Budget: $121,110 Actual Spend to Date: $126,587 as at 02/11 Status: Will exceed total project budget cap early next month when project gets invoiced by Quanton for September invoice. 27/09/19 - ICT funding has just been exceeded by $1,000 16/09/19 - Project will run out of Quanton (vendor) funding by the end of Sprint 6. (23rd September). Refer Change Comment below for cost to complete project. 11/07/19 - Project has paid $1,390 towards new Robot Deployment. Agreed by Chris Bennett.
CCDHB Security Remediation		The team are working operationally to implement the agreed MS cyber security remediation plan, which also works to address many of the documented audit vulnerabilities.	**Expected Project Completion:** 31 March 2020 **% Complete:** 50% **Status:** Implementation	Budget Approved: $264,110 Actual spend to date: $110,948 Status: On budget

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
			This activity is expected to continue operationally.	The project has an additional 126,773 allocated from the HVDHB budget, of which 77,076 has been spent to date No project funding has been approved by Wairarapa DHB.
CCDHB Synapse Echocardiography Implementation		Updated 14 October 2019: Planning and discovery work for Phase 2 underway.	**Project Initial Go Live:** TBC Q1 2020 **% Complete:** 5% **Status:** Planning	Budget: $560,000 Actual Spend:$0 Status: On Budget
CCDHB Virtualisation Platform Refresh		Steady progress	**Expected Project Completion:** May 31st 2020 **% Complete:** 50% Status: Phase 1 - On-time and budget, completed. Phase 2 start delayed due to dependency on SAN project. Phase 2 started in January. This includes preliminary work such as scheduling and creation of internal communications and change control plans.	Approved Budget: $ 930,860 Actual Spend to Date: $670,000 Status: On budget and time for Phase 1. All hardware purchased for whole project (phase 1 & 2)
CCDHB Whiteboards 2018 Tranche 2		Tracking well using scrum with 2 week sprints. Whiteboards in production: CRS, Delivery Suite, ED AHAC view, Faster Cancer Treatment (FCT) (Second iteration), Maternity, My Patient, NICU, Ra Uta (Second iteration), Second Stage Recovery (SSR) Enhancements in production: Implementation of: Radiology appointments column, Surgical Admissions view of Elective Theatres whiteboard, Pharmacy referral column and integration with Pharmacy prioritisation tool, whiteboard autologin functionality, BAU removal tool, staff vulnerability flag, alphabetical ward sort, increase of comment column size, close button to SMT pop up, filter for specialty, allow name field to include special characters on comments column	**Expected Project Completion:** Iterative weekly Go Lives, two week sprints. **% Completed:** N/A **Status:** Execution	Budget: $198,768 Actual Spend to Date: $195,527.81 Status: Tracking to budget

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Project	Project Health Status	Highlights and Comments	Time Comments	Budget Comments
		Requested changes, updates and fixes to the following whiteboards: 24hr MHAIDs, Acute Specialty referrals, Acute Theatre, Allied Health, CAREful, CRS, ED, EDOU, Delivery Suite, Elective Theatres, FCT, ICU, MAPU, Maternity, NICU, OPRS, Ra Uta, SA1, SAPU, SSR, Surgical Admissions, Theatre, Wards 1, 2, 5, 6, Wards 4/5/6/7 Kenepuru Other: Feasibility and requirement gathering sessions, Mobility FHIR server, TrendCare, RIS and WebPAS upgrade testing and support, BAU monitoring, bug fixes, maintenance and support of all whiteboards		

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3.2 Regional items

3.2.1 Regional Digital Health Service (formerly RHIP)

The Regional Health Informatics Programme has now been renamed the Regional Digital Health Services (RDHS). The programme is making steady progress to deliver on board DHBs and to delivery agreed enhancements to regional systems.

3.2.1.1 Regional Radiology

Whanganui and MidCentral DHBs are already on the Regional Radiology Information System (RRIS).

CCDHB started its migration in Q1 2017/18 and was targeting completion in Q1 2018/19. The project team identified significant performance issues with RRIS during its testing. CCDHB has delayed its migration to RRIS until RDHS has completed its upgrade of the RRIS to a newer version. These performance issues have now been resolved and CCDHB will resume its migration if there performance requirements can be met. It is currently expected that the transition will be completed by Q3 FY 2019/20.

HVDHB has signed its business case to transition to RRIS and the discovery phase of this project has commenced. The target transition for HVDHB to the RRIS is Q3 2019/20. **Wairarapa DHB** which shares a radiology system with HVDHB will transition at the same time as HVDHB.

Hawkes Bay DHB will transition to RRIS after HVDHB.

3.2.1.2 Regional Clinical Portal

CCDHB and **HVDHB's** electronic health record system (MAP or Concerto) is old, at thresholds of capacity and can no longer support new clinical workflow or requirements.

3DHB ICT has been working with Orion and the Regional Digital Health Services programme to analyse a number of options to transition to a new, supported Clinical Portal. We are currently in the discovery phase and likely to present a final business case in February 2020 given the complexity.

In the interim, CCDHB is continuing to replicate its patient data to the Regional Clinical Portal. So far, Patient Demographics and most Laboratory Results have been replicated with additional result types being worked on.

3.2.1.3 Other Regional Initiatives

The Regional Programme is also working on a range of other projects including:

- Enhancements to the Regional Clinical Portal including addressing existing performance and capacity constraints;
- Upgrade of the Patient Administration System (WebPAS) that is shared by Wairarapa, MidCentral and Whanganui DHBs.

For FY 19/20, the Regional CIOs have proposed a set of priority projects for the Regional Programme including:

- Further development of the Regional Clinical Portal and RRIS;
- Moving our Radiology Image Archive (PACS) to the Cloud; and
- Integration with Primary Care Records.

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There will be a regional cap of $5m for new development against agreed priorities.

4. ICT OPERATIONAL ASSURANCE

4.1 Security and Privacy

4.1.1 Cyber Security Phishing Incidents

In this reporting period the 3DHBs did not suffer any known phishing attack or cyber security breach.

However following previous incidents, 3DHB ICT has initiated a review of security tools that had been originally planned to commence as part of the Office 365 project later this quarter. The outcome of the review has resulted in the following;

- The current email filter is no longer fit for purpose and an emergency procurement process has been conducted with a preferred replacement product selected. The implementation of the replacement email filter is now completed.

- Additional firewall scanning to be implemented as part of the new firewalls.

- Recently 3DHB ICT conducted a DHB wide phishing test to ascertain levels of cyber security awareness across the organisations. Realistic appearing email messages were sent to staff inviting them to use Linked In to connect with Tracy Voice, the new CDO. On accessing the link, people were asked to enter their DHB login credentials.

  Of the 12184 emails sent, 1152 users opened the link and a further 171 people entered their credentials.

  This result was poorer than expected and indicates to the DHB that additional, possibly mandatory cybersecurity training should be delivered to all DHB staff.

Once these two controls are implemented full access to Outlook web access will be reinstated.

4.1.2 New Cyber Security Controls

Work to implement multi factor authentication and the first bi-annual staff phishing simulation exercises has commenced. This work is expected to be completed by Q2 2019/20

4.1.3 Security Governance and Work Programme

The 3DHB Information, Privacy and Security Group continues to provide effective oversight of the 3DHBs' Privacy and Security controls and activities.

The following Privacy Impact Assessments were initiated during this reporting period:

- Access to DHB patient information, via Conporto
- Review of Square PIA
- Review of MHAIDS PIA

Security reviews were also conducted to identify and mitigate any security threats that use of selected systems may pose:

- Intranet upgrade using Microsoft SharePoint Online
- Microsoft Intune for managing mobile devices

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4.2 ICT systems resilience and business continuity

Steady progress is being made towards improving the resilience of the 3DHBs' ICT infrastructure. By the end of 2019, ICT expects to have completed the first tranche of its resiliency programme that will establish resilient infrastructure that a disaster recovery capability can be built on.

Component	Status	Target Completion
Tranche one		
Firewall Replacement	Project has been completed.	Q1 2019/20
Citrix Upgrade	The new Citrix production and disaster recovery environments have now been implemented. Testing and clean-up work continues.	Q1 2019/20
Storage Area Network	The new production and disaster recovery storage infrastructure has been implemented and tested. Migration from the old Storage Area Network continues.	Q1 2019/20
3D Wide Area Network	The responses to an RFP to select a new service provider are being evaluated. It was expected that we would have completed our transition to new resilient network services by June 2019. The target date is now Q3 2019/20.	Q3 2019/20
Office 365 (phase one)	Phase one (Identity) is has been completed and has established a Cloud copy of the DHB's identity and authentication system (Active Directory).	Completed

The second tranche of projects for 19/20 will build upon this foundation and:

- Increase the adoption of cloud solution including Office 365 applications;
- Complete the implementation of a backup system to protect our critical data; and
- Establish Disaster Recovery configuration and procedures for our top 20 critical systems.

Component	Status	Target Completion
Tranche two		
Backup replacement	The backup strategy and approach completed. A business case for the purchase and implementation will be submitted for approval in Q3 2019/20	Q2 2019/20
Office 365 (phase two)	A business case for Email in the Cloud (Exchange Online) has been approved for pilot and work has commenced. A business case for Intune Mobile Device Management in the cloud has been approved and work has commenced. Business cases to consume SharePoint online for the Intranet and Contract Management applications have been approved and work has commenced. A further business case for the transition to all other Office 365 applications will be developed in Q3 2019/20.	Q4 2019/20
Disaster Recovery (phase one)	This project will develop the detailed procedures and configuration to implement disaster recovery for our top 20 essential and critical systems. A business case will be submitted for approval in Q3 2019/20	Q4 2019/20

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ICT has successfully tested its Disaster Recovery capability for its top 20 Citrix applications.

ICT will undertake a risk review at the end of 2019/20 to assess the residual risk and may propose a third tranche of investment for 2020/21 to complete the configuration and detailed procedures for its remaining critical systems following.

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HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DISCUSSION** **Date:** 28 November 2019

Authors	Service Manager, Regional Public Health - Peter Gush Service Manager, Regional Child Oral Health Service - Nicky Smith Service Group Manager, Medical and Acute Care - Lindsay Wilde
Endorsed by	Director of Provider Services – Joy Farley
Reviewed/approved by	Chief Executive – Fionnagh Dougan
Subject	**SUB-REGIONAL PUBLIC HEALTH SERVICES UPDATE**

RECOMMENDATIONS

It is recommended that the Boards:

a) **NOTE** the updates from the three sub-regional services.

b) **NOTE** the additional educational work being undertaken in the early prevention and intervention area to aid the reduction in the incidence of childhood caries in the under 5s.

c) **NOTE** the ongoing commitment by the Regional Child Oral Health Service on eliminating service arrears by end of 2020.

d) **NOTE** the proposed utilisation of Kaiawhina workforce to reduce health inequities.

APPENDICES:

1. Regional Public Health service map of measles cases distribution by DHB
2. Regional Child Oral Health Service holiday programme report
3. Regional Child Oral Health Service September 2019 balance scorecard.

1. PURPOSE

This report provides an update for the Board on the work of the sub-region's Population Health Based Services.

2. MEASLES RESPONSE IN CCDHB AND HVDHB DISTRICTS

2.1. Local (Sub-Regional) Picture as at 5 November 2019

A total of 34 measles cases in the greater Wellington region year to date; to 05 November. This has resulted in 1070 people having been contact traced. All of our cases are linked to either international or domestic outbreaks. A map showing the distribution of cases by DHB is attached as **Appendix 1.**

RPH continues to adopt a 'Stamp it Out' approach to new cases, utilising our Communicable Disease Nursing and Medical Team work forces, whilst supplementing staffing from other parts of RPH as required. We continue to work closely with primary and secondary care.

Good use of our own and DHB social media channels has enabled good reach for messaging, with further resources on various health webpages. This is a link to our own page as an example.

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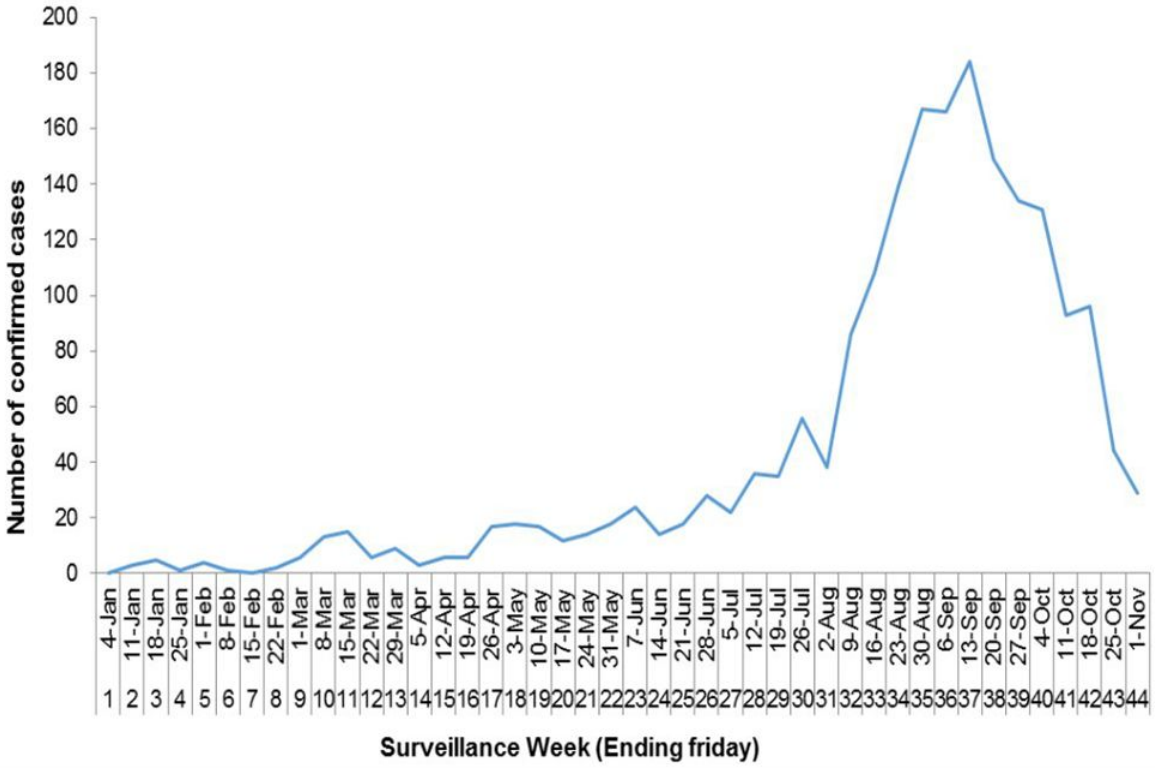
2.3 National Picture as at 7 November 2019

From 1 January 2019 to 7 November 2019 there have been 2,010 confirmed cases of measles notified in New Zealand. Over the two week period 24 October to 7 November, 79 new cases were notified nationally, 70 in the Auckland region. The National Health Coordination Centre response has been stood down.

Figure 1:

Number of confirmed measles cases nationally, by week, 1 January - 7 November 2019. Weekly notifications appear to have peaked in the week beginning 20 September.



3. DRINKING WATER UPDATES

3.1. Proposed Drinking Water Regulator

Cabinet has made a decision to establish a standalone drinking water regulator as a new Crown entity. The objectives of the proposed regulator are to protect and promote public health, administer the system, build capability and recognise and provide for Te Mana o te Wai (The Mana of the Water). It is expected that it will take at least 18 months to get the new regulator up and running as new legislation is required. There will be a Water Services Bill, Crown Entity (Water Services) Establishment Bill and amendments to section 125 of the Local Government Act. The new regulator will also include the delivery of centralised wastewater and storm water regulatory functions. The Ministry of Health will continue to provide drinking water policy advice, while the Ministry for the Environment will provide policy advice for wastewater and storm water components of the regulator.

The structure for the proposed regulator includes: Science and Technical, Operational Policy, Regulatory Operations, Legal, Education and Engagement and Corporate and Governance.

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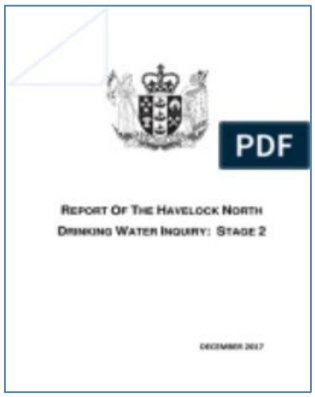
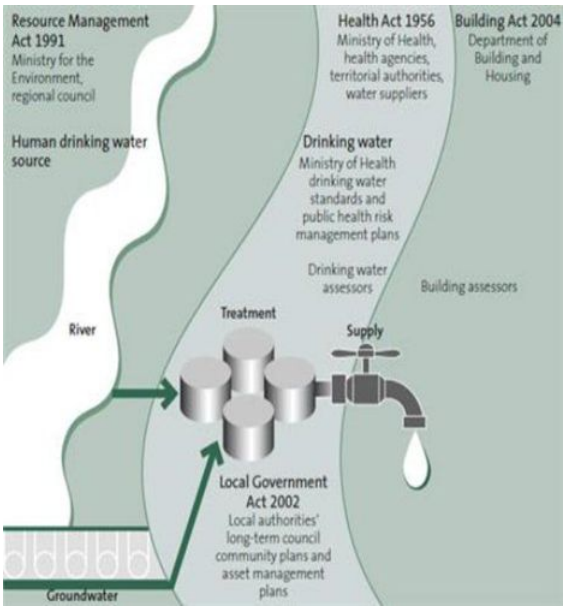
3.1.1. Working with Other Agencies to Make our Drinking Water Safe



One of the areas of work the Medical Officers of Health are involved with is around oversight of safe drinking water. In 2016, New Zealand experienced one of the largest ever recorded outbreaks of campylobacter as a result of contaminated drinking water. The Inquiry of the Havelock North Campylobacter outbreak has resulted in many changes and proposed changes to the way we ensure safe drinking water. One of the recommendations was to establish Joint Working Groups with councils, water suppliers and public health unit staff. The purpose of these groups is to ensure good collaboration and sharing of information to protect drinking water from its source, to the point where it is delivered to people's properties.



As a Medical Officer of Health, starting the conversation about establishing our own regional group with our Regional Council and one of our largest water suppliers, has resulted in the formation of the Wellington Region Drinking Water Joint Working Group. The need to establish such a group became even more critical following our own regional issues with contamination detected in the Lower Hutt bores in 2017 and 2018.

The joint working group consists of all council water suppliers (operators and management), Wellington Water (a council controlled organisation responsible for all water infrastructure for five local councils and the regional council bulk water supply), the Regional Council resource consent/compliance and water quality environmental science staff, and RPH staff involved with drinking water (Drinking Water Assessors, Medical Officer of Health, Health Protection Officers and Management).

So what has the group achieved or hope to achieve? Already we have seen the benefit of meeting regularly, sharing information and expertise, and forming specific working groups.

- We have an agreed shared vision and are finalising our lines of accountability via a Memorandum of Understanding document.
- Methods to assess risk within the pipework and storage systems of drinking water supplies is being shared between different water suppliers – supports better efficiency with shared knowledge and agreement on best practice.
- Frameworks for development of emergency response plans to drinking water major incidents have been workshopped and shared, ensuring they align between different agencies, ensuring rapid and effective interagency response to water emergencies.

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- All agencies are informed about groundwater quality monitoring being planned by the Regional Council, the results of which can then be shared with everyone, so the response to any unfavourable results can be collaborative.
- Identification of opportunities for other areas to join an existing project utilising new technology to better understand groundwater flow and security. This information will help suppliers to better protect the catchment area of their water sources.
- Reviewing together new information about the regulatory environment for drinking water or expert technical advice, so we are on the same page regarding best practice and our respective roles and responsibilities. This is important during the current period of drinking water regulatory review.

This year the response to the contamination detected in the Martinborough town supply was strengthened by a strong collaborative approach. There are many moving parts that need to align to ensure our drinking water remains safe to drink and this collaborative approach is one of the important activities that contributes towards achieving safe drinking water.

SOUTH WAIRARAPA DISTRICT COUNCIL

NOTICE TO HOUSEHOLDERS
WATER SUPPLY - MARTINBOROUGH

Users of the Martinborough Township water supply are advised that E.coli has been detected in the township. While the results were very low, in consultation with Regional Public Health, a Boil Water notice has been issued for the supply considering the recent event.

BOIL WATER

Water for drinking, food preparation and oral hygiene (brushing teeth) should be boiled to ensure the water is safe for consumption.

Council will be clearing pipelines of water and carrying out further investigation. Council will also be testing the supply to identify the source of the contamination and will keep you informed with advice you when the boiling of water is no longer necessary.

If you have any queries, please contact SWDC on 06 30 69611.

Lawrence Stephenson
Asset and Operations Manager

3.1.2. Release of Taonga Mokopuna Videos

The Healthy Communities Team from RPH have just launched a new resource for early childhood centres - '*Taonga Mokopuna video learning series'* designed to reduce the spread of illness and keep centre environments healthy.

Taonga Mokopuna includes six short videos:

- Introduction to the series
- Gastroenteritis Outbreaks
- Illness Policy
- Handwashing
- Hygienic Nappy Changing
- Healthy Centre Environments

Each video outlines simple steps that help reduce the spread of illness in a centre. They are easy to follow and implement but are the steps that can often get missed in a busy centre environment. When these steps are followed correctly, they will help centres manage the spread of illness and create the best environment for tamariki and staff.

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Taonga Mokopuna is an innovative way to share public health information and is the result of feedback from centre staff across the Greater Wellington region which indicated an online learning tool would be an effective way to get these messages across.

Taonga Mokopuna can be accessed at Healthyecc.org.nz, and is available for all centres across the country to use. However, the advice provided in these videos was developed from the experiences our Public Health Advisors have had with a range of centres in varied communities across the Wellington region.

4. Contract/Funding Gains

4.1. Partnership with Wellington Free Ambulance (Porirua)

The Community liaison team has been successful in securing funding through the Ministry's Acute Drug Harm Discretionary Fund through a proposal which was submitted to the Ministry, along with Wellington Free Ambulance (WFA). This funding will open up further opportunities for RPH and WFA to work collaboratively to support other providers in the Porirua area. Problematic substance use has been a concern for this community, so this fund will be used to address harm minimisation messaging alongside co-ordinating training sessions for CPR and understanding addictions.

5. Alcohol Related Harm

During the last week of August TV3 news ran a four part "because it matters" series focused on the problem of alcohol in New Zealand. In the second part, RPH's Dr Palmer was one of three Medical Officers of Health who called for urgent, meaningful action by the government to address our shameful drinking culture:

https://www.newshub.co.nz/home/politics/2019/08/justice-minister-andrew-little-warnsalcohol-industry-a-law-review-is-on-the-cards.html

Later in part 2 the Justice Minister, Andrew Little, confirmed that he wants a review of our alcohol laws within "one to two years". The Prime Minister affirmed this in part 3 of the series:

https://www.newshub.co.nz/home/new-zealand/2019/08/bias-and-inconsistentdecisions-raise-concerns-about-authorities-tasked-with-liquor-licensing.html

This change is a significant turn-around as up till then it appeared that government had little appetite to revisit the alcohol laws.

Some may not be aware that New Zealand is one of the very few countries where health has an input into the liquor licensing process. Since 1990 the Medical Officer of Health is one of the three reporting agencies, along with the police and the liquor licensing inspector. Up until the new Act the focus was only on bars and club licenses, however, with the new Act input was extended to all types of liquor licence.

Under the leadership of our Medical Officers of Health (particularly Dr Palmer), RPH has pushed the new Act about as far as it can go in curbing alcohol-related harm. We were involved in two recent liquor licence decisions that went all the way to the High Court where ground-breaking case law was established.

Our first High Court case in 2018 was the Liquor King Kent Terrace. In this High Court decision case law was set around "causal-nexus" and linking harm to a premises. Essentially, Justice Clark agreed that a nexus was required, but that the nexus was between the application in question and the Act's object of minimising harm and not between any specific harm and the conduct of a specific premises. The Court found that "requiring proof of a 'causative link is not only unrealistic but is contrary to the correct legal position", which it held was more akin to a risk analysis and not anything involving standards of proof.

This High Court decision reinstated the Wellington District Licensing Committee (WDLC) decision and is a tipping point that shifts the balance in the case law towards the use of the precautionary principle.

The second High Court case, this year, was for the Capital Liquor in Manners Street, at the other end of Courtenay Place. Here WDLC reduced the trading hours from 10.30pm to 6pm seven days a week. At appeal the Alcohol Regulatory Licensing Authority (ARLA) reaffirmed the decision made by WDLC and reinstated 6pm closing on the Friday before Christmas. However, the licensee ignored this and the bottle store continued trading late until Christmas Eve when the police and the liquor licensing inspector pointed out they were breaking the law.

The licensee took the ARLA decision to the High Court where, Justice Clark reaffirmed her Liquor King decision and extended it further by confirming that dishonesty can be taken into account in liquor licensing decisions. Also, she confirmed that the economic viability of the alcohol business cannot be considered in decisions relating to liquor licenses.

This progress in case law is important and has flowed on to enable us and communities to make some progress in relation to other liquor store licences. This is a very slow way to make progress in addressing the country's drinking culture. It is not only slow but requires considerable effort and the need to involve lawyers with the associated expense. This is one of the reasons why the three Medical Officers of Health in the TV3 news series are calling for urgent action from the government.

5.1. Khandallah Bottle O - New Off Licence Application

One of our regulatory staff attended the hearing for a new Bottle O store located in the Khandallah village. This new application was not opposed by any of the agencies (Medical Officer of Health included) due to its location. However there was a large number of the community objections. Five hundred plus objections were received and the number was reduced to about 70 that had standing (i.e. people living within 1km of the proposed store or organisations having a greater interest than the general population). The hearing took 4 days and, although we did not oppose, the Medical Officer of Health appeared as a witness and presented health data.

The District Licensing Committee released the decision and the application was declined on suitability of the applicant, amenity and good order and the object of the Act. This is a great result and showed the strength and value in the community having their say.

5.2. Shalimar Store Aro Valley- Renewal of Off Licence

One of our regulatory staff attended the hearing for Shalimar Store in October. The hearing was focused on whether the store met the criteria of a grocery store (where food sales make the greatest revenue). If a store does not reach a set criteria as a grocery store, it cannot hold an off licence to sell alcohol (Sale and Supply of Alcohol Act 2012). An investigation into the accounts found evidence food was not the biggest seller. A point of interest was the unusually high volume of poppy seeds being sold. This store sold 3,810 kilograms of poppy seeds a year worth $66,255.90 that amounted to 20 percent of their food sales.

The District Licensing Committee decision was released this month and declined the renewal of the store's liquor license. The committee found that the volume of poppy seeds sold were questionable as to their purpose as food. Considerable work was carried out by one of our Medical Officers of Health and regulatory staff.

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This is a great outcome as Shalimar store is situated at the lower end of Aro Valley and within an area with a high proportion of young people and tertiary students, and a number of social housing complexes.

There is an appeal period in which the applicant could appeal the DLC decision.

6. REGIONAL CHILD ORAL HEALTH SERVICE (RCOHS)

6.1. Background

Hutt Valley DHB is the current Ministry of Health contract holder for the Regional Child Oral Health Service (RCOHS) that encompasses thirteen dental hubs and twelve mobile vans covering Wellington (including Kapiti - Mana) and the Hutt Valley.

6.2. Strategic Fit and Government Priorities for Children

Shift Care Closer to Home

September 2019 school holiday programme

The RCOHS held 3 holiday programmes over the October school holidays at Wainuiomata Community Centre, Ora Toa PHO (Cannons Creek), and Te Rauparaha (Porirua). Over the course of the 2 days at each site, 39 children in total were seen (Appendix 1).

New location Wainuiomata Community Centre October Holiday Programme.

Health Promoter Maria Eneliko and Oral Health Therapist Noella Dushime

Early Intervention and Prevention Health Promotion Activities

The Early Intervention and Prevention team (EIP) have led on a number of community health events in term 3. These have included a GIFT (Giving It Forward Together) Miramar Community event, Refugee Health Orientation, School and Early Childhood Centres (ECC) Oral Health Education Sessions and a guest slot on Samoan Radio Talk to discuss child oral child health and key messaging.

"Lift the Lip" training/ refresher sessions have been delivered to all Primary Health Organisation Well Child Tamariki Ora providers in the region which include Maraeroa Marae Health Centre and Hora Te Pai (Kapi-M), Plunket Wellington, Lower Hutt, Wairarapa and Kapi-Mana, Pacific Health Services and Tamariki Ora

The knee-to-knee programme which targets low decile, high need ECCs has, for 2019 thus far, examined 372 ECC children (34 centres visited). Of the 372 children examined, 300 children

identified as either Màori or Pacific ethnicity. A 32 further ECCs have been contacted to extend the scope of this programme wider across the region for 2020.

JACKY HUNT (EIP) ATTENDING G.I.F.T COMMUNITY ORAL HEALTH AND BEE HEALTHY

MARIA ENELIKO (EIP) TALKING ON A SAMOAN RADIO EVENT IN MIRAMAR WITH MA'A NONU (EX ALL BLACK)

KNEE TO KNEE CHECKS DEMO AT KATOA KINDAY – MAT SESSION WITH CHILDREN TO FAMILIARISE THEM WIT HTHE PROCESS

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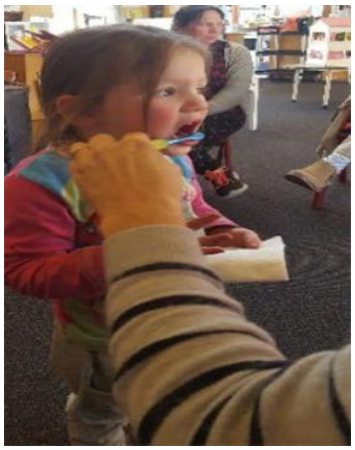
Supervised tooth brushing pilot programme

This programme has now commenced in Best Start Naenae and Haleema ECC. Workshops for parents and teachers have been held by RCOHS, to familiarise the pilot with parents and provide the opportunity for parents to be fully familiarised with the programme. Knee-to-knee checks have been undertaken and completed at both these centres pre-programme, to enable audit of current dental state of enrolled children. Each centre has an individualised programme of support including health and safety considerations, dedicated mat time for children with demonstrations on how to brush their teeth by RCOHS staff and evaluation of the programme. Tooth brushing packs were distributed to centres in September. Further considerations for high need, low decile early childhood centres are currently being worked through with RCOHS.



Education session to the teachers/tooth brushing champions at Haleema Kindergarten, Taita – led by EIP team and Clinical Director, Kathy Fuge.

Regional Public Health (RPH) – Water in Schools Initiative

To date, 83 school principals and their respective school boards have been contacted following a scheduled RCOHS school-based visit to provide statistics on the percent of caries within their schools. Positive feedback continues to be received from schools in regards to the usefulness of the data provided to inform school planning for healthier options for children.

7. DELIVER SHORTER, SAFER AND SMOOTHER CARE

7.1. Service balance scorecards – September 2019 (appendix two)

For September, 4203 school-aged examinations was 15% below the 4920 target. Unfortunately, the Hutt team were impacted severely with illness in September, despite our service having a 71% influenza vaccination rate, an 80% Boosterix vaccination rate and a 100% MMR vaccination rate. Brandon, Raroa and Miramar exceeded their Hub target. X-rays taken at examination for 5-13 year olds are within expected range.

1305 preschool children were examined, 9% less than the service target of 1435. Raumati beach and Selby exceeded their target.

At the hubs, a greater proportion of Māori and Pacific children did not attend (DNA) booked examination and treatment appointments when compared with non- Māori and non-Pacific children[1]. This proportion is lower than in 2018.

This inequity in attendance is also evident for preschool children whose examination and treatment appointments all take place at a hub clinic (except for children who have participated in the equity outreach programmes). This was 22% for Māori, and 28% for Pacific children. For non-Māori and non-pacific preschoolers DNAs were 8%. All less than 2018.

7.2. Caries prevention

It is a focus for this service to imbed actions and initiatives to allow children to remain free from decay. This includes fluoride varnish applications at examination appointment and 6-monthly for children at high risk for dental decay. High risk children also have preventive fissure sealants placed on their first permanent molars. A supervised tooth brushing programme was commenced at two high risk Early Childhood Centres. There is strong evidence to demonstrate well run supervised tooth brushing programmes have good outcomes.

A new process is in place to reduce the number of unconfirmed appointments being posted via NZ Post. RCOHS makes 2 documented attempts (phone, email or letter) to contact families to remind them to make these important. This process has already impacted on a reduction in calls to change appointments and do not attend reduction for the overall service of 3%. In addition, this process has allowed to "clean" our data of those children that no longer reside in the RCOHS catchment area.

Access: Outreach programmes (e.g. preschool knee to knee, school holiday mobile programme) are utilised throughout 2019 to allow more options for these children and their families to engage. The 6 monthly fluoride application initiative has recently been approved, another opportunity to apply a preventive programme within school time.

7.3. High risk preventative strategy proposal 2019/20

The RCOHS have put forward proposals to CCHDB and HVDHB Funding and Planning directorates to fund a Kāiawhina-led fluoride varnish programme for all children currently enrolled in both RCOHS and attending a decile 1 or 2 school or Early Childhood Centre.

This is a high risk targeted population strategy; the intention of this programme is to enable access for children who are identified as having a high caries risk to receive a second application of fluoride varnish in a year, without depending on attendance at a dental clinic. It is anticipated that this initiative will reduce the inequity demonstrated by the 'did not attend' data for Māori and Pasifika children. RCOHS are awaiting confirmation from HVDHB SPO and CCDHB SIP, as to whether this proposal has been successful.

7.4. Arrears and accessibility of Service

The service continues to see a reduction of arrears and are currently at 5 months as of end of September 2019 for Wellington and Hutt teams respectively, and 7 months for Kapiti-Mana team (original rates of arrears for all teams >36 months <July 2017). Additional emphasis has been placed on further reducing the arrears during 2019, with the end target of <5 month arrears for all teams by end of 2020. In addition, focus for this year will continue to be on pre-school aged children and reduction of waitlists for first examinations.

[1] Examination on-site at school continues to be the principal strategy to address inequity in access to examination and prevention. This data is not included in the balanced score card as the attendance for examinations on the mobile is equal for Māori, Pacific and Other (100%) and as a result would skew the results and be less effective at identifying inequities present in attendance.

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8. SMART INFRASTRUCTURE

8.1. Digital Radiography

Digital radiography was successfully implemented from 28 September through to 10 October. The Service is now fully digitised across its entire mobile fleet and static hubs to provide point of care diagnosis and treatment planning for all enrolled children. The project was successful due to collaborative working and support between RCOHS, ICT, Building Services and Clinical Engineering, with able support from the Project Management Office and dedicated ICT Project Management support. The capital expenditure came in under budget; final surplus to be confirmed.

9. ADAPTABLE WORKFORCE

9.1. 2020 New Graduate Recruitment

RCOHS attended Otago Dental School in October to recruit 4 New Graduates to the Service for 2020. As always, the Service raised the bar on shortlisting and interviewing potential candidates. The majority of the successful incumbents originate from Wellington, so are in effect coming home to RCOHS. The new graduates will be starting in Service in late January 2020, supported by a robust and proven mentorship support programme.

9.2. Upskilling Workforce

All of RCOHS workforce are now upskilled to provide stainless steel crowns and hall crown techniques as an effective treatment option. These techniques are projected to positively impact on ASH admissions to secondary dental significantly over the next 5 years. Current children who access secondary dental will be offered these treatment options within the RCOHS (dependent on individual assessment of each child's tolerance/ threshold for treatment in community setting), thus reducing the need for treatments under general anaesthetic for this patient group.

9.3. Support and Progression of Service Kaiawhina Workforce

RCOHS currently have 2 Dental Assistants (DAs) undertaking the NZDA online Introduction to Dental Assisting module. In addition, 3 experienced DAs have expressed a strong interest in undertaking the NZDA Certificate in Dental Assisting, which is a 12 month course in 2020. RCOHS is committed to ensuring that its Kaiawhina workforce is appropriately supported to reach their full scope and potential.

9.4. Dental Council New Zealand (DCNZ)

RCOHS recently collaborated with the DCNZ and granted permission for consented photographs of our staff and children to be used in the DCNZ annual report. The RCOHS contribution can be found here DCNZ Annual Report 2019

10. REGIONAL SCREENING (BREAST AND CERVICAL)

10.1. Breast Screening Quarter One July – September 2019

Breast Screen Central (BSC), covering Hutt, Capital & Coast and Wairarapa DHBs continues to exceed the 70 percent screening target for all women overall during quarter four 18/19 (note our data runs a quarter behind as we rely on BSA/NSU to make the data available).

It is worth remembering that Breast screening books women into screening every two years ideally but of course it is not always possible to book every woman in at exactly 2 years so the accepted range is anywhere between 21 and 27 months. The screening data works on a two year cycle so if we book women on or after 24 months and screen them a month after this they do not appear in the 24 month data period.

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Our Service continues to focus its recruitment and retention work for our priority women to ensure the equity gap continues to decrease. We are confident that the initiatives in place do work, as mentioned in our previous reports, but we are always looking for new ways to engage these groups.

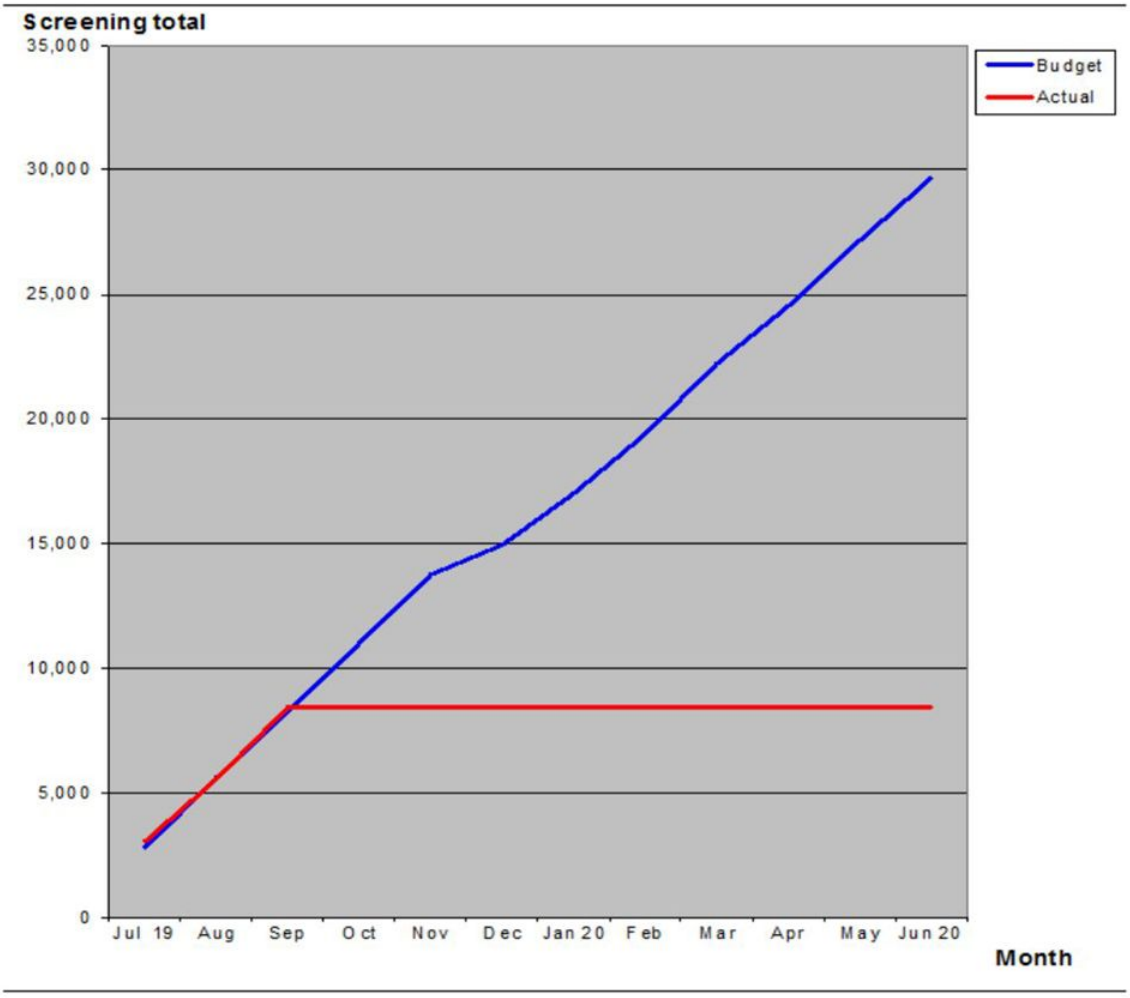
It is often difficult to contact ladies during work hours so in recent times the recruitment and retention team have been trialling evening calls with marked success.

Figure one: Target Breast Screen Central Volumes for 2019/20

Service Overview

Target Screening Volumes for 2019/2020

Month	Jul 19	Aug	Sep	Oct	Nov	Dec	Jan 20	Feb	Mar	Apr	May	Jun 20
Budget	2757	2850	2600	2800	2750	1200	2055	2350	2843	2315	2621	2509
Cumul.	2,757	5,607	8,207	11,007	13,757	14,957	17,012	19,362	22,205	24,520	27,141	29,650
Actual	3,086	2,458	2,863									
Cumul.	3,086	5,544	8,407	8,407	8,407	8,407	8,407	8,407	8,407	8,407	8,407	8,407



Currently we are ahead of target screens for the financial year.

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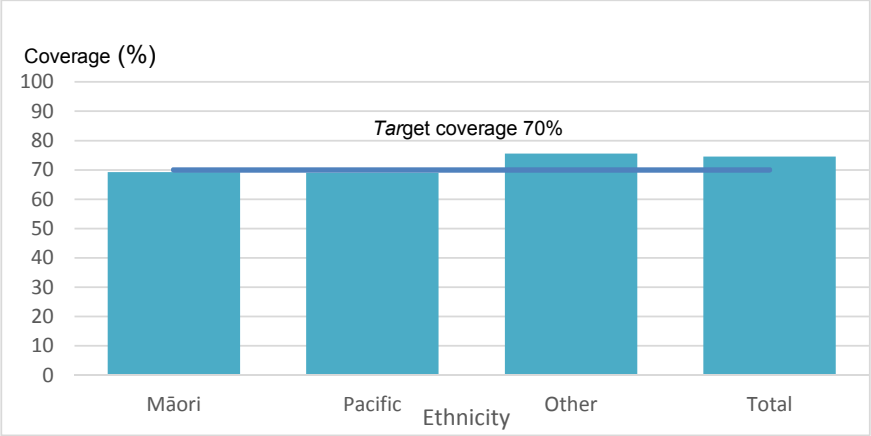
10.2. Hutt Valley DHB (HVDHB) Coverage

HVDHB Coverage by Ethnicity in the Two Years Ending 30 June 2019 (Women Aged 50–69 Years)

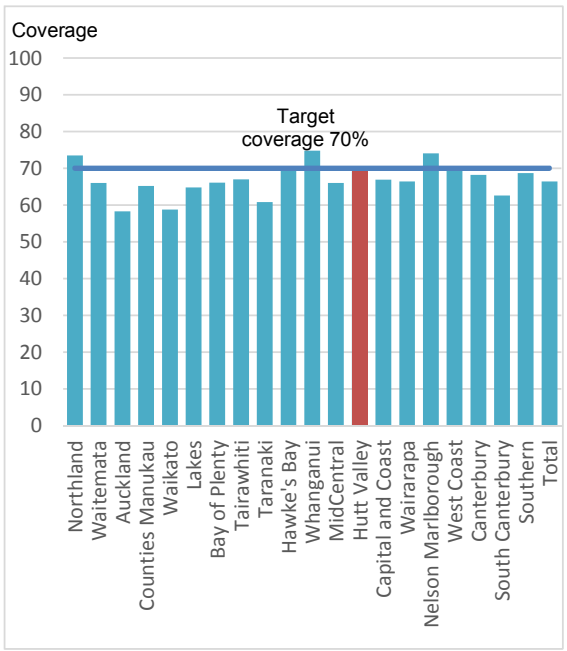


Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	2,140	1,481	69.20%	17
Pacific	1,000	690	69.00%	10
Other	15,140	11,442	75.60%	
Unspecified		11		
Total	**18,280**	**13,624**	**74.50%**	

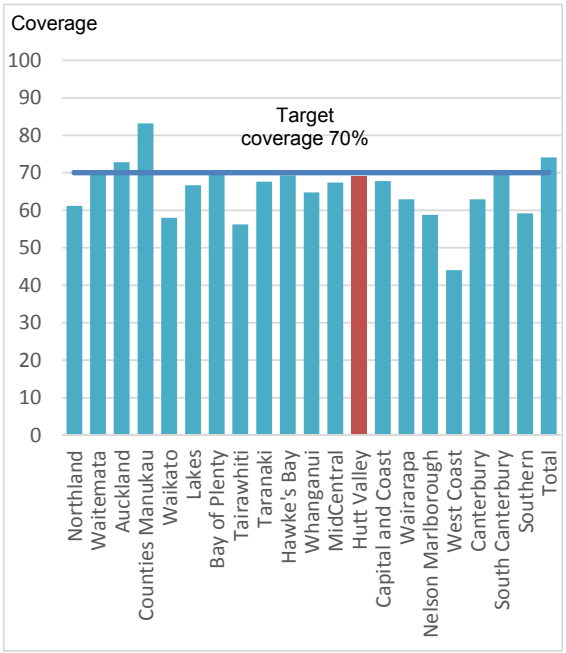
*For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%.

DHB coverage comparisons (for priority populations)

Māori



Pacific



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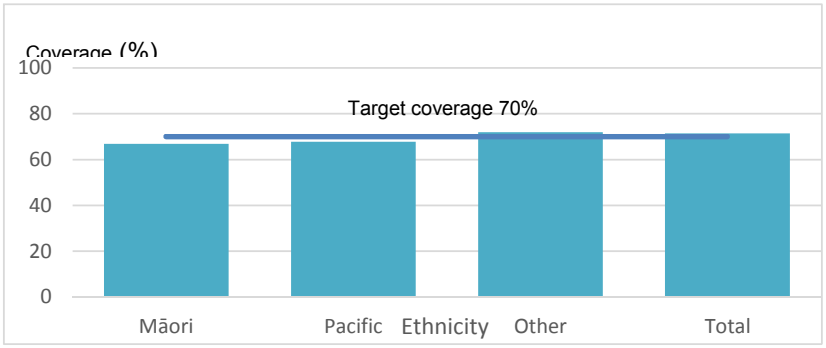
10.3. Capital And Coast (ccdhb) Coverage

CCDHB Coverage by Ethnicity in the Two Years Ending 30 June 2019 (Women Aged 50–69 Years)

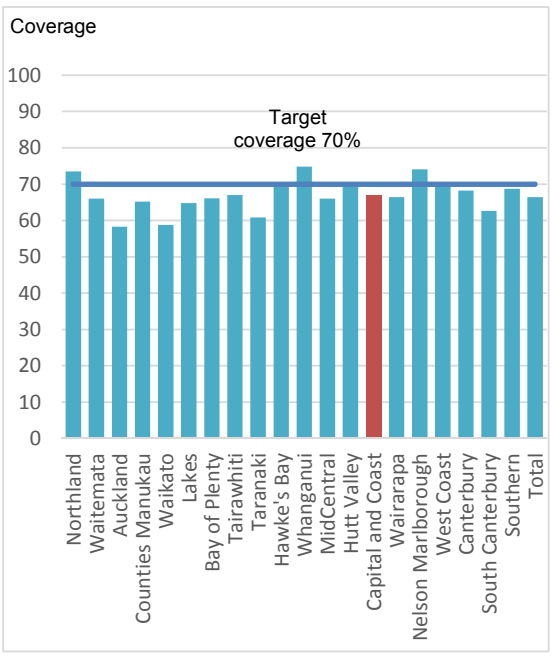


Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	2,850	1,907	66.90%	88
Pacific	2,000	1,355	67.80%	45
Other	31,150	22,441	72.00%	
Unspecified		37		
Total	**36,000**	**25,740**	**71.50%**	

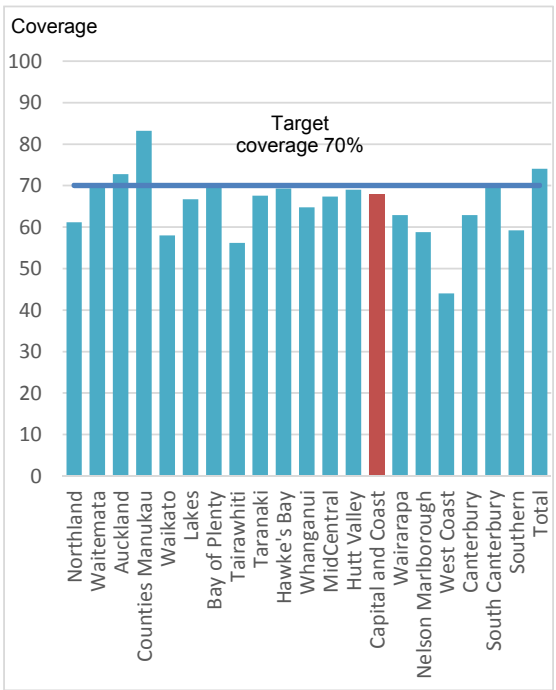
For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%

DHB COVERAGE COMPARISONS (FOR PRIORITY POPULATIONS)

Māori



Pacific



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10.4. Wairarapa (WRDHB) Coverage

Wairarapa Coverage by Ethnicity in the Two Years Ending 30 June 2019 (Women Aged 50–69 Years)

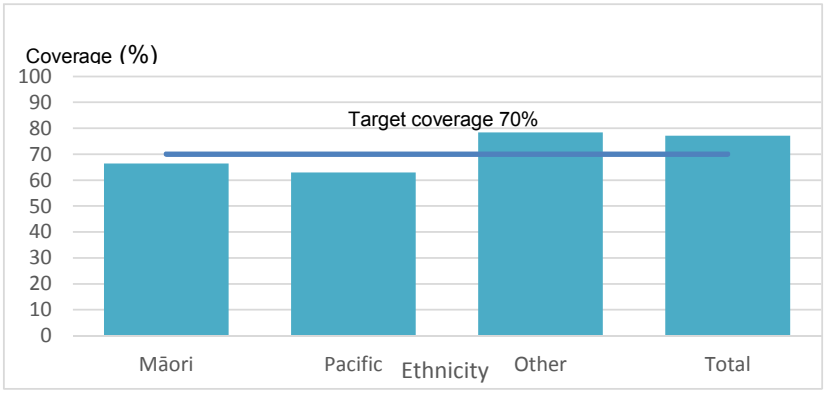


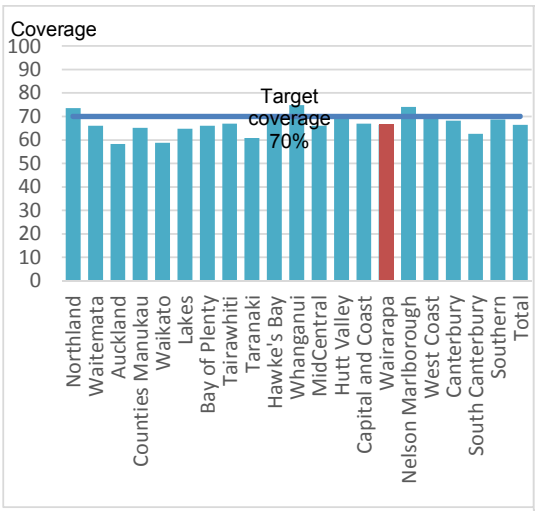
Table 1: BSA coverage (%) in the two years ending 30 June 2019 by ethnicity, women aged 50–69 years, Total Coverage

Ethnicity	Population	Women screened in last 2 years	2-year coverage	Additional screens to reach target*
Māori	700	465	66.40%	25
Pacific	70	44	62.90%	5
Other	5,685	4,457	78.40%	
Unspecified		8		
Total	**6,455**	**4,974**	**77.10%**	

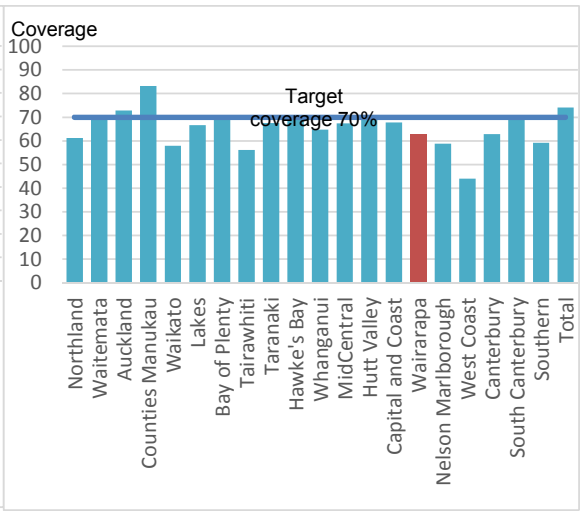
**For the total population the number of additional screens is the number required to move from the total population coverage to 70%. This may not be the same as the sum of additional screens required for each ethnic group to reach 70%.*

DHB coverage comparisons (for priority populations)

Māori



Pacific



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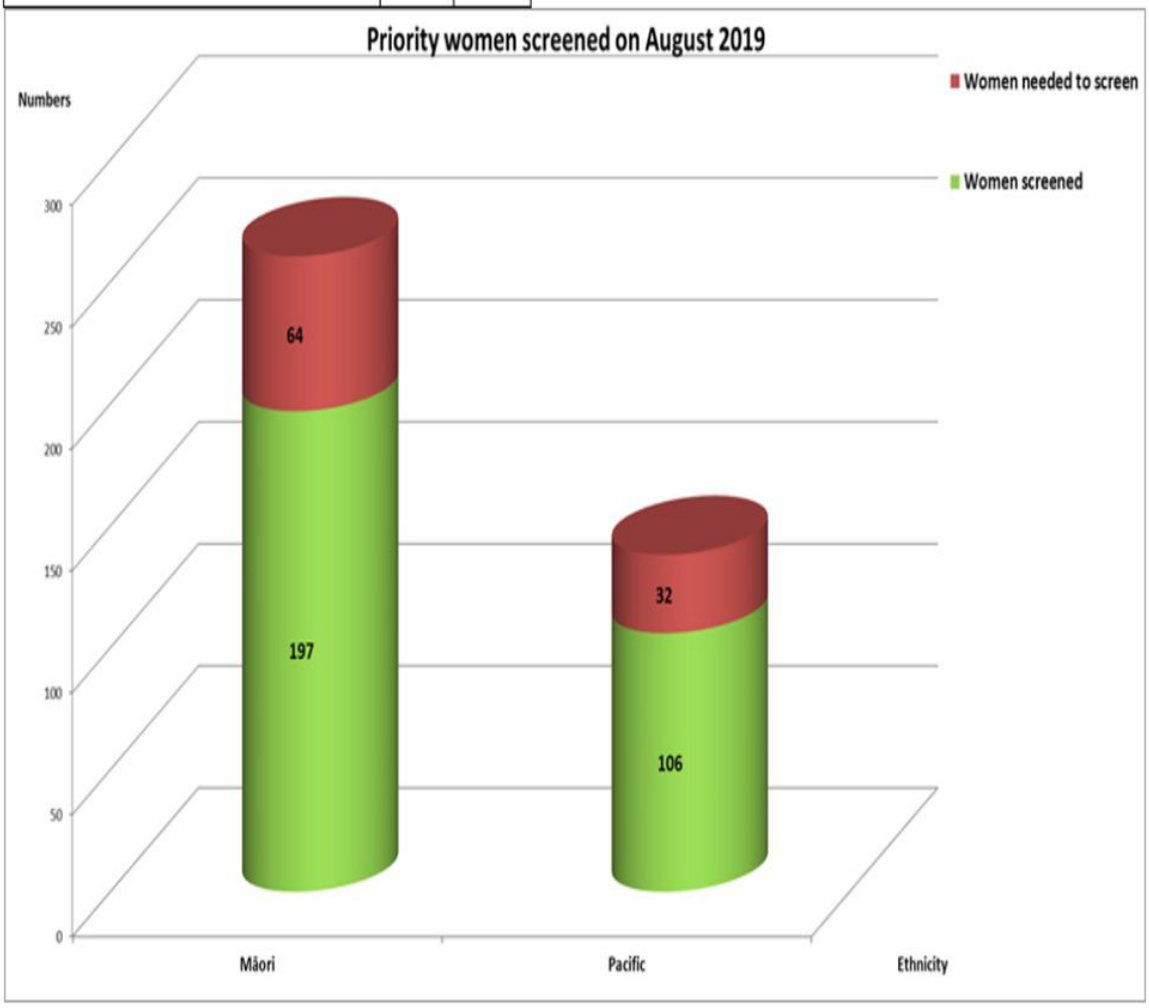
Some initiatives and success stories for this quarter

The 'Ethnicity Target and Graph' we use has been adjusted to clearly show the number of priority women needed to be screened each month to reach target. Coverage (70%)**.**

Details of priority women August 2019	Māori	Pacific
Target	261	138
Women screened	197	106
Women needed to screen	64	32



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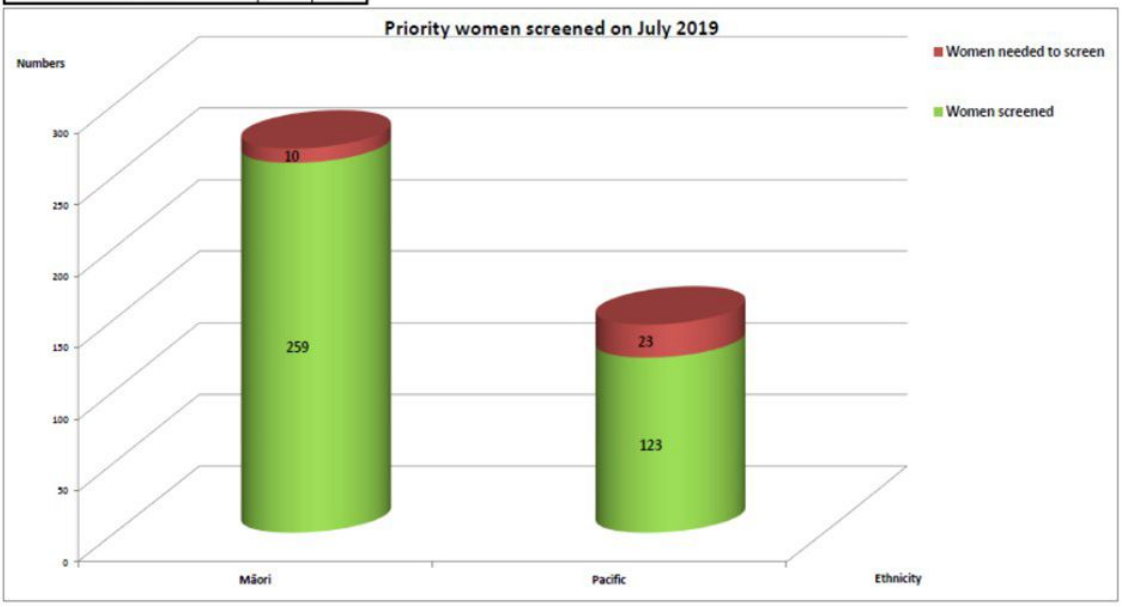
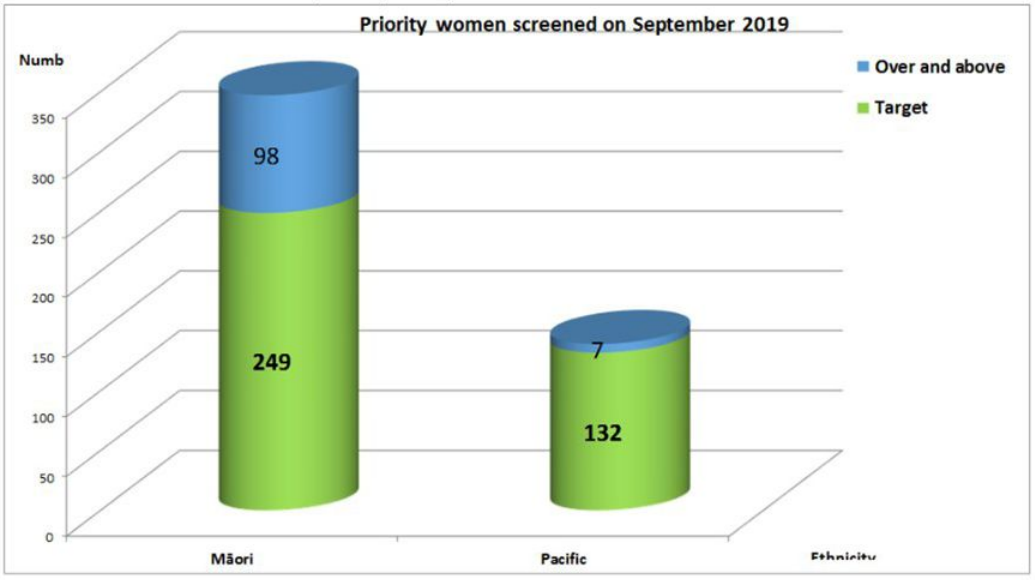
BreastScreen Central

Details July 2019	Māori	Pacific
Target	269	146
Women screened	259	123
Women needed to screen	10	23



Coverage in the winter months is often affected but the recruitment and retention team is working hard to rectify this as seen in the September chart:

Details September 2019	Māori	Pacific
Target	249	132
Women screened	347	139
Over and above	98	7



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10.5. National Cervical Screening Programme (NCSP) data – Quarter One July to Sept 2019

Quarterly NCSP screening coverage reports are available up to June 2019. NCSP national coverage is set at 80% for all eligible women. Hutt Valley District Health Board (HVDHB) continues to maintain the highest national coverage for Asian women at 75.30%.

There has been a marked increase in population for Asian and NZ European women in all 3 DHB regions. Māori women population has increased significantly in the CCDHB region over the last quarter.

- CCDHB coverage has decreased for all ethnic groups.
  Population has increased across all ethnicities in particular Māori, Asian and NZ European/Other women.
- HVDHB coverage has decreased for all ethnic groups.
  Population increased across all ethnicities in particular for Asian women.
- WDHB coverage has increased for Māori and Pacific for this period and decreased for Asian NZ European/Other ethnic groups.

Strategies to improve coverage:

- Using data matching to identify women who are missing out from screening, and systematically inviting them for screening. Engagement with high needs general practices.
- Linking with support services Māori and Pacific to provide targeted support to priority group women in order to facilitate screening.
- Encourage General Practice to refer earlier to support services for early intervention.
- Reducing barriers to screening by providing free smears to priority group women.
- 4 Saturday 'Free Cervical Screening Clinics' held annually at BreastScreen Central, HVDHB targeting 50 women at each clinic. Support and transport is provided. A further 4 Saturday screening days to be introduced at Wellington Hospital and Wairarapa Hospital 2020.
- Provision of 'Free' community-based cervical screening evening clinics in high-needs communities across the 3 DHB Region, targeting Māori, Pacific, and Asian women.
- 'Free' day-time community-based cervical screening day clinics held in high-needs communities.
- Providing individual support to primary care providers to improve cervical screening systems and processes, and improve screening rates.
- Holding regular meetings where key stakeholders work collaboratively on strategies for improving cervical screening coverage.
- Developed a Facebook Page to broaden reach for advertising 'Free Smear Clinics' on community pages.
- Mapping overdue lists to identify priority women unscreened or under screened.
- Increased education and attendance at community health events.
- Undertaking initiatives to improve attendance by priority group women at colposcopy clinics. Supporting early referrals to support services and community health workers.
- Contracted a Smear Taker Nurse to provide 'Free after-hour Smear Clinics' in high needs population areas.
- Partnering with all Primary Care Organisations to identify NCSP priority women who are unscreened or under screened and invite and support to screening.
- Encourage Practices to increase the nursing workforce able to provide Cervical Screening.
- Smear Taker Grants are available through NCSP. Actively encourage nursing workforce to apply for this.
- Work with Practices to look at implementing after-hours smear clinics evening and Saturday.

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NCSP 3-Yearly Coverage Hutt Valley ending 30 June 2019

Figure 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

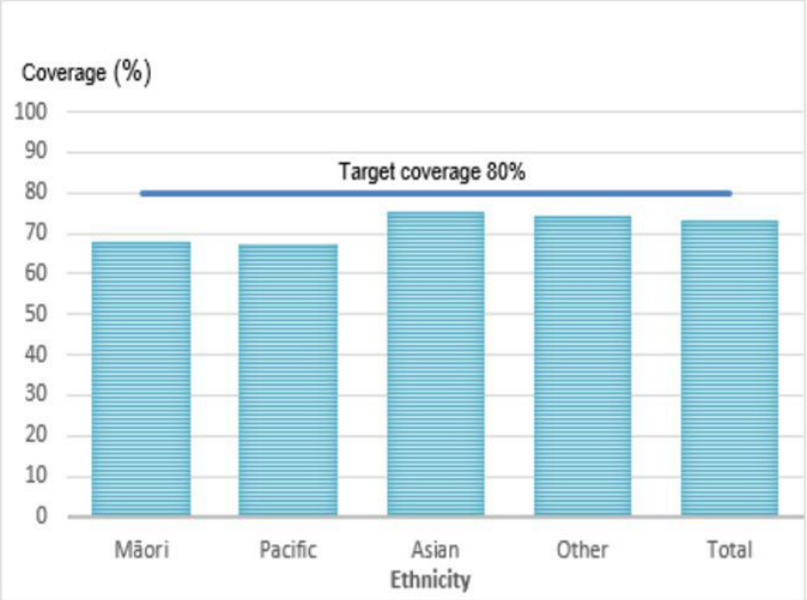

Table 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

Ethnicity	Population	Women screened in last 3 years	3-year coverage	Additional screens to reach target*
Māori	5,874	3,991	67.90%	708
Pacific	2,769	1,873	67.60%	342
Asian	5,471	4,121	75.30%	255
Other	26,555	19,692	74.20%	1,552
Total	**40,669**	**29,677**	**73.00%**	**2,858**

**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

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NCSP 3-Yearly Coverage Capital and Coast ending 30 June 2019

Figure 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

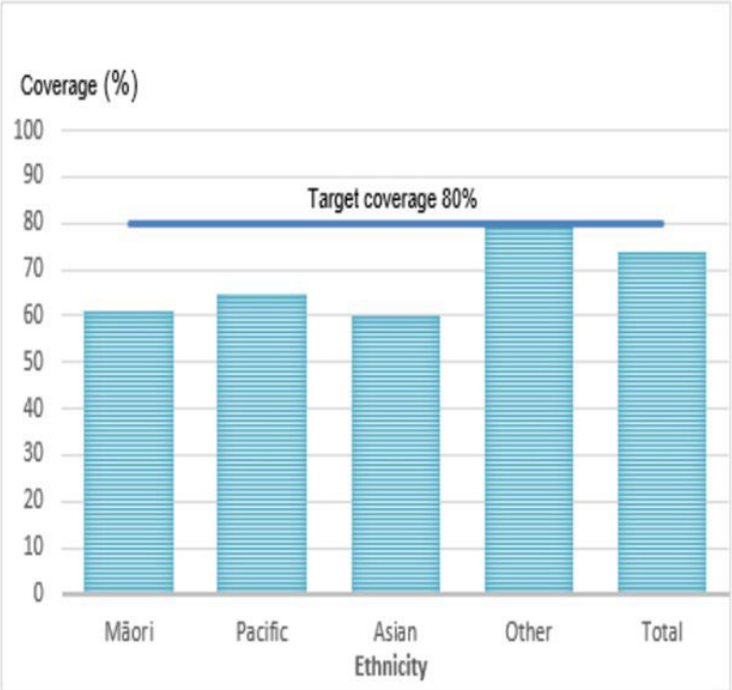

Table 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

Ethnicity	Population	Women screened in last 3 years	3-year coverage	Additional screens to reach target*
Māori	8,917	5,459	61.20%	1,674
Pacific	5,509	3,569	64.80%	838
Asian	14,955	8,928	59.70%	3,036
Other	58,609	46,892	80.00%	
Total	**87,990**	**64,848**	**73.70%**	**5,544**

**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

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NCSP 3-Yearly Coverage Wairarapa ending 30 June 2019

Figure 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

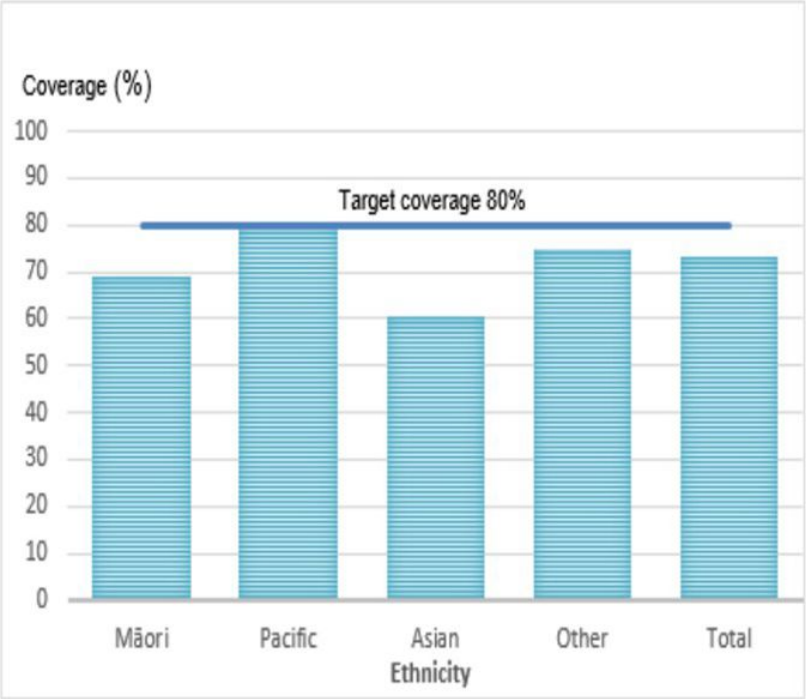

Table 1: NCSP coverage (%) in the three years ending 30 June 2019 by ethnicity, women aged 25–69 years, Total Coverage

Ethnicity	Population	Women screened in last 3 years	3-year coverage	Additional screens to reach target*
Māori	1,700	1,173	69.00%	187
Pacific	173	138	79.80%	
Asian	447	271	60.60%	86
Other	9,532	7,118	74.70%	507
Total	**11,852**	**8,700**	**73.40%**	**781**

**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

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Table one NCSP coverage (%) of women aged 25–69 years in the three years ending 30 June 2017, 2018, 2019, by ethnicity and District Health Board

DHB	Māori			Pacific			Asian			Other		
	Jun-17	Jun-18	Jun-19	Jun-17	Jun-18	Jun-19	Jun-17	Jun-18	Jun-19	Jun-17	Jun-18	Jun-19
Northland	73.3%	72.6%	71.2%	70.9%	68.9%	63.4%	55.0%	52.1%	54.3%	79.4%	76.5%	74.5%
Waitemata	62.1%	61.3%	60.1%	69.9%	65.4%	62.1%	69.8%	67.8%	68.4%	74.0%	72.6%	72.0%
Auckland	54.7%	52.6%	50.5%	66.0%	62.9%	59.3%	51.9%	49.7%	50.1%	73.2%	73.7%	74.4%
Counties Manukau	66.3%	65.0%	61.5%	79.5%	74.9%	68.1%	68.3%	66.7%	66.2%	69.6%	68.5%	67.0%
Waikato	70.1%	69.6%	68.5%	75.9%	73.1%	71.5%	63.4%	64.5%	65.5%	78.1%	77.6%	77.4%
Lakes	71.4%	74.3%	74.2%	76.5%	82.6%	85.0%	47.8%	48.9%	51.8%	79.4%	81.4%	80.7%
Bay of Plenty	72.6%	72.6%	72.6%	72.7%	73.7%	74.9%	54.7%	55.1%	55.8%	85.6%	85.3%	83.6%
Tairawhiti	71.1%	70.9%	72.7%	66.3%	70.1%	68.2%	54.7%	58.0%	64.0%	78.6%	78.4%	78.6%
Taranaki	75.1%	75.6%	74.4%	80.3%	87.1%	81.0%	65.9%	64.5%	65.0%	82.4%	82.1%	80.5%
Hawke's Bay	75.2%	75.6%	74.3%	71.1%	72.2%	74.8%	60.5%	59.3%	58.7%	77.5%	75.8%	74.9%
Whanganui	71.5%	71.9%	70.7%	68.7%	74.2%	72.8%	51.5%	52.2%	50.6%	77.7%	76.9%	75.4%
MidCentral	64.7%	65.5%	64.6%	73.1%	75.6%	77.5%	56.1%	56.0%	56.6%	78.2%	77.6%	77.9%
Hutt Valley	66.3%	67.5%	67.9%	67.6%	66.9%	67.6%	75.9%	74.2%	75.3%	75.5%	75.0%	74.2%
Capital and Coast	61.5%	61.3%	61.2%	62.2%	64.5%	64.8%	59.6%	59.5%	59.7%	78.3%	79.5%	80.0%
Wairarapa	74.4%	70.3%	69.0%	91.2%	83.9%	79.8%	67.8%	63.2%	60.6%	79.7%	76.7%	74.7%
Nelson Marlborough	74.4%	73.9%	72.5%	69.0%	73.4%	78.9%	61.0%	62.5%	63.2%	82.0%	80.9%	79.7%
West Coast	72.5%	69.6%	68.3%	59.6%	66.3%	66.7%	51.9%	56.1%	59.9%	75.0%	74.2%	73.1%
Canterbury	68.1%	67.1%	67.8%	75.4%	77.1%	78.0%	62.8%	65.5%	68.7%	74.6%	74.0%	73.3%
South Canterbury	66.2%	64.2%	62.4%	105.0%	99.2%	104.8%	63.7%	66.9%	68.7%	77.1%	76.8%	74.7%
Southern	70.7%	70.2%	69.3%	79.0%	77.7%	74.2%	48.0%	47.2%	48.7%	79.2%	78.6%	78.7%
Total	**68.3%**	**67.9%**	**66.8%**	**73.0%**	**70.3%**	**66.6%**	**61.5%**	**60.4%**	**60.9%**	**76.8%**	**76.2%**	**75.6%**

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD INFORMATION**
	Date: 28 November 2019
Author	Director, Strategy, Innovation and Performance – Rachel Haggerty
Endorsed by	Chief Executive, CCDHB – Fionnagh Dougan
Subject	**HEALTH SYSTEM COMMITTEE RECOMMENDATIONS**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Notes** the proposed work plan for 2020;

(b) **Notes** the collaborative work underway between the Kāpiti Health Advisory Group (KHAG) and CCDHB;

(c) **Notes** the publication of the inaugural Pacific Health Profile for the Wellington region;

(d) **Notes** updates on primary care performance, health of older people and regional public health activity.

APPENDIX

1. Draft HSC Minutes 13 November 2019.

1. PURPOSE

This report summarises the key discussions at the Health System Committee (HSC) meeting on 13 November 2019. The minutes of the meeting are attached as **Appendix 1**. The full papers from this meeting are available on Boardbooks.

2. PROPOSED WORK PLAN 2020

The proposed work plan is written for a CCDHB Health System Committee but can be modified to a 2DHB Committee if required. It adopts a slightly different structure based on the learnings of previous years.

Topics covered in the 2020 work plan are Strategy, Health System Investment and Prioritisation, Health System Integrated Performance Reporting and System and Services Planning.

It is proposed that performance of the DHB provider arm and contracted community services are monitored through the Finance Risk and Audit Committee (FRAC) and the full Board consistent with the accountability responsibilities of these Committees.

3. DISCUSSION

Kāpiti locality Presentation - Kāpiti Health Advisory Group Work Programme 2019/20
Adrian Gregory, Chair of Kāpiti Health Advisory Group (KHAG) gave an update on the Group's activities since their last meeting with HSC in November 2018.

Since November 2017, CCDHB and KHAG has adopted a collaborative approach to better understand and address the health priorities in the locality. This has led to an integrated work programme designed to improve service coordination, provide higher quality of care and reduce demand for acute services, enabling services closer to home.

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This collaboration has used data, analytics and insights from community engagement to inform KHAG's five priority areas:

- Access to Services (including transport)
- Urgent Care
- Mental Health Services
- Care of Older People
- Care for People with Disabilities

CCDHB has invested $20,000 supporting KHAG with community activation to provide CCDHB with insights into the health and wellbeing of the Kāpiti community.

Through the Community Acute Response Services (CARS) an investment of approximately $200,000 has been made with new services delivered for gastroenteritis management, rehydration and asthma, to enable GP-delivered non-complex case management, with additional subsidies available to treat Māori and Pacific patients.

This investment is also supporting ambulance redirection to GP services instead of secondary and/or Wellington-based services, to support care closer to home. Since going live in May 2019, there have been approximately 100 (75 percent are over 65 years of age) successful ambulance directions to GP services in Kāpiti.

The recent Primary Mental Health RFP process which was run by the Ministry of Health, if successful, will provide a new model of primary mental health and addictions care and support across the entire district including the Kāpiti Coast. The Piki programme which provides mental health support to young people 18-25 years old is also available in Kāpiti.

Future collaborative opportunities include the continuation of KHAG's advice on aged friendly and end of life care strategies; providing input to Community Health Network development and co-design of services.

Equity – CCDHB Pacific Population Health Profile

In May 2019 the CCDHB Localities team and the Pacific Directorate, contracted Pacific Perspectives Limited to prepare the inaugural Pacific population health profile describing the health needs and health service utilisation of Pacific peoples in CCDHB and in the wider Wellington region. The aim of this population health profile was to:

- build a robust evidence based for Pacific health equity, which would support health services to identify areas for Pacific health improvement and
- inform localities planning and service integration activities for Pacific populations across the wider Wellington region.

Dr Debbie Ryan, Principal of Pacific Perspectives presented the report's high level findings.

Key findings from the Pacific population health profile are:

- There is a clustering of Pacific peoples resident in the Wellington region, which may enable localities-based approaches to healthcare service delivery and implementation;
- The Pacific population in Wellington is diverse and unique. Particular attention should be given to addressing the specific needs of Pacific ethnic groups;
- The distribution of selected social determinants of health among Pacific peoples in Wellington reflects that seen among Pacific peoples nationally. These determinants can play an important role in access to and use of healthcare services. Understanding this role can help services to better respond to the social and health literacy needs of different population groups; and

- There are marked and long-standing inequities in health outcomes between Pacific and non-Māori non-Pacific peoples. These inequities are driven by a higher prevalence of risk factors and long-term conditions and poorer access to primary health care.

These statistics paint a picture of a health system that is not adequately responding to the needs of its Pacific populations. The detailed analysis in the report enables a better understanding of Pacific peoples in the CCDHB and the greater Wellington region and provides support in the development of strategies and services that can contribute to Pacific health equity.

Gender Affirming Healthcare at CCDHB - Update
An update on progress with Gender Affirming Healthcare at CCDHB was presented. This work is supported by the Sex and Gender Diverse (SGD) Working Group, which sits under the Youth ICC Steering Group. Members include community providers of Gender Diverse Healthcare and Support, people with lived experience and DHB clinicians who support the delivery of gender affirming health care services. The Group's mandate is to improve pathways with a future focus for the SGD community within CCDHB.

Pathways available include:

- GP consultation
- Readiness assessment for Hormone Therapy
- Prescribing Hormone Therapy in Secondary Services and Primary Care
- Community Support Services
- Physiotherapy
- Speech and language therapy
- Hysterectomy and Orchidectomy
- Access to high cost treatment pool for Gender Reassignment Surgery

The SGD working group is also working with a range of services and organisations to achieve more equitable outcomes for the SGD community such as Prototyping a primary care led model of care, speech and language therapy and gender affirming mastectomy.

The SGD working group will continue to advocate for:

- The expansion of the number of primary care sites involved in gender affirming healthcare from three to five or six and to ensure that practice at these sites aligns with contemporary best practice; and
- supporting the SGD community including mental health support, information and advice to the community.

An investment proposal has been developed and is supported by the SGD working group for investment in 2020/21.

Investment and Performance – Core Primary Care Services
The Committee considered a paper describing our investment and performance within core primary health care services. In 2018/19, CCDHB invested $67 million in core primary care services provided under the PHO Services Agreement. This investment purchases services including doctor and nurse visits, immunisation, health promotion, support for people with long term conditions (care plus), management services, and provides performance-based funding.

Primary care is not fully funded and attracts a co-payment per visit from the patient. Specific Government initiatives are targeted to removing the cost barrier and improve access to primary care. From 1 December 2018 additional funding was provided to:

- Expand the zero fees for children scheme to include 13 year olds (zero fees for under 14s), and
- Provide low-cost visits for Community Services Card holders and their dependents.

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Investment in core primary care services is forecast to increase to $72 million in 2019/20 as these initiatives implemented in December 2018 are funded for a full financial year.

93% of CCDHB's population are enrolled with a PHO either in CCDHB or elsewhere, however coverage is not consistent across ethnicity groups. According to Statistics New Zealand population projections all Pacific peoples living in CCDHB are enrolled with a PHO, in contrast with 88% of Māori and 93% of non-Māori non-Pacific peoples.

Factors driving performance include workforce challenges across primary care practices, a number are experiencing instability in workforce with experienced staff resigning and difficulty in recruitment. Practices and PHOs are reinvigorating their focus on sustainable processes for target achievement to protect against future effects of workforce changes. We are actively working with our PHO partners to identify opportunities to improve performance. These responses differ based on the particular needs and challenges of each organisation.

78% of the population of CCDHB is enrolled in a general practice in the HCH programme, making HCH a powerful lever to drive primary care performance. Our Health Care Home (HCH) model strengthens primary care to provide comprehensive and continuous health care with the goal of supporting people to optimise health outcomes.

HCH practices receive additional funding directly linked to achieving targets for core primary care indicators including:

- population health indicators - immunisation coverage for children at 8 months and brief advice for smokers to quit;
- access indicators - time to third next available appointment and year of care plans completed; and
- acute flow indicators – rates of ED presentations, ambulatory sensitive hospitalisations (ASH), and acute admissions.

At a national level, the Ministry of Health is also driving diversification of the general practice workforce through funding of mental health services delivered in general practice settings.

In October, PHOs and DHBs across the sub-region partnered to submit a response to the Ministry of Health request for proposal (RFP) opportunity to *develop a service to make a range of supports rapidly available to a general practice's enrolled population to help people manage challenges that adversely affect their wellbeing.* The RFP prescribes the model of care and requires Health Improvement Practitioners (registered health professionals) and Health Coaches (non- registered workforce) to be based on site in general practice clinics, further diversifying the practice workforce. If successful, this service will build upon the Piki programme now in place supporting 18-25 year olds in our communities with mild to moderate mental health concerns.

Community Health Networks are our mechanism for developing and delivering services tailored to the needs of particular communities in a particular locality. Health Care Home practices form the core services in the Networks. Our approach acknowledges communities as partners in understanding need and service planning, and it is improving co-ordination and integration between those who use services and those who develop and provide them.

Our next steps include developing investment plans to support people with, or at risk of developing, long term conditions, and health of older people. These plans will include initiatives to be developed with communities across our localities and in Community Health Networks to strengthen both planned care and prevention prioritising actions to achieve equity.

Health of Older People – Areas of Focus

In 2018 around 318,000 people were living within the CCDHB district, 44,000 (14%) of whom were 65 or over. Only four percent of over 65s identify as Māori and four percent as Pacific peoples. We also know that Māori

and Pacific peoples experience complexity in health need much earlier (10 to 20 years) than non-Māori non-Pacific peoples. We also need to partner with these communities to ensure our responses support people to age well. We need more appropriate supports for Māori and Pacific peoples with long term conditions intensifying supports for older Māori and Pacific peoples who are younger than the usual view of older person's services being for those aged 65 and over.

Currently, CCDHB's three localities experience notably different age distributions with a greater proportion of older people living in Kāpiti compared with Porirua and Wellington. These differences emphasise the value in a localities approach and the establishment of Community Health Networks (CHNs) within those localities so that services are responsive and appropriate for the needs of those communities. For older people in CCDHB, our CHNs will be a critical coordinating point for services that support living well in the community.

Use of general health services by older people

CCDHB's generally wealthier and healthier population means people over 65 largely remain living independently at home and are generally well engaged with primary care. However, there is ethnic variation in primary care enrolment with Māori less likely (88%) and Pacific peoples all enrolled (114%), based on Statistics NZ population projections.

95 percent of this age group enrolled with primary care have visited a primary care practice in the last twelve months. During the same period, 22 percent of Māori and 29 percent of Pacific peoples, 65 and over were admitted to our hospitals compared with 13 percent of non-Māori non-Pacific people in the same age group. In 2018, there were 12,414 ED presentations for 7,895 people aged 65 and over who live in the CCDHB district.

Use of specific services by older people

We invest around $71.5 million per annum in residential care, community support services and in support for carers for all eligible older people. The number of people in aged residential care (ARC) has consistently reduced from 2016. Approximately 59% of those who receive funded support are being supported at home. Aged residential care (ARC) is a demand driven service and facilities provide four levels of care: rest home, hospital, dementia and psychogeriatric. Eligibility is determined through the needs assessment and service coordination service (NASC). ARC is also an income and asset tested service. ARC will always play an important role in meeting the needs of older people, however our Health System Plan focus on the life course including our "simplify, intensify" approach and Community Health Network (CHN) development anticipates a more diverse range of service responses for older people over the medium term.

There are around 2400 people 65 years and over who are Home and Community Support Services (HCSS) clients. Older Māori access HCSS broadly in line with their population size and Pacific peoples less than their population size would predict. Given Māori and Pacific peoples access ARC services at lower rates than our 'other' population we may have expected them to access higher levels of HCSS.

Frailty is a contributor to increased use of hospital services, unless it is well managed. The time spent in hospital can lead to deteriorating health status. More effective use of a wider health workforce in community settings helps to avoid hospitalisation or support earlier mobilisation and discharge has the potential to prevent further decline for people with frailty. We are prioritising actions to support older people with frailty and have begun to respond to this challenge through the Acute Demand and Bed Capacity programme in place throughout 2019.

The Community Health of Older People Initiative (CHOPI) provides proactive, responsive geriatric expertise to support primary care in their management of frail older people. The initiative aims to support frail older people to stay at home longer, and during periods of acute illness. CHOPI promotes and delivers early intervention that addresses polypharmacy and refers to other services as appropriate (e.g. strength and balance) to promote restoration of function.

Advanced Wellbeing at Home Initiative (AWHI) aims to help people who have been in hospital return to the level of function they had before they were admitted. Allied Health, nursing and home support are provided

to people immediately after they are discharged from hospital. It also links people and their families and whānau with the services they were receiving before they came to hospital.

We are establishing a Health of Older people steering group underneath the Integrated Care Collaborative (ICC) to develop an across-system model of care and identify priority work for 2020 to better meet the needs of older people with frailty. The group will also identify other priority work to develop and support sustainable health services for older people.

Regional Public Health Update
This provide provided an update on:

Measles
A total of 34 measles cases in the Greater Wellington region year to date with all cases linked to either international or domestic outbreaks. RPH continues to adopt a "Stamp it Out" approach to new cases, utilising our Communicable Disease Nursing and Medical Team workforces. RPH continues to work closely with primary and secondary care.

Release of Taonga Mokopuna Videos
The Healthy Communities Team recently launched a new resource for early childhood centre, designed to reduce the spread of illness and keep centre environments healthy. It is available for all centres across the country.

Child Health Team (activities for the first quarter 2019)
The Child Health Team provides services to 112 primary and intermediate schools across CCDHB, with a total population of 31,804 children. Our Pubic Health Nurses (PHN) received 298 new referrals in the first quarter of 2019. The top ten identified personal health referral conditions include vision, hear concerns, social concerns, dental, and impetigo.

Spirit Service Awards 2019
The Prime Minister's Award / Te Tohu a Te Pirimia and overall winner of the year was the Healthy Housing Initiative, which of course includes the Well Homes Partnership between Regional Public Health, Tu Kotahi Maori Asthma Trust, Sustainability Trust and He Kainga Oranga. The initiative also won the Better Outcomes Award.

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 13 November 2019 at 9am
Kāpiti District Council Chambers, Kāpiti

PUBLIC SECTION

PRESENT

COMMITTEE: Dame Fran Wilde (Chair)
Ms Sue Kedgley
Dr Roger Blakeley
Ms Eileen Brown (arrived 9.50am)
Ms Sue Emirali
Ms 'Ana Coffey (left at approx. 11am)
Mr Tristram Ingham

STAFF: Ms Fionnagh Dougan, Chief Executive Officer
Ms Arawhetu Gray, Director Māori Health Development Team
Ms Gerardine Clifford-Lidstone, General Manager, Child Youth & Localities (items 3.1 and 3.2)
Ms Jenny Langton, General Manager, Primary Care & Long Term Conditions (items 3.4 and 3.5)
Ms Astuti Balram, General Manager, Integrated Care (items 3.1 & 3.5)
Mr Peter Gush, Service Manager, Regional Public Health (item 4.1)
Ms Lisa Smith, System Development Manager (item 3.4)
Ms Jan Marment, Senior System Development Manager (item 3.5)

PRESENTERS: Dr Debbie Ryan, Pacific Perspective (item 3.2)
Mr Adrian Gregory, Kāpiti Health Advisory Group (item 2.1)

GENERAL PUBLIC:

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL
Tristram Ingham opened the meeting. The Chair welcomed Ms Ayesha Verrall, the new CCDHB Board Member, members of the Kāpiti Health Advisory Group, staff and public.

1.2 APOLOGIES
Apologies received from Andrew Blair, Sue Driver, and Tino Pereira.

1.3 INTERESTS
1.3.1 Interest Register
No changes were received.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 17 October 2019, taken with public present, were confirmed as a true and correct record.

Moved: Roger Blakeley **Seconded:** Sue Kedgley **CARRIED**

1.5 MATTERS ARISING

1.6 ACTION LIST

The reporting timeframes on the other open action items were **noted**.

Actions:

1. The Chair and Chief Executive to put a paper to the Board to advise:
   - a briefing and recommendations to be organised for the incoming Board members;
   - minutes and discussion of each meeting to made available on the CCDHB website prior to the next meeting
2. The Committee requests for relevant consumer groups to attend the meeting to speak to their agenda items.

1.7 PROPOSED WORKPLAN 2020

The paper was taken as **read**.

The Committee:

a) **Noted** that the proposed work plan has Strategy, Health System Investment and Prioritisation, Health System Integrated Performance Report and System and Services Planning sections

b) **Noted** that the section focused on Provider Performance – Efficiency, Outputs, is proposed to move to FRAC and the full Board.

Discussion:

i. The Chief Executive noted the intention to establish a Capital Investment Committee to enable major capital pieces to be taken out of the Financial, Risk and Audit Committee (FRAC). This would allow FRAC to fulfil its accountability role more comprehensively beyond financial performance to include both financial and non-financial performance across our providers, against key indicators and determine remedial actions. This would allow the Health System Committee to focus on its role ensuring DHB commissioning aligns with our strategic direction.

Action:

3. Management to organise a Board workshop to focus on the allocation of work between the Committees.

2 PRESENTATION

2.1 KĀPITI UPDATE

The Committee **noted** the presentation.

3 DISCUSSION

3.1 LOCALITIES UPDATE – KĀPITI HEALTH ADVISORY COMMITTEE WORK PROGRAMME 2019/20

The paper was taken as **read**.

The Committee:

(a) **Noted** that the Kāpiti Health Advisory Group works closely with CCDHB to improve access to health services for the Kāpiti Coast community

(b) **Noted** the work programme of the Kāpiti Health Advisory Group for 2019/20.

Discussion:

i. We ran a 2 month telehealth pilot to look at the processes. The telehealth steering group will identify services to be provided. We are also looking to expand our services in the community such as including specialist services. The next step is the development of Community Health Networks which provides infrastructure in the community.

ii. KHAG is running four workshops on ageing and disability issues until Christmas using the existing information, triangulation exercise and surveys with various focus group. The group will be in a position to present their findings and recommendations in the first half of 2020.

iii. The Committee acknowledged the positive progress KHAG and the genuine engagement of KHAG with the DHB and other groups. KHAG also acknowledged Taulalo Fiso, Director for Localities for his commitment to Kāpiti.

iv. KHAG emphasised that the work programme is a multi-year programme and that it will be essential to review effectiveness of the initiatives annually, where needed.

v. Discussion focused on the possible need for a Community Asset Mapping exercise.

Action:

4. Management to provide data on services.

3.2 EQUITY – CCDHB PACIFIC POPULATION HEALTH PROFILE

The paper was taken as **read**. The Chair thanked Dr Debbie Ryan for the report.

The Committee:

(a) **Noted** that CCDHB has completed its first Pacific population health profile.

(b) **Noted that Pacific Peoples come from a multitude of Pacific Nations but that this is often not reflected in how ethnicity data is collected**

(c) **Noted that any narrative on Pacific Peoples does not victim blame and includes the voice of Pacific Peoples**

(d) **Noted the need for a comprehensive Pacific Strategy and Action Plan to be finalised. Actions should be specific to the individual ethnic group, one size does not fit all for Pacific Peoples.**

(e) **Noted** the aim of the Pacific population health profile was to:
- build a robust evidence base for Pacific health equity and which would support health services to identify areas for Pacific health improvement and
- inform localities planning and service integration activities for Pacific population across the wider Wellington region

(f) **Noted** the key findings of the report which will be discussed briefly by Dr Debbie Ryan at the HSC meeting

(g) **Noted** that Dr Ryan's slide presentation is to also be included with all papers for future reference

(h) **Approved** the release of this report to external stakeholders

Discussion:

i. Type 2 diabetes is common among the Pacific population groups. We used to see the Pacific population developing type 2 diabetes in their 50s but now we are seeing more of the younger Pacific population (in their 30s) developing the disease. This is not just a national issue but an international one. There are some initiatives to help the Pacific population such as green prescription and ethnic monitoring. CCDHB also has contracts with some providers to provide healthcare support to the Pacific population. At the same time, the Pacific communities need to champion a healthy lifestyle themselves.

ii. Despite the identified socio economic problems, we need to address service delivery issues in our own sector. In a recent housing survey, nearly 60% of the Pacific population interviewed said they face barriers to primary in Hutt Valley.

iii. Areas of poverty that become a barrier to care needs to be considered. Statistics on the report showed a difference income for the Pacific population, showing some earning as low as $12,000 a year.

iv. We have a unique opportunity to work closely with multiple agencies in the Capital & Coast and the Hutt Valley districts. As health leaders, we should call upon other agencies to action. We have to intervene to treat diseases and we have to rethink our intervention approach to issues such as dental services, nutrition services, mental health and addiction services.

Actions:

5. Management to provide an update on the housing data.
6. Management to invite the Pacific groups and communities to respond to the issues highlighted in the report.
7. Management to report back to the Committee on regularly on Pacific Population Health.

3.3 GENDER AFFIRMING HEALTHCARE AT CCDHB - UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the Sex and Gender Diverse (SGD) Working Group work which sits under the Youth ICC Steering Group and is supported by Strategy, Innovation and Performance

(b) **Noted** the development of the primary care led prescribing model for hormone therapy that has been prototyped in three practises

(c) **Noted** support from SGD working group for the next investment to be in expansion of the number of primary care sites involved in gender affirming healthcare including mental health support, information and advice to the community

(d) **Noted** the SGD working group are developing a strategy to support the work programme in line with international best practice and agreed that it will be available on our website

(e) **Agreed** that a future invitation will go to the SGDWG to attend an HSC meeting, at their convenience.

Discussion:

i. Although the SGD working group sits within ICC Youth but the group does cover the older population affected by this issue.

Actions:

8. Management to involve consumer groups in the meetings for such topics.
9. Management to publicise strategy on the CCDHB website once it is completed.

DRAFT

3.4 INVESTMENT AND PERFORMANCE – CORE PRIMARY CARE SERVICES

The paper was taken as **read**.

The Committee:

(a) **Noted** in 2018/19 CCDHB invested $67 million in core primary care services provided under the PHO Services Agreement. This is forecast to increase to $72 million in 2019/20 as Government initiatives implemented in December 2018 are funded for a full financial year

(b) **Noted** this reporting is part of our process for understanding how our investments in core primary care services are working for our population including equity (or not) of access to health services and outcomes achieved.

(c) **Noted** that they are not yet seeing the proportionate response to inequity.

Discussion:

i. Healthcare Homes have been used to drive performance and we are commissioning evaluations to look at the impact of services for mainstream and the Māori and Pacific population. Priorities for 2020 are around long term conditions and strategic approaches around primary care. We are also taking an equity approach to performance payment.

ii. Additional clinics for breast and cervical screening are run in partnership between primary care and regional screening services. They prioritise Māori and Pacific women and women who are significantly overdue for these screenings. There is particular focus on cervical screening on Asian women as they have lowest screening coverage.

iii. BEE Heathy programme is getting good enrolment due to the triple enrolment which covers the national immunisation register, PHO pre-enrolment and BEE healthy. The team is also running a project refreshing our focus on newborn enrolments and looking at where we can improve.

iv. The DHB is engaging providers that are capable of reaching the communities that needs our support.

v. Management acknowledged that a lot of the Taurite Ora work programme has been uplifted from the work of the SIP team. The Committee also acknowledged the great work that the SIP has done so far.

3.5 HEALTH OF OLDER PEOPLE – AREAS OF FOCUS

The paper was taken as **read**.

The Committee:

(a) **Noted** CCDHB's strong development focus on services that support older people to be well

(b) **Noted** the inequity for Māori and Pacific peoples that means they die earlier and the important relationship between long term conditions investment and that for healthy ageing

(c) **Noted** the priority focus on older people with frailty to improve both health outcomes and manage demand pressures in our health system

(d) **Endorsed** the establishment of an ICC Steering group for Health of Older People that will initially focus on older people with frailty

Discussion:

i. In considering frailty, the gerontology team uses a specific assessment tool that tends to focus on particular aspects of physical and mental ability. Primary care runs an algorithm in primary care practices based on patient's age, ethnicity, long term conditions and scores people for different settings such as proactive care and acute care. We also have good health pathways, an online tool, providing guidelines to older people.

ii. The establishment of an ICC Steering Group for Older People will look into providing services to the Māori and Pacific peoples from an earlier age due to their complex health issues they experience at the younger age compared to the other population.

iii. The Steering Group will also inform with localities focus on what our commercial business is doing, what models we want to see implemented, provide a blue print of what the sector looks like. The Healthy Ageing Strategy will underpin the work going forward.

iv. Management is looking at incorporating international practices on integrated care and primary care and frailty practices to apply in the local context.

Action:

10. Committee Secretary to send an invitation to the Committee on the Health of older people, home and community support meeting scheduled on 9 December 2019.

4 INFORMATION

4.1 REGIONAL PUBLIC HEALTH UPDATE

The paper was taken as **read**.

The Committee:

(a) **Noted** the update.

The meeting closes at 12.15pm.

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

DATED this .....day of.....2019

Fran Wilde
Health System Committee Chair

DRAFT

PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION**
	Date: 28 November 2019
Author	Capital & Coast and Hutt Valley District Health Board Chair — Andrew Blair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

It is **recommended** that the Board:

(a) **Agrees** that the 2019 newly elected Capital & Coast and Hutt Valley District Health Board member designates who wish to attend the Public Excluded part of the meeting be permitted to attend as observers;

(b) **Agrees** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers.	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers.	
Chair's report CEO's report FRAC Recommendations and minutes Risk Report CCDHB and HVDHB Financial and Operational Performance Report October 2019 CCDHB and HVDHB Quality Improvement and Patient Safety Report CCDHB Health and Safety Report 3DHB MHAIDS Update New Children's Hospital Works Programme Status Update Joint Health System Planning MHAIDS Lead District Health Board Project Report	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

* Official Information Act 1982.