PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA v.2** Held on Wednesday 7 April Location: **Wellington Regional Hospital, Level 11 Boardroom Grace Neil Block** Zoom: **876 5068 1844** Time: 9:00am
	MEETING

	Item	Action	Presenter	Min	Time	Pg
1	**PROCEDURAL BUSINESS**					
1.1	Karakia		All members	15	9:00am	2
1.2	Apologies	**ACCEPT**	Chair			
1.3	Public Participation - Nil	**VERBAL**	Public			
1.4	Continuous Disclosure 1.4.1 Combined Board Interest Register	**ACCEPT**	Chair			3
	1.4.2 Combined ELT Interest Register					7
1.5	Minutes of Previous Concurrent Meeting	**ACCEPT**	Chair			9
1.6	Matters Arising from Previous Concurrent Meetings	**NOTE**	Chair			13
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			14
1.9	Board Work Plan 2021	**DISCUSS**	Chair	10	9:15	30
2	**DHB Performance and Accountability**					
2.1	HVDHB January 2021 Financial and Operational Performance Report 2.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services	10	9.25	32 34
2.2	CCDHB January 2021 Financial and Operational Performance Report 2.2.1 Report	**NOTE**	Chief Financial Officer Director Provider Services			76 79
3	**Updates**					
3.1	HSC Update and Items for Approval	**NOTE**	Chair of HSC	20	9.35	
3.2	Māori Health Strategy Reporting -Te Pae Amorangi -Taurite Ora 3.2.1 Progress and Performance 3.2.2 Health Literacy Report	**NOTE**	Director Māori Health	20	9.55	137 141 164
3.3	Pacific Health & Wellbeing Strategic Plan 2020 - 2025 update 3.3.1 Progress and Indicators	**NOTE**	Director Pacific People's Health	20	10.15	214 216
4	**OTHER**					
4.1	General Business	**NOTE**	Chair	5	10.35	
4.2	Resolution to Exclude the Public	**ACCEPT**	Chair			227

10:40am – SIGNING OF THE ACCESSIBILITY CHARTER

DATE OF NEXT FULL BOARD MEETING:

5 May 2021, Zoom: 876 5068 1844, **Location:** Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room

NOTE TIME CHANGE TO 9:30AM

Karakia

Kia hora te marino

Kia whakapapa pounamu te moana

Hei huarahi mā tātou i te rangi nei

Aroha atu, aroha mai

Tātou i a tātou katoa

Hui e! Tāiki e!

Translation

May peace be wide spread

May the sea be like greenstone

A pathway for us all this day

Let us show respect for each other

For one another

Bind us all together!

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

01/04/2021

Name	Interest
Mr David Smol *Chair*	• Chair, New Zealand Growth Capital Partners • Chair, Wellington UniVentures • Director, Contact Energy • Board Member. Waka Kotahi (NZTA) • Director, Cooperative Bank • Chair, DIA External Advisory Committee • Chair, MSD Risk and Audit Committee • Director, Rimu Road Limited (consultancy) • Sister-in-law works for Capital and Coast DHB
Mr Wayne Guppy *Deputy Chair*	• Mayor, Upper Hutt City Council • Director, MedicAlert • Chair, Wellington Regional Mayoral Forum • Chair, Wellington Regional Strategy Committee • Deputy Chair, Wellington Water Committee • Deputy Chair, Hutt Valley District Health Board • Trustee, Ōrongomai Marae • Wife is employed by various community pharmacies in the Hutt Valley
Dr Kathryn Adams	• Contracted Vaccinator, Kokiri Marae Hauora Clinic, Lower Hutt • Fellow, College of Nurses Aotearoa (NZ) • Reviewer, Editorial Board, Nursing Praxis in New Zealand • Member, Capital & Coast District Health Board • Member, National Party Health Policy Advisory Group • Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health • Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa
Dr Roger Blakeley	• Board Member, Transpower New Zealand Ltd • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member of Capital & Coast District Health Board • Member, Harkness Fellowships Trust Board • Member of the Wesley Community Action Board

	• Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young • Staff seconded to Health and Disability System Review • Contact with Associate Minister for Health, Hon. Peeni Henare
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd
Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Board Member, Health Quality and Safety Commission • Director, Foundation for Equity & Research New Zealand • Director, Miramar Enterprises Limited (Property Investment Company) • Member, Independent Monitoring Mechanism to the United Nations on the United Nations Convention on the Rights of Persons with Disabilities • Chair, Te Ao Mārama Māori Disability Advisory Group • Co-Chair, Wellington City Council Accessibility Advisory Group • Chairperson, Executive Committee Central Region MDA • National Executive Chair, National Council of the Muscular Dystrophy Association • Trustee, Neuromuscular Research Foundation Trust • Professional Member, Royal Society of New Zealand • Member, Disabled Persons Organisation Coalition • Member, Scientific Advisory Board – Asthma Foundation of NZ • Member, 3DHB Sub-Regional Disability Advisory Group

	• Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori medical Practitioners Association) • Senior Research Fellow, University of Otago Wellington • Wife is a Research Fellow at University of Otago Wellington • Co-Chair, My Life My Voice Charitable Trust • Member, Capital & Coast District Health Board • Member, DSAC • Member, FRAC
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission • Locum Contractor, Karori Medical Centre • Contractor, Lychgate Funeral Home
Sue Kedgley	• Member, Capital & Coast District Health Board • Member, Consumer New Zealand Board
Ken Laban	• Chairman, Hutt Valley Sports Awards • Broadcaster, numerous radio stations • Trustee, Hutt Mana Charitable Trust • Trustee, Te Awaikairangi Trust • Member, Hutt Valley District Health Board • Member, Ulalei Wellington • Member, Greater Wellington Regional Council • Member, Christmas in the Hutt Committee • Member, Computers in Homes • Commentator, Sky Television
Prue Lamason	• Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Member, Hutt Valley District Health Board • Daughter is a Lead Maternity Carer in the Hutt
John Ryall	• Member, Social Security Appeal Authority • Member, Hutt Union and Community Health Service Board • Member, E tū Union
Naomi Shaw	• Director, Charisma Rentals • Councillor, Hutt City Council • Member, Hutt Valley Sports Awards • Trustee, Hutt City Communities Facility Trust
Vanessa Simpson	• Director, Kanuka Developments Ltd • Executive Director Relationships & Development, Wellington Free Ambulance • Member, Kapiti Health Advisory Group
Dr Richard Stein	• Visiting Consultant at Hawke's Bay DHB • Chairman and Trustee, Crohn's and Colitis NZ Charitable Trust

	• Member, Executive Committee of the National IBD Care Working Group • Member, Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy • Clinical Senior Lecturer, University of Otago Department of Medicine, Wellington • Assistant Clinical Professor of Medicine, University of Washington, Seattle • Locum Contractor, Northland DHB, HVDHB, CCDHB • Gastroenterologist, Rutherford Clinic, Lower Hutt • Medical Reviewer for the Health and Disability Commissioner

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

2 FEBRUARY 2021

Fionnagh Dougan *Chief Executive Officer 2DHB*	• Board, New Zealand Child & Youth Cancer Network • Trustee, Wellington Hospital Foundation • Adjunct Professor University of Queensland
Rosalie Percival *Chief Financial Officer 2DHB*	• Nil
Joy Farley *Director Provider Services 2DHB*	• Nil
Rachel Haggerty *Director, Strategy Planning & Performance 2DHB*	• Director, Haggerty & Associates • Chair, National GM Planner & Funder
Arawhetu Gray *Director, Māori Health 2DHB*	• Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group • Director, Gray Partners • Chair, Tangata Whenua Advisory Group, Te Hiringa Hauora, Health Promotion Agency
Junior Ulu *Director, Pacific Peoples Health DHB*	• Member of Norman Kirk Memorial Trust Fund • Paid Member of Pasifika Medical Association
Declan Walsh *Director People, Culture and Capabilityn2DHB*	• Nil
Helen Mexted *Director, Communications and Engagement 2DHB*	• Director, Wellington Regional Council Holdings, Greater Wellington Rail • Board member, Walking Access Commission • Partner owns Mexted Motors (supplies/services vehicles for the CCDBH)
Dr Sisira Jayathissa *HVDHB Chief Medical Officer*	• Member of the Medicine Adverse Reaction Committee Medsafew (MOH) • Member Standing committee on Clinical trials (HRC) • Member Editorial Advisory Board NZ Formulary • Member of Internal Medicine Society of Australia and New Zealand • 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 • Company Director of Family Company Strik's Nurseries and Garden Shop 100&1 House and Garden Plans

Wednesday, 31 March 2021

John Tait *CCDHB Chief Medical Officer*	• Vice President RANZCOG • Ex-offico member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Trustee, Wellington Hospitals Foundation • Board member Asia Oceanic Federation of Obstetrician and Gynaecology • Chair, PMMRC
Christine King *Chief Allied Health Professions Officer 2DHB*	• Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Tracy Voice *Chief Digital Officer 3DHB*	• Secretary, New Zealand Lavender Growers Association • Gateway Reviewer
Sarah Jackson *Acting CCDHB Executive Director, Quality Improvement & Patient Safety*	• Nil
Saira Dayal *Acting HVDHB General Manager Quality, Service Improvement and Innovation*	• Fellow of NZ College of Public Health Medicine
Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington
Nigel Fairley *General Manager MHAIDS 3DHB*	• 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

BOARD MEETING **PUBLIC**

HUTT VALLEY DHB / Capital & Coast District Health Board Ūpoko ki te Uru Hauora	**MINUTES** Held on Wednesday 3 March Location: **Hutt Hospital, Level 1, Clock Tower Building, Auditorium Room** Zoom: **876 5068 1844** Time: **9.30**am
BOARD MEETING	**PUBLIC**

IN ATTENDANCE

David Smol	Chair, Hutt Valley and Capital & Coast DHBs		
Dr Kathryn Adams	Board Member	Josh Briggs	Board Member
'Ana Coffey	Board Member	Yvette Grace	Board Member
Dr Tristram Ingham	Board Member	Ken Laban	Board Member
Sue Kedgley	Board Member	Prue Lamason	Board Member
Vanessa Simpson	Board Member	John Ryall	Board Member
Hamiora Bowkett	Board Member	Naomi Shaw	Board Member
Roger Blakeley	Board Member	Dr Richard Stein	Board Member
		Keri Brown	Board Member

Hutt Valley and Capital & Coast DHB

Fionnagh Dougan	Chief Executive
Rosalie Percival	Chief Financial Officer
Amber Igasia	(Acting) Board Secretary
Tracy Voice	Chief Digital Officer
Helen Mexted	Director of Communication and Engagement
Cheryl Goodyer	(Acting) Director Maori Health
Chris Kerr	Chief Nursing Officer
Christine King	Chief Allied Health Officer
Junior Ulu	Director Pacific People's Health

CCDHB

John Tait	Chief Medical Officer
Sarah Jackson	(Acting) Executive Director Quality Improvement and Patient Safety

HVDHB

Sisira Jayathissa	Chief Medical Officer
Saira Dayal	(Acting) General Manager, Quality Service Improvement and Innovation

OTHER

Clare Ansley	Minutes
Paul Douglas	Member of the public

APOLOGIES

Chris Kalderimis, Wayne Guppy
Rachel Haggerty, Joy Farley and Arawhetu Gray – ELT
Hamiora Bowkett has to leave at 2 pm

BOARD MEETING **PUBLIC**

1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia following which the Chair welcomed everyone to the meeting.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

One member was present for the meeting.

1.4 CONTINUOUS DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

It was **noted** as current and any changes to be sent to the Board Liaison Officer via email.
Petition for a medication.

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Combined Board **approved** the minutes of the previous Combined Public Board Meeting held on 3 December 2020.

	Moved	**Seconded**
HVDHB	Prue Lamason	John Ryall
CCDHB	Roger Blakely	Kathryn Adams

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

Action Number	Due Date	Status	Action	Notes
20-P0010	7-Apr-21	NEW	Management to bring to the CCDHB Board a paper on what the issues are and the potential options available to a CCDHB Board only session in April at the earliest. Include likely cost, impact and taking into account equity. Hutt Valley Board will remain informed.	In progress
20-P0011	5-May-21	NEW	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	In progress
20-P0012	3-Mar-21	NEW - Complete	Board requested the HVDHB Consumer Council attend a meeting with the Hutt Board members only.	Attending 3 Mar 2021 meeting

20-P0013	07-Apr-21	NEW	Management to bring the engagement plan looking at alternative strategies back to the Board once complete.	Once completed will be brought to Board
20-P0014	3-Mar-21	NEW - Complete	Maternity Deep Dive brought to the Board with Clinicians to attend.	Attending 3 Mar 2021 meeting
20-P0015	05-May-21	NEW - Complete	Board requested a Deep dive on Rheumatic Fever to be in the 2021 workplan.	Workplan updated

1.7 CHAIR'S REPORT AND CORRESPONDENCE

- Nothing to report.

1.8 CHIEF EXECUTIVE'S REPORT

The Chief Executive provided an update on the following:

- Work has been largely focused on external engagement and positive stories around the DHB, and acknowledgement was given to the staff in the stories being told.
- There is a strong focus on the Measles, Mumps and Rubella regime being rolled out.
- The roll out of the COVID-19 vaccine in Wellington is on schedule, and further instruction is awaited from the Ministry of Health. Management will start providing weekly updates to the board of people being vaccinated.
- The Board acknowledged the good work that is being undertaken.

1.9 BOARD WORK PLAN 2021

The work plan was received and feedback is to be sent to the Board Liaison Officer.
ACTION: The Sub-Regional Disability Advisory Group to be added to Stakeholder engagement list of stakeholders to attend meetings.

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 CCDHB OCTOBER 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**
A question was raised and answered with regard to wait times.

	Moved	**Seconded**
CCDHB	Roger Blakely	Kathryn Adams

2.2 HVDHB OCTOBER 2020 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

This report was taken as **READ.**

	Moved	**Seconded**
HVDHB	John Ryall	Ken Laban

3 UPDATES

3.1 2DHB HEALTH SYSTEM COMMITTEE UPDATE

BOARD MEETING **PUBLIC**

NOTES:

- Not discussed.

4 OTHER

4.1 GENERAL BUSINESS

Nil.

4.2 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**
HVDHB	Prue Lamason	John Ryall
CCDHB	Vanessa Simpson	Kathryn Adams

5 NEXT MEETING

Wednesday, 7 April 2021. Grace Neil Block, Level 11 Boardroom, Wellington Regional Hospital.

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

DATED this day of 2021

David Smol
BOARD CHAIR

MATTERS ARISING LOG

Action Number	Date of meeting	Due Date	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	How Action to be completed
20-P0010	3-Dec-20	5-May-21	Chief Financial Officer	In progress		Board - Public	1.3	**PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING**	Management to bring to the CCDHB Board a paper on what the issues are and the potential options available to a CCDHB Board only session in April at the earliest. Include likely cost, impact and taking into account equity. Hutt Valley Board will remain informed.	In progress.
20-P0011	3-Dec-20	2-Jun-21	Chief Financial Officer	In progress		Board - Public	1.3	**PUBLIC PARTICIPATION – CCDHB STAFF PETITION, CAR PARKING**	Management to bring to Board a paper on the long term Climate Emergency Response Plan.	In progress.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 18 February 2020 to 25 March.

The COVID-19 Update statistics are as recent as possible their dates are noted.

2 COVID-19 Update

2.1 Current cases (to 30/03)

Number of cases: 0
Number of days without cases, HVDHB: 131
Number of days without cases, CCDHB: 138

2.2 Managed Isolation Facilities

Number of COVID-19 cases: 0
Number of guests: (as 30/03):

- Bay Plaza: 55
- Grand Mercure: 75

2.3 Testing statistics (to 30/03)

	2DHB	HVDHB	CCDHB
Tests performed to date	133,084	29,646	103,440
People tested to date	99,352	24,969	75,443
Testing coverage	22%	17%	24%
Tests performed last week (22/3 - 28/3)	2,043	369	1,674

2.4 Testing statistics by ethnicity (to 30/03)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	12,001	8,814	3,444	1,994	8,557	6,820
People tested to date	8,830	6,523	2,812	1,607	6,137	4,968
Testing coverage	18%	20%	14%	14%	21%	24%
Tests performed last week (22/3 - 28/3)	172	121	38	19	134	102

2.5 Vaccinations (to end 29/03)

Please note the vaccine is given in two doses.

All groups	2DHB	HVDHB	CCDHB
Total immunisations	3,716	1,318	2,398
Dose 1 total	3,371	1,315	2,056
Completed total	345	3	342

Group 1	2DHB	HVDHB	CCDHB
Group 1 total	2,268	511	1,757
Group 1 dose 1	1,973	510	1,463
Group 1 completed	295	1	294

Group 2	2DHB	HVDHB	CCDHB
Group 2 total	1,448	807	641
Group 2 dose 1	1,398	805	593
Group 2 completed	50	2	48

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

As part of our ongoing engagement with local leaders, we have met with Lower Hutt, Porirua and Kāpiti Mayors and Chief Executives, and regional leadership for the Ministry of Social Development and Oranaga Tamariki. Key topics of our discussions are the COVID-19 vaccination programme, our 2DHB strategic priorities, and shared local matters of interest.

3.2 External communications and engagement – press releases and pitches

We have continued our focus on proactive external news media and story-telling through highlighting strategies, services and work programmes in our DHBs, along with a continued focus on how we are improving health outcomes for the people of our regions – a sample of these stories is below and featured on following pages.

DHB	Subject	Outlet / Channel
RPH (3DHB)	COVID-19	Launched the 'COVID-19 Contact Tracker' booklet as an alternative for those who may not be able to access the NZ COVID Tracer app. www.rph.org.nz/news-and-events/news-and-media-releases/2021-03-01-tracking-and-tracing/
CCDHB	Equity	Highlighted the equity work happening at Kenepuru Older Adult, Rehabilitation and Allied Health Service (ORA). www.ccdhb.org.nz/news-publications/news-and-media-releases/2021-02-19-kenepuru-team-works-towards-equity/.

2DHB	COVID-19	Outlined visitor restrictions under alert level 2.
CCDHB	Child health	Announced the name of our new children's hospital and child health service. www.ccdhb.org.nz/news-publications/news-and-media-releases/2021-03-04-dhb-announces-name-of-new-child-health-service-and-childrens-hospital/.
HVDHB	ED	Reminder for people that ED is for emergencies only. www.huttvalleydhb.org.nz/media-and-latest-news/latest-news/2021-02-23-keep-ed-free-for-emergencies/.
HVDHB	Maternity	Update on planning and progress for redevelopment of Hutt's Maternity services. www.huttvalleydhb.org.nz/media-and-latest-news/latest-news/2021-02-23-planning-progresses-for-redevelopment-of-hutt-maternity-services/.

3.3 Health promotion campaigns

3.3.1 Measles

Our measles promotion is going well through Youth One Stop Shops (YOSS) in Wellington, Kapiti and Lower Hutt. Outreach has been through events such as a Whitireia open day for students focusing on awareness raising around the importance of vaccination for an age group who may have missed out on being immunised. Decked out in campaign t-shirts with striking red flags, the YOSS teams were handing out small business cards with Protect Your Whanau messaging and a QR code taking them to a website with more information.

An advertising campaign on Giggle TV shows almost 5000 ads being played on screens around Capital & Coast and Hutt Valley DHB regions each month, with an estimated reach of 1.5 million views based on eftpos receipts indicating foot traffic through locations where giggle screens are displayed.

The campaign team also produced a 30 second video with captions and sign language which is being shared on social media with the message 'It's easy as' – It's easy as getting a coffee with a friend, it's easy as buying a movie ticket, it's easy as getting a ride. It shows our actor popping in to a pharmacy to get immunised. See it here on vimeo: https://vimeo.com/527564846/3e5f19ddb2

Participating pharmacies have been supplied with flags and sandwich boards for outside their stores, and posters for instore.

3.3.2 COVID-19 Vaccination Programme

As the COVID-19 vaccination programme gathers pace, communication and engagement with our key local audiences has also increased. Our 2DHB regional communications and engagement strategy is built on an equity focus, prioritising our Māori, Pacific and Disabled communities, and leverages off the Government's national campaign.

In late March, working with our PHO partners, five community vaccination centres (CVCs) were opened to vaccinate frontline health workers and the household contacts of the border and MIQ workforce. To highlight this work, media were invited to attend an opening event on 24 March at the new CVC at Walter Nash Centre in Lower Hutt, where we also hosted Hutt City Mayor Campbell Barry. Coverage from the event was as follows:

- 'It's a bit exciting' — Covid-19 vaccinations well underway in Hutt Valley (One News)
- Lower Hutt families keen for Covid-19 vaccination (Radio NZ Checkpoint, also republished by NZ Herald. RNZ also had a shorter item playing in their news bulletins)
- Wellington frontline workers and families of border staff get Covid-19 jabs (Stuff / Dominion Post)

We are currently developing communication material for our key audiences and engaging with local partners and providers to reach our target groups. We have collated guidance produced by the Ministry of Health and the All-of-Government COVID-19 Group, and have produced a booklet: Your COVID-19 Vaccination Guide, which is provided to everyone who receives a vaccination to provide the information they need.

We are now working with clinicians and other trusted faces to produce a series of videos aimed at encouraging vaccination and providing people with confidence to be vaccinated, which will be used in our local communications activity. Olivia, one of our DHB infectious disease experts, was eager to book in her vaccination. Our patients trust us, Olivia says. "The more we can do to protect them, the better."

Hear from Olivia on why getting vaccinated is the best way to look after ourselves, our colleagues and our patients.

3.3.3 Disability Equity – E-learning Module

Our Disability Strategy team has developed and launch a new e-learning module for all staff – Disability Equity. The intent is to promote appropriate interactions with disabled people coming in to the hospital either as outpatients or inpatients and uses rights-based language and encourages a more open mind-set. The module is available to all 20 DHBs with all staff being asked to complete this as a core competency.

The module reinforces both ours and the Ministry of Health's priority work on equity, and relates directly to nurses providing safe and quality care.

SPP's Violence Intervention Programme Coordinator, Leanne Scott, was the first CCDHB staff member to complete the module saying "it was enlightening and really useful for my role".

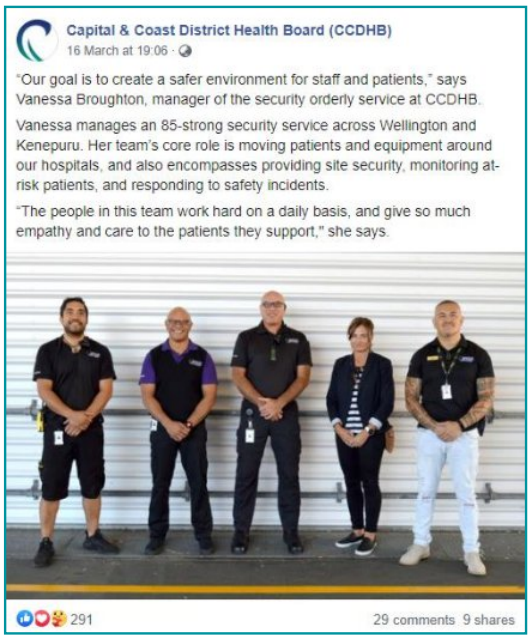
3.3.4 Focus on Māori and pacific Mamas

Breastfeeding has wide ranging benefits for the mother and baby, and an equity gap has been identified which our Families & Wellbeing team within SPP is working to fill. Women will benefit from five new Maori and Pacific lactation consultants across the CCDHB catchment area as well as a Maori and Pacific midwifery service- Te Ao Marama Midwifery Tapui. The new midwifery service will support mamas and whanau in Porirua, reducing the number of times women in Porirua need to come to Wellington Regional Hospital for antenatal, birthing and postnatal care.

3.4 Social media views and stories

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 119,938 Twitter: 5,644 LinkedIn: 20,466	Facebook: 155,999 Hutt Maternity Facebook: 6,812 Twitter: 19,491 Instagram: 9,835 LinkedIn: 10,723	Facebook: 13,298

3.4.1 Top social media posts



CCDHB	HVDHB	RPH	MHAIDS
159,305 page views	43,979 page views	19,314 page views	17,225 page views

3.5 Website page views and stories

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

Top five webpages CCDHB

- Staff login
- Careers with CCDHB
- Search
- Wellington Regional Hospital
  COVID-19 Community based assessment centres (CBACs)

Top five webpages HVDHB

- Staff login
- Contact us
- Hutt Hospital campus map
- Careers with HVDHB
- COVID-19 Community based assessment centres (CBACs)

Top five webpages RPH

- Coronavirus (COVID-19) frequently asked questions
- Measles
- Fruit and Vege Co-ops
- Authorised vaccinators
- Coronavirus (COVID-19)

Top five webpages MHAIDS

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

3.5.1 Website stories and releases

Centres open to provide COVID vaccines in the community

The Hutt Valley and Wellington regions have now entered the next phase of the COVID-19 vaccination rollout – the vaccination of border workers' household contacts, and of the frontline health and emergency workforce – with five community vaccination centres (CVC) now in operation.

Operated by Te Awakairangi Health Network PHO, and supported by Capital & Coast and Hutt Valley DHBs, the CVC in Lower Hutt was the first to begin providing vaccinations.

Te Awakairangi provides quality primary care services across the Hutt Valley. It works with general practices, other healthcare providers, and community organisations to empower and enable people to receive the care they need.

"We are pleased to be starting the next phase towards protecting our communities from COVID-19 – making sure that the frontline health workers have their COVID vaccinations so they can continue to do their awesome work, caring for all of us," said Te Awakairangi Health Network Chief Executive Bridget Allan.

The vaccine is the most effective way to protect people from COVID-19. It has been tested locally and internationally, is safe, and is completely free for everyone in New Zealand. The DHBs, Te Awakairangi, and other PHO partners are working closely together to ensure those who are eligible for the vaccine can receive it in their communities and close to their homes.

"CVCs and our wider vaccination programme are only possible through effective partnerships with our PHOs, and we are immensely proud of our continuing partnership with Te Awakairangi," said CCDHB and HVDHB Chief Executive Fionnagh Dougan.

"Te Awakairangi has been doing an amazing job to care for and support its communities throughout COVID-19, and we will continue to support the PHO throughout the different phases of the vaccine rollout to ensure that everyone can access a vaccination and that no communities miss out."

CVCs across the Hutt Valley and Wellington regions will administer vaccinations throughout all phases of the rollout, and additional CVCs will be opened later in the year.

Tracking and tracing

Over 2.3 million of us are familiar with the COVID-19 Tracer App, however when the App was launched in May 2020, Regional Public Health (RPH) quickly identified that there was a gap for parts of our community. A collaborative team quickly set-about creating an accessible alternative to the NZ COVID Tracer App, the 'COVID-19 Contact Tracker' booklet to circulate within our Wellington communities. Initially over 10,000 copies were distributed to libraries and community groups in our region.

Two key members of the creative team were Siobhan Murphy, graphic designer, from RPH and Leo Goldie-Anderson from the 3DHB Disability Strategy team. Siobhan designed the booklet and Leo was able to provide advice and feedback to ensure the content was accessible for as many people as possible. Staff from our Māori and Pacific Health units were also involved early at the drafting stage to provide feedback on the concept. The booklet was created with older people and disability groups in mind. People who may not own a smart phone, or who may not be adept at scanning QR codes. By helping people keep track of where they have been and who they have seen, in turn, helps our contact tracing efforts.

Not long after the booklet was launched in the Wellington region, the Unite Against COVID-19 team, saw the potential to nationalise the booklet. Utilising the Regional Public Health concept and designs, they published the 'NZ COVID-19 Tracer Booklet.' At the same time taking accessibility to another dimension by translating this version into over 20 languages.

"What thrilled me the most about this collaboration was the dedicated effort to accessibility, and considering the information needs of the disabled community right from the beginning of the project. Being brought on board at draft stage, and having my feedback actively sought and quickly responded to was a great way to build accessibility in from the start," said Leo. Last year, Leo was also seconded into the Ministry of Health team as the alternate formats lead for the disability communications team.

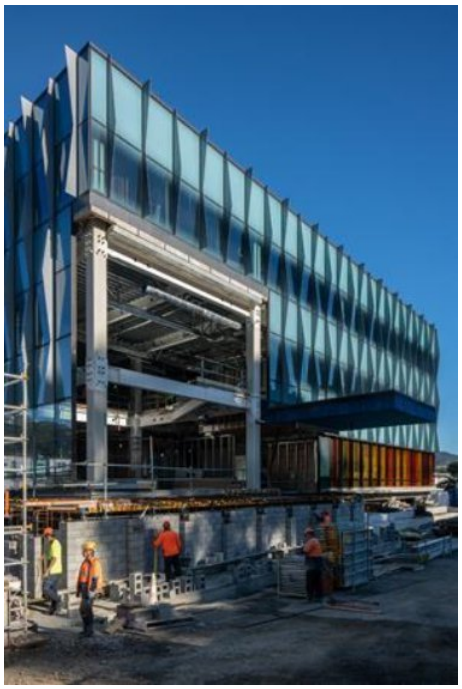
"Access to information is a human rights issue, and any gaps or problems in communication are magnified during a crisis! Disabled people need all the same information at the same time as the rest of the community, and it needs to be easy to find, easy to access, and easy to understand. Clear communication was New Zealand's best weapon against COVID-19, and our fantastic national response relied on everyone in our team of five million knowing what was happening and what to do," said Leo.

The response from the community has been positive too. "I have had people contacting me saying how much they love the booklet and how useful it is. A community board member contacted me to say she saw the booklet at the Paraparaumu Library, she had many contacts within her community who would benefit from the booklet, so she asked for 100 that she would hand out," said Siobhan. "Similarly, an employee at a retirement home said 'we have received the COVID-19 booklet and our residents love it!' Then she placed an order for 300 more copies. It's cool that what started out as a communications project for our Wellington community, turned into a really valuable resource that people from all over New Zealand can now access."

DHB announces name of new Child Health Service and children's hospital

Capital & Coast DHB is today excited to announce that the integrated Child Health Service and new children's hospital will be named Te Wao Nui – 'The Great Forest of Tāne' – in recognition of the cultural significance and life-giving properties that Māori associate with the forest.

The name will take effect when the service transitions into the new children's hospital building from late 2021 and was developed in collaboration with tamariki, CCDHB's Māori Partnership Board, the Wellington Hospitals Foundation, Child Health staff, and Weta Workshop.



"Te Wao Nui reflects the ecosystem of integrated health services designed for the tamariki, rangatahi and whānau of central Aotearoa," said Hutt Valley and Capital & Coast DHBs Chief Executive Fionnagh Dougan.

"It also underpins the 'tree of life' concept, forest murals, and kaitiaki whānau that have been developed for the new hospital's interior."

Helping to bring the new hospital name and its interior concepts to life are nine kaitiaki who will be present across the hospital building and are designed to make tamariki and rangatahi feel supported and cared for during their hospital journey.

Each kaitiaki has its own special attributes and values that reflect the values of CCDHB and its child health service in caring for young people.

"This new purpose-built facility will place our child health services – which are currently located in different parts of Wellington Regional Hospital – under one roof for the very first time.

"The new hospital has been designed with tamariki, rangatahi and whānau at the centre. It allows for the provision of high-quality services and brand new equipment, and also ensures clinical collaboration and communication across an important part of New Zealand's specialist children's hospital network.

"We look forward to opening Te Wao Nui's hospital doors early next year and would once again like to acknowledge Mark Dunajtschik's unprecedented and incredibly generous donation which has allowed this wonderful project to come to fruition."

Read more here.

Planning progresses for redevelopment of Hutt Maternity services

The redevelopment of three maternity facilities on the Hutt Hospital campus is set to begin in March.

The Maternity Assessment Unit, Maternity ward (birthing and postnatal) and the Special Care Baby Unit, will be redeveloped over the next two years.

Associate Minister of Health Dr Ayesha Verrall, visited Hutt Valley DHB on Friday to discuss the $9.47m project and hear about plans to improve maternal and neonatal health outcomes across the region.

“The new designs make sure that women and pregnant people have a positive experience throughout their pregnancy, birthing and postnatal journey”, she said.

“I was pleased to see plans that support breastfeeding, whānau involvement, privacy and improved support for those with complications or experiencing loss”.

The redesign will improve and increase the physical space available in the maternity outpatient areas, birthing and postnatal care, and special care for babies.

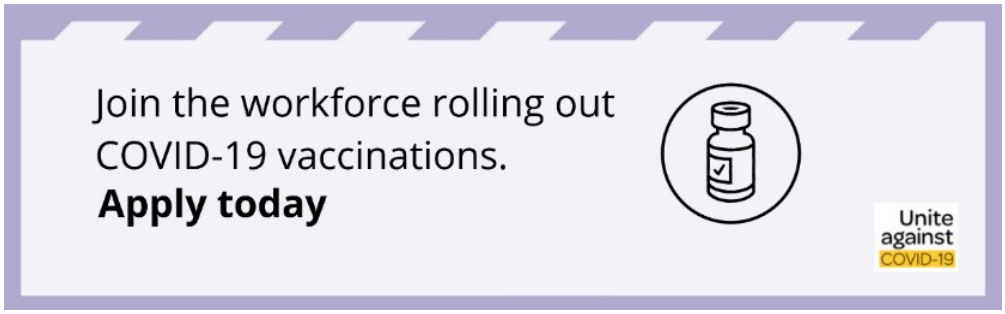
“This important project will enable the service to continue to implement significant improvements made to maternity services over the past 18 months”, said Chief Executive Fionnagh Dougan.

“The new facilities will improve outcomes for people across the wider region and create an inclusive, modern and quality environment for all pregnant persons, babies and their whānau.

“This work is part of a wider review and strategic planning process that achieves equitable and optimal outcomes and experiences. The hospital setting is only one part of the equation and we are also focused on improving equity and outcomes for Māori, Pacific and other families whose needs are not always met by traditional models of care.”

The project comes after Hutt Valley Maternity services has reached milestones in recruitment, resourcing, environment, clinical improvements, quality, safety and culture.

3.5.2 New website banners



3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
Data unavailable for this period	235,162 page views

We continue to provide news and information that people need for their jobs, and feature a range of human interest and stories that celebrate the success of our workforce in delivering improved health outcomes for the people of our regions.

3.6.2 Top intranet stories

Kia Ora Hauora

Three students have completed four-week allied professions work placements at CCDHB. This is the second cohort at CCDHB in six months supported by Kia Ora Hauora (KOH), a national Māori health workforce programme aimed at increasing the number of Māori working in the health sector.

Students had the opportunity to assist with the development of the draft Allied Health, Scientific & Technical (AHST) Māori and Pacific Workforce Strategies with Tutangi Amataiti, associate director of AHST - Pasifika Health, with a focus on encouraging Māori and Pacific students to choose a career in health. She said "It was great to get the perspective of these positive, engaged and motivated students."

Student Mika enjoyed the opportunity to understand the highlights and challenges of Psychologists working in healthcare, including the impact of inequities. "I knew about this before – but understand it more now. I feel lucky to have had this opportunity."

Te Aroha, who juggled a placement in the MHAIDS service with university and motherhood, was also struck by inequities - and the potential to transform them.

"In university you read a lot and see the statistics, but it's not until you go into people's homes and see how they're doing… it was hard to see some of our Māori and Pacific whānau feel so lost in the system. But there are so many opportunities for change." She also struggled with not taking the work home, but was thankful for the support she had received from the MHAIDS workforce.

Victoria University student Nai completed her second placement and hopes to return to healthcare as a professional. "This was an amazing opportunity. Other Māori would benefit from this opportunity. Networking has been a valuable part of the experience, and people here had a big impact on how comfortable I felt."

"This is a great opportunity to support more Māori into an Allied Professions career," said Tutangi, while chief allied professions officer Chris King said "It feels like we are moving from talking, to actually building our Māori workforce. It makes me feel hopeful that things will be different in the future."

Find out more about Kia Ora Hauora.

Leadership group moves on up

The CCDHB Māori & Pacific Nurse and Midwife Leaders' Group is going from strength to strength, with growing membership and clarity of purpose.

The group was established by nursing and midwifery leadership early last year, with the goals of supporting Māori and Pacific leadership and ultimately promoting more equitable outcomes.

"We were responding to under-representation of Māori and Pacific at a leadership level, and settled on a group as a way to foster that, by sharing information and building connections," says Anjana Naidu, Associate Director of Nursing Workforce Development.

"We don't have enough Māori and Pacific nurses and midwives in the senior positions that could help influence change. It was time to try a new approach."

Support from the Mental Health, Addictions and Intellectual Disability Service, and the Māori and Pacific Health teams, were crucial in setting up the group.

"The Pacific Directorate has a responsibility to support any initiatives, such as developing workforce career pathways, that will ultimately improve outcomes for Pacific Peoples," says Sipaia Kupa, the directorate's senior systems development manager.

Since the first meeting in March 2020, the group has held monthly meetings sharing data to better understand existing disparities, workforce plans to help rectify them, and a dashboard to track progress. Group members working across a variety of roles - including primary and community - have also profiled their work.

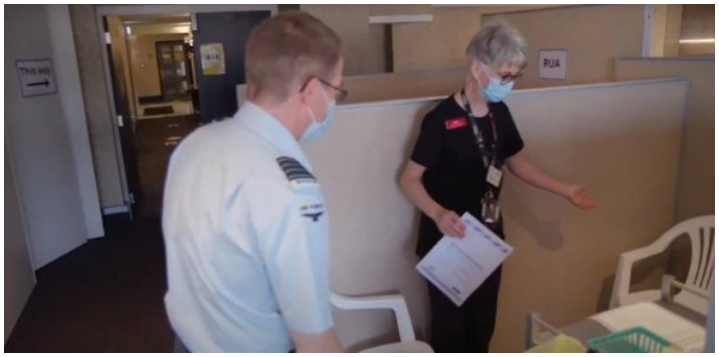
"It's good to showcase the huge variety of roles across the DHB, but It also helps people see where they should be going in terms of clinical pathways, and helps identify potential mentors," says Anjana.

With membership growing each month from across clinical areas and campuses, this is an exciting time for the group as it plans for the future. A terms of reference has been established and planning for a hui and fono, to be held later this year, is underway. Anjana also hopes to see the group become an advocacy body within the organisation, that can provide oversight and ensure Māori and Pacific are represented in wider decision-making.

"We want to be a pro-equity organisation, but without Māori and Pacific at the leadership level, we are not able to do that," says Anjana, adding, "And you can't do it with only one person - it needs to be a collective."

Vaccinations of managed isolation staff begin

The first phase of New Zealand's largest-ever immunisation programme kicked off in Wellington today, with border staff and workers at our managed isolation and quarantine facilities (MIQFs) receiving the first vaccinations.



This is a significant milestone in New Zealand's fight against COVID-19 and will help to protect our communities.

"I want to acknowledge the massive effort it has taken to get to the point of delivering the vaccination in such a short timeframe," said Fionnagh Dougan, chief executive of Hutt Valley and Capital & Coast DHB. "It is truly outstanding.

"Thanks to all of you who have been involved in planning and delivery of the vaccine, and to all the people who have worked so hard over the last year to keep COVID-19 out of our communities."

New Zealand's border workforce, such as cleaners, the nurses who undertake health checks in MIFQ, security staff, customs and border officials, airline staff and hotel workers, will be vaccinated over the coming weeks, followed by their household contacts.

Nurse educator Marie Ryan-Hobowska says she is proud to be part of one of the first groups getting vaccinated and being able to vaccinate others.

"Our workers here in Wellington are eagerly anticipating their invitation for vaccination. Having the vaccination available gives us another level of confidence that we are safe, and our whānau and friends are safe too," she said.

"I want to thank our staff and administration crew who've started our vaccination programme today," said Rachel Haggerty, Director of Strategy Planning and Performance. "They've done an outstanding job of setting up the process and making sure the people working in the MIFQs get their vaccinations as part of the first group to be vaccinated.

"This is the beginning of our programme as we vaccinate all border workers, and then move to high risk front line healthcare staff."

"This work could only have been achieved as a result of effective partnerships – between DHBs, the Ministry of Health, MBIE and MIQ, Defence, hotel management, Aviation Security, NZ Police, and many other agencies," said Fionnagh.

"There is a long way to go to overcome this infection - but today we can celebrate."

Work Plan

Year	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Board Focus:	**Strategic Direction**	**Equity and Integration, Multi-Year Plan (6)**	**Annual Plan (5) Equity and Integration (6)**	**Community Based Initiatives (2)**	**Provider Arm Financial and Non Financial (1)**		**Annual Plan (5) Equity and Integration (6)**	**Hospital Network (3)**	**Equity and Integration - Multi-Year Plan (6)**
Provider/Service	**Orthopaedics**	**TBC**							
Patient Story:	**Orthopaedics**	**Dialysis**				**MHAIDS**	**Trauma**		
DATE	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Hutt Valley Board ONLY TIME		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board		Hutt Valley Board	
Capital and Coast Board ONLY TIME	Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board		Capital and Coast Board
Regular Reporting	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report	Workplace Health and Safety Report
People, Capability and Culture Report	People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
Facilities and Infrastructure Report inc. Enviro Sustainability		Facilities and Infrastructure Report				Facilities and Infrastructure Report		Facilities and Infrastructure Report	
Digital Report	Digital Report			Digital Report				Digital Report	
FRAC items for Board Approval	FRAC items for Board Approval	FRAC items for Board Approval		FRAC items for Board Approval		FRAC items for Board Approval		FRAC items for Board Approval	
HSC items for Board Approval including below	HSC items for Board Approval including below		HSC items for Board Approval including below		HSC items for Board Approval including below		HSC items for Board Approval including below		HSC items for Board Approval including below
Te Pae Amorangi Quarterly Report	Te Pae Amorangi Quarterly Report		Te Pae Amorangi Quarterly Report		Te Pae Amorangi Quarterly Report				Te Pae Amorangi Quarterly Report
Taurite Ora Quarterly Report	Taurite Ora Quarterly Report		Taurite Ora Quarterly Report		Taurite Ora Quarterly Report				Taurite Ora Quarterly Report
Pacific Health and Wellbeing Strategic Plan Quarterly Report	Pacific Health and Wellbeing Strategic Plan Quarterly Report		Pacific Health and Wellbeing Strategic Plan Quarterly Report			Pacific Health and Wellbeing Strategic Plan Quarterly Report			Pacific Health and Wellbeing Strategic Plan Quarterly Report

DSAC items for Board Approval	DSAC items for Board Approval		DSAC items for Board Approval				DSAC items for Board Approval		DSAC items for Board Approval
Children's Hospital									
Engagement	**7-Apr**	**5-May**	**2-Jun**	**7-Jul**	**4-Aug**	**1-Sep**	**6-Oct**	**3-Nov**	**1-Dec**
Māori Partnership Board (CCDHB)	~~Māori Partnership Board (CCDHB)~~		Māori Partnership Board (CCDHB)			Māori Partnership Board (CCDHB)		Māori Partnership Board (CCDHB)	
Iwi Relationship Board (HVDHB)	~~Iwi Relationship Board (HVDHB)~~		Iwi Relationship Board (HVDHB)			Iwi Relationship Board (HVDHB)		Iwi Relationship Board (HVDHB)	
Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group		Sub-Regional Disability Advisory Group
Sub-Regional Pacific Health Strategy Group			Sub-Regional Pacific Health Strategy Group						Sub-Regional Pacific Health Strategy Group
Wellington Hospital Foundation								Wellington Hospital Foundation	

Board Information

April 2021

Hutt Valley DHB January 2021 Financial and Operational Performance Report	
Action Required **The Hutt Valley DHB Board note:** (a) The release of this report to the public. (b) The DHB had a $309k surplus for the month of January 2021, being $686k favourable to budget; (c) The DHB year to date had a deficit of ($4.7m), being $1.6m favourable to budget; (d) The Funder result for January was ($0.5m) unfavourable, Governance $0.1m favourable and Provider $1.1m favourable to budget; (e) Total Case Weighted Discharge (CWD) Activity was 7% ahead of plan.	
Strategic Alignment	Financial Sustainability
Authors	Rosalie Percival, 2DHB Chief Financial Officer Judith Parkinson, General Manager Finance & Corporate Services, HVDHB Joy Farley, 2DHB Director of Provider Service Rachel Haggerty, Director Strategy Planning and Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board on financial performance and delivery against target performance for the DHBs
Contributors	Finance Team, Health Intelligence and Decision Support, 2DHB Hospital Services.

Executive Summary

The trends seen in prior months for our Emergency Department continue to place pressure on wait times and beds. We are working on a range of specific initiatives to identify more sustainable options for afterhours services across the district.

Year to date, caseweights for Surgical are 5% over budget with acute demand the key driver. Medical caseweights are higher than budget year to date, with both Neonatal and Maternity closely aligned with last year. This level of activity is placing pressure on hospital flow which is the key area of focus for improvement.

Addressing outpatient and inpatient surgical waiting lists remains a significant challenge and risk for HVDHB with a high number of patients waiting more than 120 days for treatment. The team are working to resolve this with the Ministry planned care team, leading out on a system improvement.

With a focus on the seamless patient journey, the Early Supported Discharge team are expanding their capacity to improve the efficiency of discharge planning and “pull” patients home from ED and wards, plus address delays in the Care Coordination Pathway.

Our Maternity Units across the region are struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

The funder is focused on reviewing core services to achieve equity.

We are promoting healthy lifestyles, improving the responsiveness of general practice by rolling out the Health Care Homes model of care, and developing Community Health Networks to provide integrated care to people in the community.

A Community Health Network / neighbourhood approach to integration is being trialled in a locality with a high priority population to support specialist support to primary care, and integration with community health services.

For January, the Hutt Valley DHB had a surplus of $0.4m which is $0.7m favourable to budget. Of this surplus $0.7m is in the provider arm services and includes accounting for donated assets. More detail can be found in the Provider Arm summary.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley population.
People	Staff numbers are 185 below plan with additional costs in outsourced personnel for roles employed by CCDHB for ICT and MHAIDs.
Financial	Planned deficit $10.6 million, with no COVID-19 or Holidays Act provision impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachment

2.1.1 Hutt Valley DHB January 2021 Financial and Operational Performance Report

Monthly Financial and Operational Performance Report

For period ending
31 January 2021

Reported in February 2021

Contents

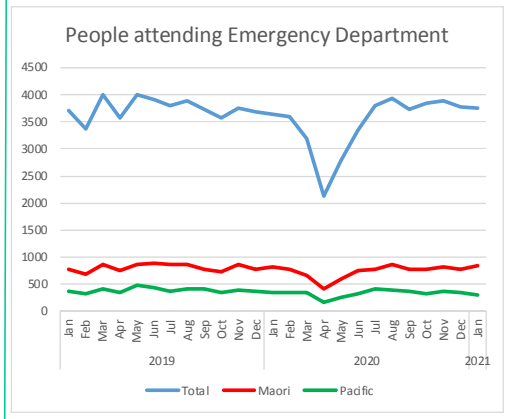
Section 1

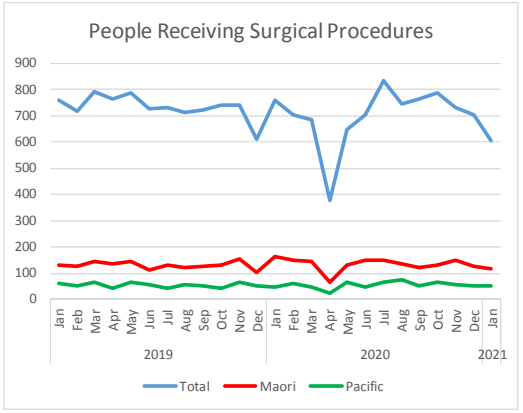
Financial and Performance Overview

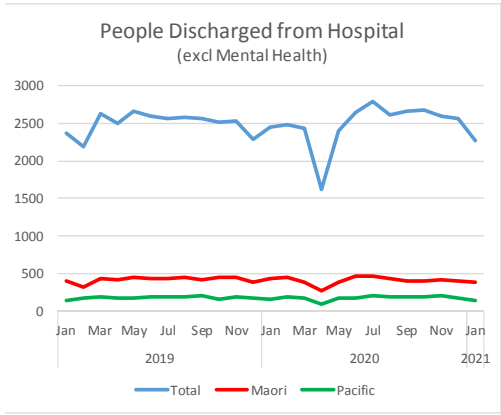
Performance Overview: Activity Context (People Served)

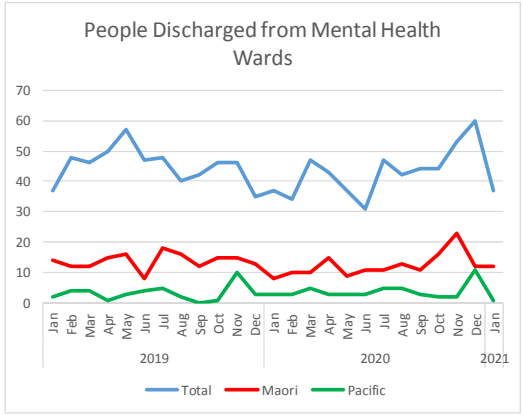
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions.

People attending ED	**3,745**	842 Maori, 309 Pacific
People receiving Surgical Procedures	**607**	117 Maori, 50 Pacific
People discharged from Hospital (excl Mental Health)	**2,272**	394 Maori, 150 Pacific
People discharged from Mental Health wards	**37**	12 Maori, 1 Pacific



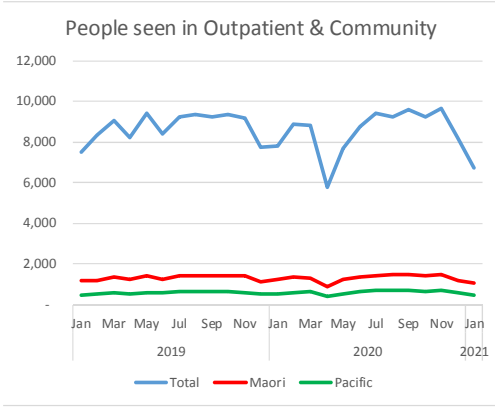


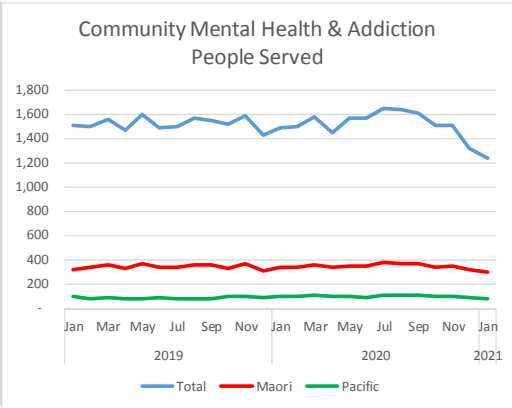


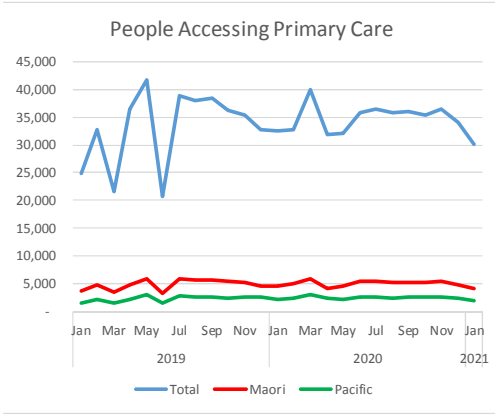


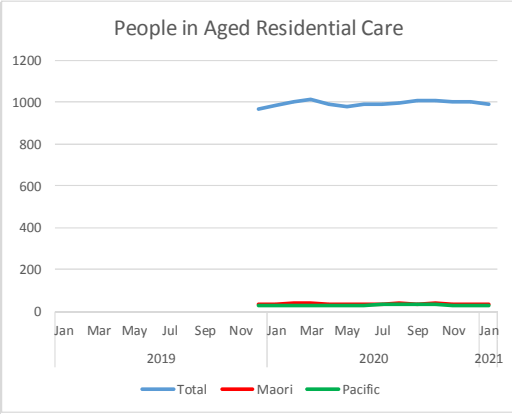
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**6,743**	1,037 Maori, 465 Pacific
Mental Health and Addiction Contacts	**1,240**	294 Maori, 77 Pacific
Primary Care Contacts	**30,132**	4,111 Maori, 1,987 Pacific
People in Aged Residential Care	**993**	35 Maori, 27 Pacific









Financial Overview – January 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$4.7m deficit	$6.1m deficit	$0.8m surplus	$4.9m
Against the budgeted deficit of $6.4m.	Against the budget deficit of $6.4m.	Against the budget deficit of $0.1m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
6% ahead	1,782	$19.9m
14 CWDs behind PVS plan for January. IDFs were 87 CWD under budget for the month	YTD 185 FTE below annual budget of 2,058 FTE. Note: The MHAIDS & ITS restructures and change of employer contributed 116FTE to this variance	This is a decrease of $1.0 m on prior period.

Hospital Performance Overview – January 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
85%	1,251	1,016	75%
10% below the ED target of 95%, Similar to January 2020.	Against a target of zero long waits a monthly movement of 136.	Against a target of zero long waits a monthly increase of 223	Did not achieve the 62 day target. The 31 day target was not achieved at 81%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
6% ahead	1,782	1
14 CWDs behind PVS plan for January. IDFs were 87 CWD under budget for the month	185 below YTD budget of 2,058 FTE. Month FTE was 276 under budget an downwards movement from December of 38 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $0.934m year to date, with revenue for IDFs being ahead of budget by $1.1m due to wash-ups from last year and increased volumes for the current year. In addition COVID-19 revenue, which is offset by costs also means we are ahead of revenue by a total of $3.5m YTD.
- Pharmaceutical costs are unfavourable ($373k) for the month and ($1,570k) YTD. This is reflects the transfer of rebates back to the provider arm and recognition of prior year rebates. Laboratory costs are favourable $52k for the month and unfavourable ($282k) YTD. The YTD result includes additional costs relating to the prior year.
- Aged residential care costs are $85k favourable for the month. Other Health of Older People costs are favourable $61k for the month and $961k YTD. The implementation of the frailty model will be supported by this underspend.
- Mental Health costs are unfavourable ($115k) for the month, favourable $1,080k YTD, reflecting timing of contracts which will be rectified with the acute care continuum funding.
- In this report we have also highlighted the below key areas of performance with a focus on our core services and achieving equity. We are responding to the needs of our children.
    - The number of people entering Aged Residential Care (ARC) remained steady since Jul 2018 until COVID-19 lockdown in Apr-Jun 2020. In April 2020 during COVID-19 lockdown, only 13 people entered ARC but has since returned to previous levels since May 2020.
    - We are promoting healthy lifestyles, improving the responsiveness of general practice by rolling out of the Health Care Homes model of care, and developing Community Health Networks to provide integrated care to people in the community
    - We are working with WCTO providers, Regional Public Health, general practices and outreach immunisation providers to make services for accessible, improve engagement with families, undertaking proactive follow-up on missed checks and immunisations.
    - A Community Health Network / neighbourhood approach to integration is being trialled in a population with high priority population to support specialist support to primary care, and integration with community health services.

Funder Financial Statement – January 2021

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

Month					$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					Revenue										
37,841	37,970	(129)	34,735	3,106	Base Funding	264,886	265,788	(902)	243,142	21,743	454,734	455,637	(902)	416,816	37,918
2,926	2,341	586	2,451	475	Other MOH Revenue	19,429	16,386	3,043	19,677	(248)	31,424	28,090	3,335	38,006	(6,582)
40	36	5	(68)	108	Other Revenue	513	249	264	271	242	691	427	264	619	72
7,964	9,229	(1,265)	8,297	(333)	IDF Inflows	65,681	64,600	1,082	60,508	5,174	111,513	110,742	771	102,280	9,233
48,771	**49,575**	**(804)**	**45,414**	**3,357**	**Total Revenue**	**350,509**	**347,022**	**3,486**	**323,598**	**26,910**	**598,362**	**594,895**	**3,467**	**557,721**	**40,641**
					Expenditure										
386	416	30	383	(3)	DHB Governance & Administration	2,786	2,909	123	2,681	(105)	4,709	4,987	278	4,597	(112)
20,255	21,031	776	19,959	(295)	DHB Provider Arm	147,109	147,209	100	140,788	(6,322)	251,728	252,577	849	241,131	(10,598)
					External Provider Payments										
3,583	3,211	(373)	2,882	(702)	Pharmaceuticals	24,930	23,360	(1,570)	21,971	(2,959)	41,364	38,866	(2,498)	37,365	(3,999)
4,317	4,369	52	4,030	(287)	Laboratory	30,862	30,581	(282)	29,563	(1,299)	52,621	52,424	(197)	50,903	(1,718)
2,581	2,541	(40)	2,412	(168)	Capitation	18,278	17,789	(489)	17,224	(1,054)	30,984	30,495	(489)	29,563	(1,421)
1,155	1,235	80	991	(164)	ARC-Rest Home Level	8,275	8,566	292	6,934	(1,341)	14,393	14,543	150	11,877	(2,517)
1,915	1,920	5	1,708	(207)	ARC-Hospital Level	12,744	13,315	571	11,316	(1,427)	22,539	22,604	65	19,154	(3,385)
2,651	2,712	61	3,588	937	Other HoP & Pay Equity	17,922	18,883	961	19,313	1,391	31,773	32,442	669	35,134	3,362
1,204	1,089	(115)	740	(464)	Mental Health	6,519	7,599	1,080	4,999	(1,520)	12,495	13,045	550	9,580	(2,914)
546	482	(64)	472	(74)	Palliative Care / Fertility / Comm Radiology	3,452	3,373	(80)	3,371	(81)	5,861	5,782	(80)	5,788	(73)
2,142	1,349	(793)	423	(1,719)	Other External Provider Payments	11,951	9,521	(2,431)	8,088	(3,864)	19,763	17,332	(2,431)	19,220	(543)
8,515	9,151	636	7,881	(634)	IDF Outflows	64,883	64,054	(829)	57,731	(7,151)	110,660	109,807	(854)	101,298	(9,362)
0	0	0	0	0	Provision for IDF Wash-ups	0	0	0	43	43	0	0	0	0	0
49,249	**49,504**	**255**	**45,470**	**(3,780)**	**Total Expenditure**	**349,711**	**347,159**	**(2,553)**	**324,021**	**(25,690)**	**598,890**	**594,905**	**(3,986)**	**565,610**	**(33,280)**
(478)	**71**	**(549)**	**(55)**	**(423)**	**Net Result**	**797**	**(136)**	**934**	**(423)**	**1,220**	**(528)**	**(9)**	**(519)**	**(7,889)**	**7,361**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($129k) to budget for the month and ($902k) year to date, reflecting the rate change from 6% to 5% for Capital Charge impacting both Income and expenditure.
- Other MoH revenue is favourable $586k for January and $3,043k year to date, including COVID-19 funding and Planned Care.
- IDF inflows are ($1,265k) unfavourable for the month driven by current year wash-ups, favourable $1,082k year to date.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel	240	(433)
Capitation Funding	23	338
Planned Care	64	450
COVID-19 Funding	388	3,465
COVID-19 Funding - RPH	(127)	(891)
Crown funding agreements		
B4 School Check Funding	(2)	38
Hospice - Cost Pressure funding	12	83
Tobacco Control	(13)	23
More Heart and diabetes checks	(5)	(64)
Additional School Based MH Services	(10)	(69)
Maternity Quality and Safety Programme	11	72
Measles Immunisation Campaign 2020	-	-
Well Child/Tamariki Ora Services	4	41
Other CFA contracts	0	11
Year to date Variance $000's	**586**	**3,043**

Expenditure:

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

External Provider Payments:

Pharmaceutical costs are unfavourable ($373k) for January and unfavourable ($1,570k) YTD, reflecting a combination of passing rebates back to the provider arm and seasonal variations in January.

Capitation expenses are ($40k) unfavourable for the month, offset by changes to revenue.

Aged residential care costs are $40k favourable for the month.

Other Health of Older People costs are favourable by $61k for the month and favourable $961k YTD.

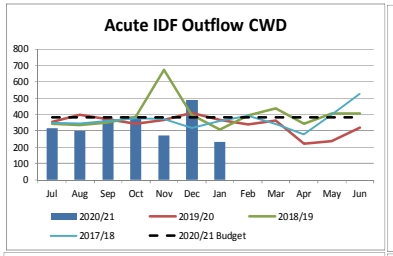
Mental Health costs are unfavourable ($115k) for the month, favourable $1,080k YTD, reflecting timing of contracts.

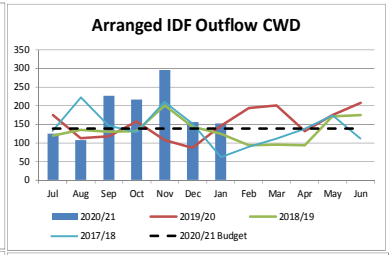
Palliative Care, Fertility and Community Radiology costs are unfavourable by ($64k) for the month.

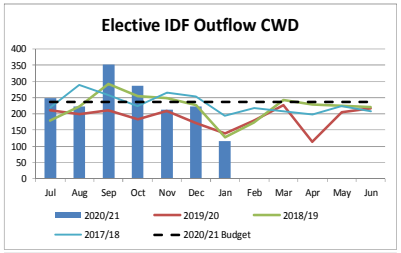
Other external provider costs are unfavourable to budget ($793k) for the month.

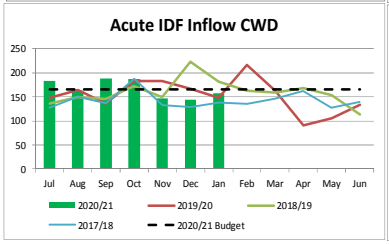
IDF Outflows are favourable $636k, due to Current Year Wash-up payments for increased volumes.

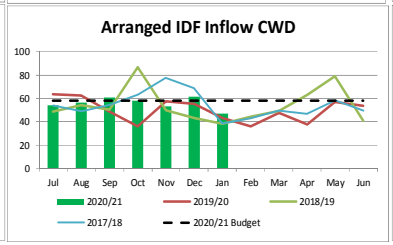
Inter District Flows (IDF)

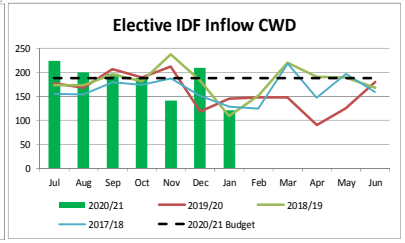












IDF Wash-ups and Service Changes Jan 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	(1)	(1)
CCDHB - Advance Care Planning	(5)	(35)
CCDHB - Mental Health (provider)	-	-
	-	-
Wash-ups		
2020/21 Outflows	712	(913)
2020/21 PHO	(70)	(133)
2019/20 Wash-up	-	254
	-	-
Rounding (timing) differences	-	-
IDF Outflow variance	**636**	**(829)**

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

IDF inflow (revenue):

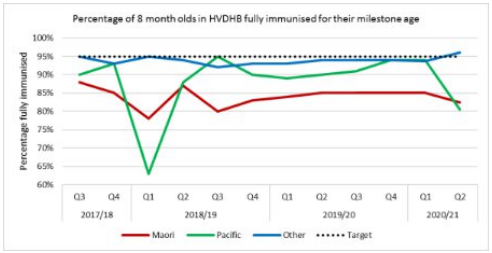
- Based on the data available, overall IDF inflows are over budget YTD by $1,082k. Inflows for other services ($1,506k) under budget and Inpatient inflows are over budget by $258k with prior year wash-ups $2,330k. Inpatient inflows are over budget mainly in in Orthopaedics, Rheumatology, Gastroenterology and ENT.

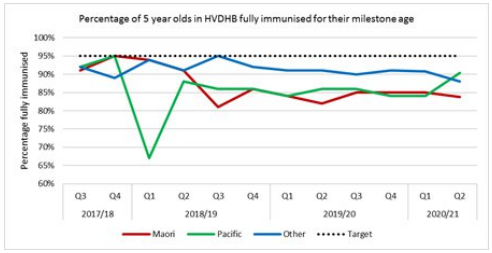
IDF Outflow (expense):

- Based on the data available, overall IDF outflows are over budget by ($829k) year to date mainly due to Inpatient outflows being over budget by ($913k). Inpatient outflows are mainly over budget in elective Vascular surgery and Cardiology and Neonates at Capital & Coast.

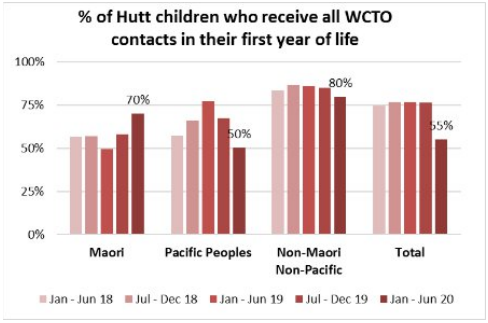
Children 0-4 years – Healthy start

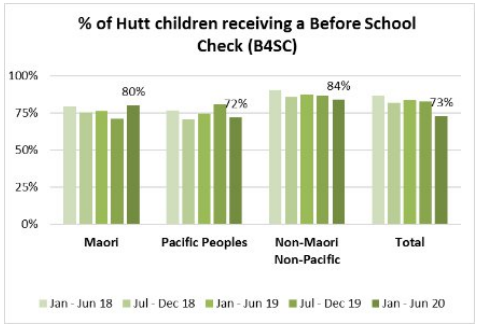
Receive all their scheduled immunisations



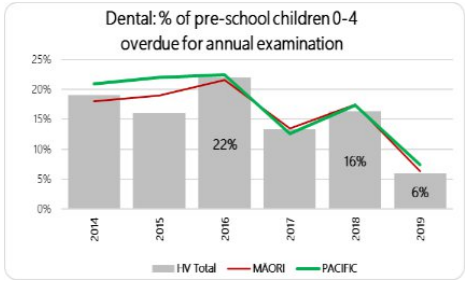


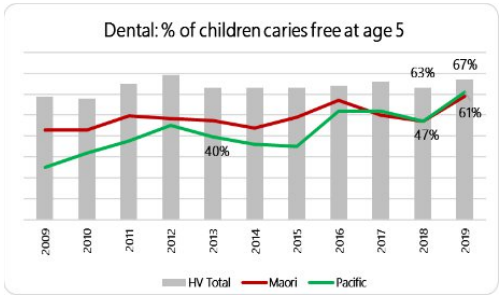
Receive all their Well Child / Tamariki Ora (WCTO) checks





Have healthy teeth





Performance at Quarter One 2020/21

PHO enrolment: 98% of estimated population is enrolled with a PHO - 91% of Maori, 97% of Pacific, 7% enrolled with PHO outside of Hutt DHB

Babies immunised at 8 months: Maori at 82%, Pacific 80% & Other over target at 96% at Q2 2020/21; Children at 5 years – little change average Maori 84% Pacific 90% Other 88%

WCTO checks – healthy development, screening for potential problems:

- 80% Other, 70% Māori, 50% Pacific had all 5 core checks in first year of life
- 84% Other, 80% Māori, 72% Pacific had B4 School Check at four years old, which is all less than the national target of ≥90%

Children's dental health is linked to regular care of teeth, healthy food and overall health. Children are enrolled with Dental service at birth and recalled at 2-4 years for examination. WCTO checks also provide oral health information

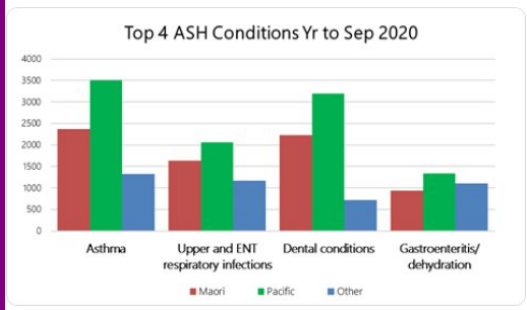
- In 2019, 6% of preschool children were overdue annual examination, which show improved performance from the previous year when 16% were overdue
- In 2019, there was a significant improvement in Māori and Pacific children's dental health, with a 14% increase in Māori and Pacific who had caries free teeth at age 5

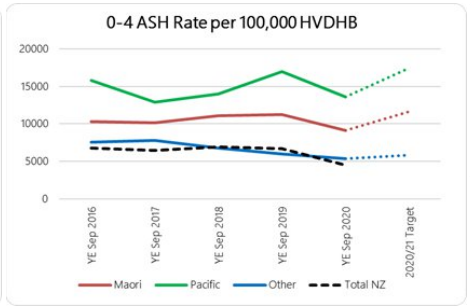
What are we doing?

- We are working with WCTO providers, Regional Public Health, general practices and outreach immunisation providers to make services for accessible, improve engagement with families, undertaking proactive follow-up on missed checks and immunisations.
- We are working to improve children's dental health through oral health promotion, healthy food and drink policies, proactive follow-up on missed appointments, and additional fluoride varnish applications in low decile schools.
- We provide the Healthy Active Learning programme to schools and early learning services, in partnership with Sport Wellington, which promotes wellbeing, healthy eating and physical activity.

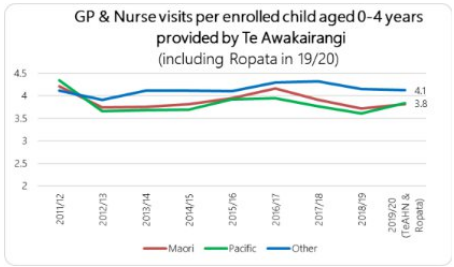
Children 0-4 years – Acute Care

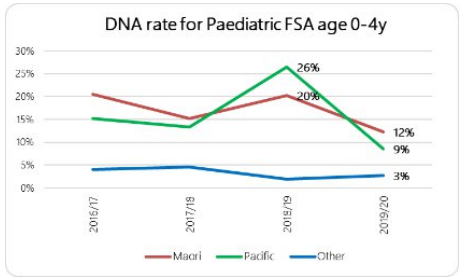
Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations



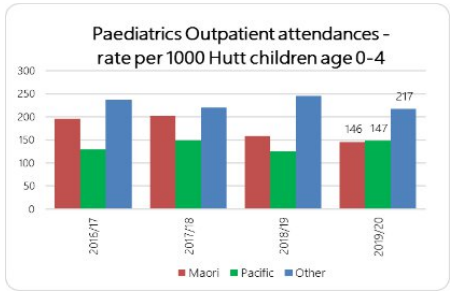


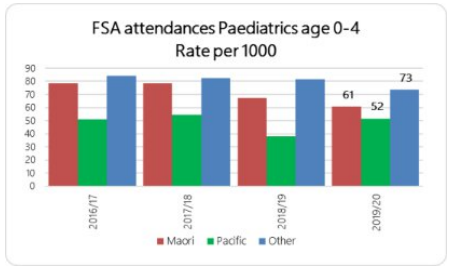
Seen by General Practice





Seen at Paediatric Specialist





Performance at Quarter One 2020/21

Ambulatory Sensitive Hospitalisations (ASH) – Avoidable Hospitalisations

- Māori 2x higher than Total NZ and Pacific 3x higher than Total NZ
- Mostly asthma, respiratory infections, dental conditions for Māori & Pacific
- Mostly respiratory and gastroenteritis/dehydration conditions for Other

Access to GP care

- Māori and Pacific had on average 4 GP & Nurse visits at Te Awakairangi practices – similar to Other ethnicities
- During COVID lockdown, there was significant drop in visits to ED at Hutt hospital, visits to general practices and visits to After Hours - as children stayed at home
- 90% of Hutt children, including Māori and Pacific, saw their GP in first 2 years of life, with on average 11 visits per child in first 2 years
- 44% of children in first 2 years of life went to Lower Hutt After Hours service – 5 visits on average. More Maori and Pacific (59%) went to After Hours and had on average 6 visits.
- In their first 2 years of life, 65% of Pacific children went to ED; 57% of Maori went to ED.

Paediatric outpatients

- Māori and Pacific have lower rates of First Specialist Appointments (FSAs) and total outpatient attendances than Other
- Did Not Attend (DNA) rates for FSAs have decreased in 2019/20 but Māori and Pacific still have higher DNA rates than Other

What are we doing?

- We are promoting healthy lifestyles, improving the responsiveness of general practice by rolling out of the Health Care Homes model of care, and developing Community Health Networks to provide integrated care to people in the community
- We are implementing the Respiratory Work Programme: specialist respiratory support model for primary care; consistent respiratory self-management plans across primary, secondary and community; and proactive planning for long-term-condition and high user patients
- We are removing barriers to attending specialist appointments, including proactive contact to avoid DNAs for FSAs e.g. we send 2 reminder texts and provide taxi-chits if needed.

Commissioning: Primary & Complex Care

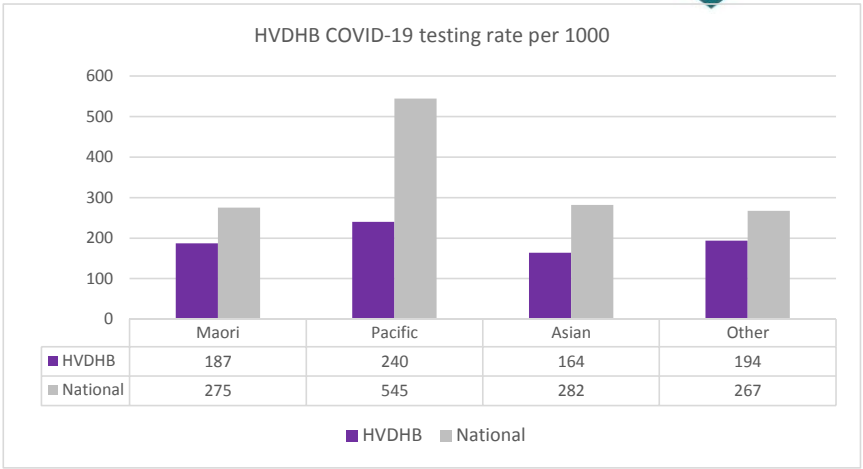
What is this measure?
- COVID-19 testing rate per 1,000 population

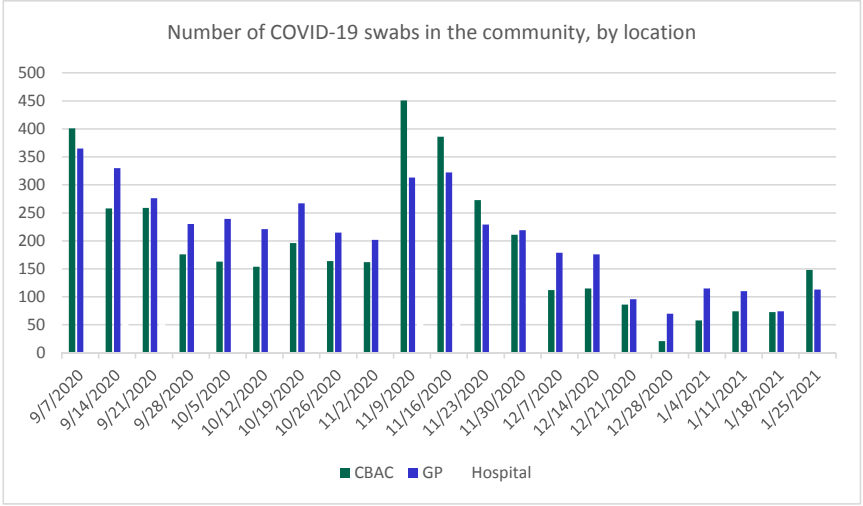
Why is this important?
- The current stage in our COVID-19 response is "maintaining the elimination of disease". This requires strong surveillance to support containment of infection at the border; and robust investigation of any identified cases within the community.
- DHBs are responsible for the organisation and delivery of health services in response to COVID-19. The availability of testing facilities is important for access to testing, and supporting surveillance and contact tracing functions.

How are we performing?
- Our testing rate per 1,000 is 187 for Māori and 240 for Pacific (lower than the national average).
- Nationally, HVDHB ranks 14th highest for testing rate for the total population (193 per 1000). We rank 14th in our testing rate for Māori and 17th for Pacific.
- CBACs have delivered high volumes of swabbing since lockdown, however, the additional swabbing capacity offered through general practices surpassed CBAC volumes until the November cases.
- Our testing volumes partly reflect the communities' responses to the presence of COVID-19 in their communities.

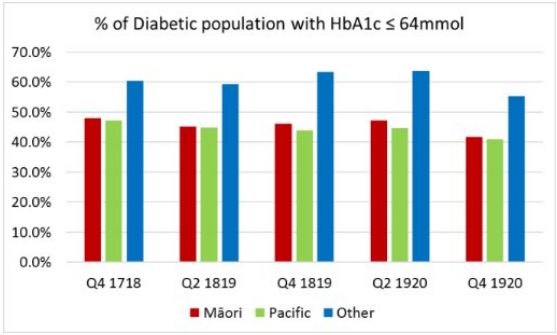
What is driving performance?
- Following the Wellington region community transmission in November, community testing at CBACs increased significantly. However, testing decreased significantly over the Christmas period, and daily swabbing is still below previous volumes.

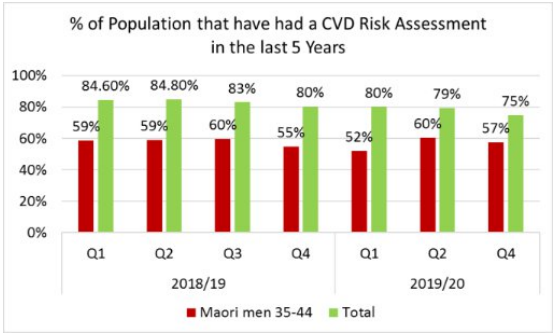
Management Comment
- Our testing regime responds to the Government's testing strategy and our MIF staff and border workers are now being tested at higher rates, and with increased frequency.
- Using our own resources and those allocated by MoH we maintain a state of preparedness in our hospitals and our Regional Public Health Response and community teams are prepared for a comprehensive response.
- Improving testing in our community following the holiday period is a priority, particularly for Māori.
- We have 3 CBACs open; designated practices, and 1 mobile team working across our region.

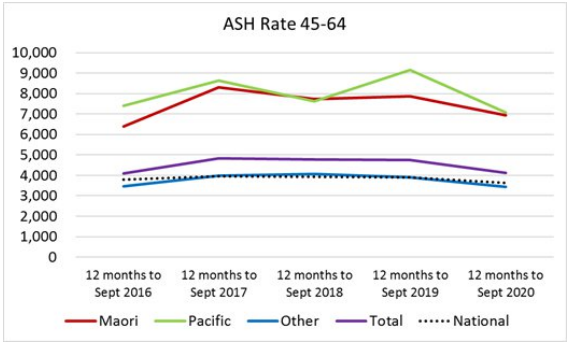


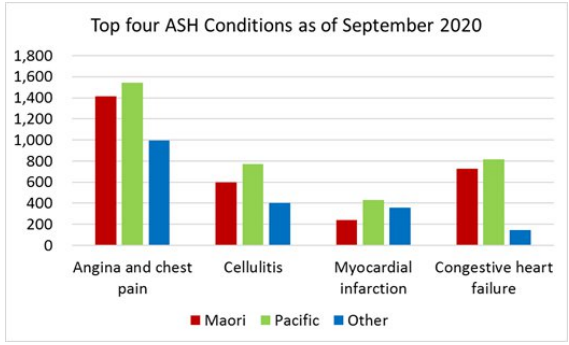


Primary Care: Long Term Conditions









Performance at Quarter Two 2020/21

Diabetes management

- The population with HbA1c ≥ 64 (unmanaged diabetes) has been increasing.
- The population with HbA1c ≤ 64 mmol (well-managed diabetes) has been decreasing over the last three years.
- The number of people without any HbA1c result has been increasing with 1,262 diabetics currently without one.

CVD risk assessment

- The number of people with a CVD Risk assessment has slightly decreased with a slight increase in Māori Men aged 35-44.

Avoidable hospitalisations (ASH)

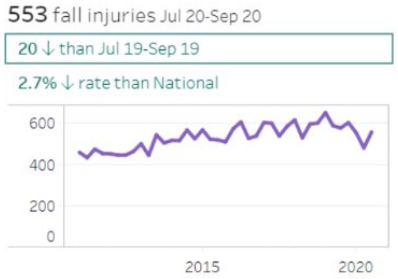
- Angina and Chest Pain highest has decrease for Pacific and Other, constant for Maori, but is still the highest condition.
- Congestive heart failure has returned to a more normal level.

What are we doing?

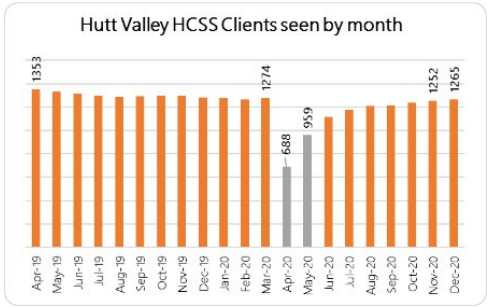
- Concern regarding the ongoing decline in performance in diabetes services has been discussed with PHOs. TeAHN has committed to moving practices to pro-active planning, working at an individual patient level.
- Specialist support to primary care is underway, with areas for expansion being considered
- A Community Health Network / neighbourhood approach to integration is being trialed in a population with high priority population to support specialist support to primary care, and integration with community health services.
- A new approach is being initiated with our Māori and Pacific Directorate. The primary care approach has limited success in these populations.

Health of Older & Frail People – community services

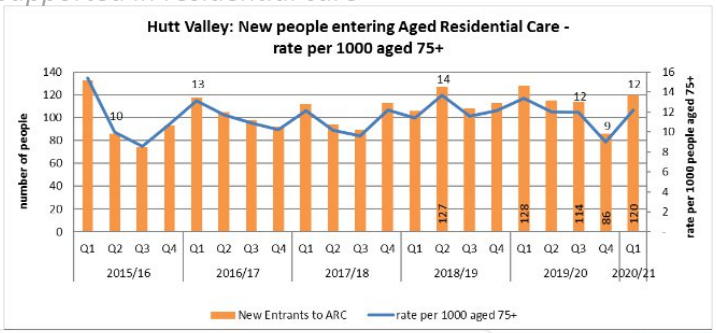
Supported to stay at home safely

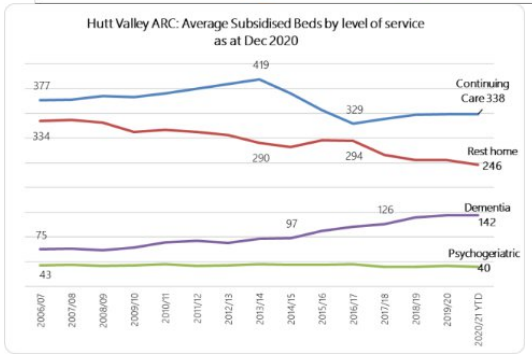


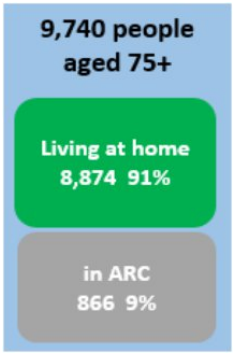
Source: ACC claims for a fall
Rate: Calculated per 1,000 population



Supported in residential care







Performance at Quarter two 2020/21

We are supporting older people to maintain their independence at home and stay healthier for longer with a good quality of life.

- About 91% (8,875) people aged 75+ years live at home, and 9% (865 clients) in Aged Residential Care facilities as at Dec 2020.
- 1,252 people received Home support during November.

COVID Impact

- The number of people entering Aged Residential Care (ARC) remained steady since Jul 2018 until COVID lockdown in Apr-Jun 2020. In April 2020 during COVID lockdown, only 13 people entered ARC but has since returned to previous levels since May 2020.
- Prior to lockdown, average 1271 Hutt people received Home support Jan-Mar 2020. This dropped during COVID lockdown as the service prioritised essential services to the most frail. HCSS providers delivered on average 3,101 support hours per week during April –May COVID level 4 lockdown
- ACC claims by people aged 75+ for Falls injuries dropped during Apr-Jun 20 due to COVID-19 lockdown but has increased since then.

Aged Residential Care:

- Rest home level – bed days for subsidised clients have been dropping over the last few years as people stay at home for longer and enter ARC at higher levels of care
- Dementia level – increasing subsidised beds as more beds have become available
- Continuing care – highest level of care – has been steadily increasing since 2016/17.

What are we doing?

- We are developing sustainable strength and balance programmes to improve our response to frailty, particularly for Māori and Pacific older peoples.
- We are improving our data to inform the development of initiatives to reduce falls. We are participating in a Regional Equity forum to improve equitable outcomes for dementia.
- We are strengthening primary care with more specialist support, embedding telehealth models of care that started during COVID-19, and continuing the roll out of the Health Care Homes to help keep older people healthy and well in the community.

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The trends seen in prior months for our Emergency Department continue placing pressure on wait times and beds. We are working closely with the Strategy Planning and Performance led work to look at sustainable models of care for afterhours services across the district
- Year to date, caseweights for Surgical are 5% over budget with acute demand the key driver. Medical caseweights are higher than budget year to date but close to last year with both Neonatal and Maternity discharges continuing are higher then plan levels. This level of activity is placing pressure on our hospital flow - the newly appointed service manager role will focus on better managing acute patient flow with a better focus on utilising the tools available (CAPPLAN, Trend Care, Dashboards) to improve performance across the system.
- Addressing outpatient and inpatient surgical waiting lists remains a significant challenge and risk for HVDHB with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. We are liaising weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue to work on strategies to provide a more positive patient journey, expand the capacity of the Early Supported Discharge team to improve efficiency of discharge planning and “pull” patients home from ED and wards, and address delays in the Care Coordination Pathway.
- Our Maternity Units across the region are struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
- Medical and Surgical service costs remain unfavourable to budget driving the overall provide result. The pressure in Medical and Surgical services is driven by personnel costs in excess of both Nursing, Allied Health and Support staff and treatment related. The trend for patient activity and acuity and the impact of increasingly older, frailer and more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Jan-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
960	985	25	1,036	76	Surgical	7,968	7,555	(413)	7,326	(642)	12,950	12,797
1,596	1,519	(77)	1,789	193	Medical	13,208	11,558	(1,650)	12,935	(273)	19,737	19,506
460	487	27	435	(25)	Other	3,392	3,225	(167)	3,215	(177)	5,374	5,474
3,016	**2,992**	**(24)**	**3,260**	**244**	**Total**	**24,568**	**22,338**	**(2,230)**	**23,476**	**(1,092)**	**38,061**	**37,777**
					CWD							
990	1,020	30	1,049	60	Surgical	8,373	8,154	(219)	8,117	(256)	13,889	12,852
871	805	(67)	964	92	Medical	6,937	6,415	(522)	6,897	(40)	10,719	11,991
483	482	(1)	497	14	Other	3,922	3,393	(529)	3,777	(145)	5,811	4,698
2,344	**2,306**	**(38)**	**2,510**	**166**	**Total**	**19,233**	**17,962**	**(1,270)**	**18,791**	**(442)**	**30,419**	**29,540**
					Other							
4,059	4,070	11	4,053	(6)	Total ED Attendances	29,235	28,485	(750)	29,243	8	48,696	47,491
982	911	(71)	961	(21)	ED Admissions	7,179	6,747	(432)	6,973	(206)	11,386	11,847
644	738	94	784	140	Theatre Visits	5,452	5,474	22	5,272	(180)	9,370	9,271
142	131	(11)	142	0	Non- theatre Proc	984	893	(91)	906	(78)	1,500	1,891
7,074	6,280	(794)	7,162	89	Bed Days	51,790	48,097	(3,693)	52,154	364	82,873	85,515
4.44	4.50	0.07	4.31	(0.12)	ALOS Inpatient	4.51	4.50	(0.00)	4.44	(0.07)	4.50	4.29
2.12	2.18	0.06	2.08	(0.04)	ALOS Total	2.06	2.18	0.12	2.17	0.11	2.18	2.20
8.20%	8.02%	-0.18%	8.36%	0.17%	Acute Readmission	8.15%	8.02%	-0.13%	8.05%	-0.09%	7.31%	7.36%

In January, Medical discharges and caseweights were over budget but lower than the same time last year. Surgical discharges were under budget for the month and the same time last year. Year to date, caseweights for Surgical services are over budget due to implementing COVID recovery plans. Medical caseweights are higher than budget year to date but close to last year. High numbers for Other due to Neonatal and Maternity.

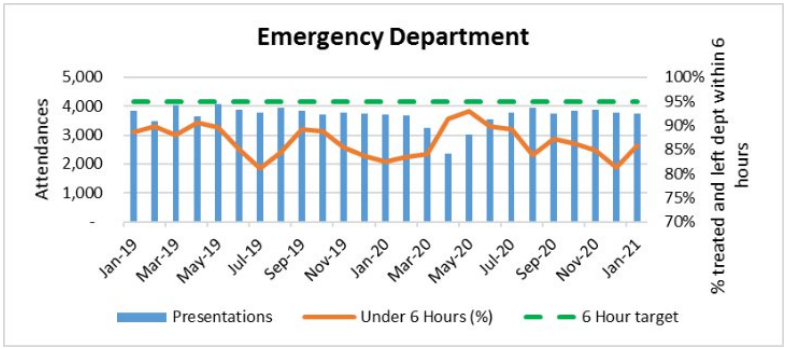
ED visits are close to budget and the same time last year. Patients admitted from ED were slightly higher than budget. Theatre visits were lower than budget for the month due to the holiday period, but close to budget year to date. Non-theatre procedures are over budget for the month and year to date. Bed days were 13% higher than budget for the month but close to the same time last year. Inpatient ALOS in January was under budget but higher than the same time last year. Acute readmission rate was higher than budget for January but lower than the same time last year.

Operational Performance Scorecard – 13 mths

Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Safe	Serious Safety Events[1]	Zero SSEs	1	4	1	2	2	2	3	3	1	2	3	0	1
	SABSI Cases [2]	Zero	2	2	1	0	0	0	1	0	1	2	1	1	1
	C. difficile infected diarrhoea cases	Zero	2	2	4	0	2	0	3	4	1	1	4	0	1
	Hand Hygiene compliance (quarterly)	≥ 80%	83%			87%			82%			TBC			
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		21.8	14.0	31.1	39.1	16.3	13.8	27.7	36.7	11.4	13.3	1.4	43.6	7.6
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%													
	Patient reported experience measure[5] (quarterly)	≥80%	N/a			N/a			N/a			N/a			
Timely	Emergency Presentations	49,056	4,053	4,028	3,558	2,405	3,104	3,721	4,039	4,281	3,997	4,273	4,328	4,259	4,059
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	82.6%	83.5%	83.9%	91.4%	93.0%	89.9%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%
	SSiED % within 6hrs - non admitted	≥95%	89.5%	90.1%	90.1%	95.7%	97.0%	94.7%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%
	SSiED % within 6hrs - admitted	≥95%	63.1%	64.4%	66.6%	81.1%	82.4%	76.1%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	726	719	821	1,012	1,077	1,130	1,082	913	915	992	1,002	1,115	1,251
	No. Theater surgeries cancelled (OP 1-8)		134	98	194	50	72	98	140	148	154	142	128	138	87
	Total Elective & Acute Operations in MainTheatres 1-8[6]		784	743	704	389	673	733	868	792	805	824	775	744	644
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,130	1,194	1,265	1,396	1,384	1,240	1,096	798	674	723	704	758	1,016
	Outpatient Failure to Attend %	≤6.3%	7.1%	7.6%	6.9%	6.1%	7.4%	8.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.1%	7.5%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($6.57)	($8.19)	($10.37)	($13.04)	($13.59)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	TBC	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($8.76)	($10.39)	($13.04)	($14.64)	($15.64)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	TBC	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.9%	89.6%	86.4%	74.5%	85.2%	87.6%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.2%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.34	4.35	5.31	4.90	4.26	4.44	4.39	4.76	4.52	4.26	4.72	4.78	4.51
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	15	16	7	12	15	14	16	21	17	15	21	24	21
	Overnight Beds (General Occupancy) - Average Occupied	≤130	131	136	129	105	118	136	141	151	144	130	138	144	130
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	87.2%	88.2%	79.5%	65.1%	73.1%	84.2%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%
	All Beds - ave. beds occupied[8]	≤250	231	244	223	179	207	241	244	254	249	231	240	240	228
	% sick Leave v standard	≤3.5%	2.0%	2.5%	3.6%	7.5%	6.9%	3.1%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%
	% Nursing agency v employee (10)	≤1.49%	3.9%	3.0%	2.6%	2.3%	3.3%	2.0%	1.6%	1.2%	2.2%	26.20%	12.70%	TBC	TBC
	% overtime v standard (medical) (10)	≤9.22%	11.6%	9.3%	7.6%	9.2%	9.7%	9.2%	6.7%	7.8%	8.1%	9.20%	10.70%	TBC	TBC
	% overtime v standard (nursing)	≤5.47%	17.9%	14.1%	10.6%	13.2%	12.6%	12.3%	10.8%	13.6%	12.3%	12.31%	14.40%	TBC	TBC

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

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	19 (166)	100% (100%)
2	681 (4699)	48% (44%)
3	1453 (10597)	28% (27%)
4	1457 (10289)	41% (38%)
5	449 (3486)	73% (73%)
	Mth (YTD)	Mth (YTD)

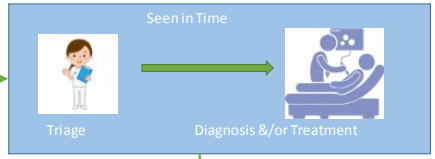
Arrivals -
Month 4,059 (4,053)
YTD 29,237 (29,243)

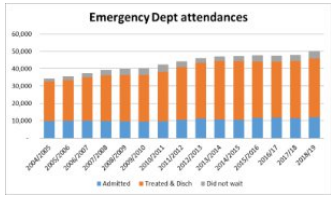
Self Referred
Month - 2,794 (2,664)
YTD - 19,421 (19,186)

GP Referred
Month - 321 (369)
YTD - 2,811 (2,861)

Other
Month - 944 (1,020)
YTD - 7,005 (7,196)

Current (Last Year)





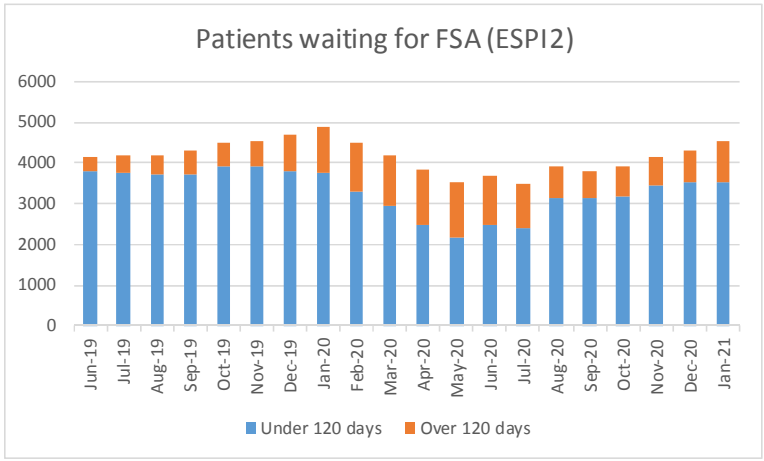
Did Not Wait
Mth - 314 (355) 8%
YTD - 2,510 (2,805) 9%

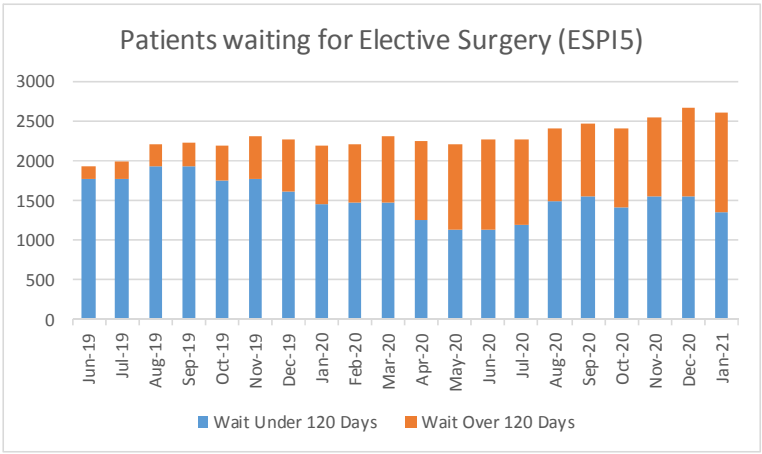
Treated & Disch
Mth - 2,763 (2,737) 91% <6hr
YTD - 19,548 (19,465) 91%

Admitted
Mth - 982 (961) 72% <6hr
YTD - 7,179 (6,973) 72%

- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - Performance of the target improved during April with lower numbers through the ED however the performance has fallen since. There was an improvement to 86% in January.
- **What is driving Performance**
  - It is pleasing to note the percentage of patients treated and discharged within 6 hours has increased in January along with an increase in the percentage seen within their triage category time.
  - There were less presentations in January compared to the following month, however an increase in less serious patients (category 4 and 5) likely a reflection of reduced primary care access. This is further supported by a reduced amount of GP referrals.
  - Trendcare continues to capture patient events and staff have embraced the use well
  - Our assessment unit had record high patient utilisation with 353 through the unit. 95% of cases are leaving the unit within 36 hours which is an improvement on last month
  - The new service manager for acute care commenced and is focusing on working with ED staffing allocation to ensure matching to demand modelling.
  - Recent work to understand the flows into the service show the vast majority of patients that present are treated and discharged (figure 3) indicating that there are many ambulatory type presentations that could be treated in the community if capacity allowed.
  - Of concern is that nearly a quarter of all lower acuity (triage 4 & 5) patients that are in the emergency department in the evening leave without being seen between 11pm and 8am and that Maori make up 24% of those cases that are leaving without been seen. This is largely due to the extremely prolonged wait overnight and is a concern that further impacts on inequity and barriers to accessing healthcare. We are working closely with the SPP led work to look at sustainable models of care for afterhours care across the district

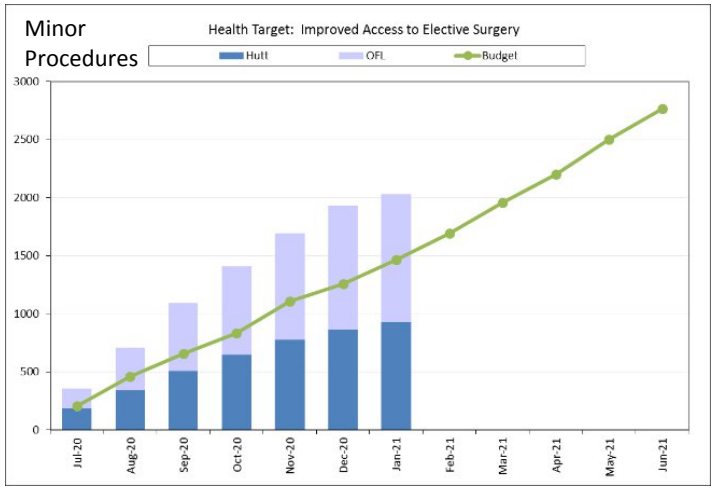
Waiting times - Planned Care

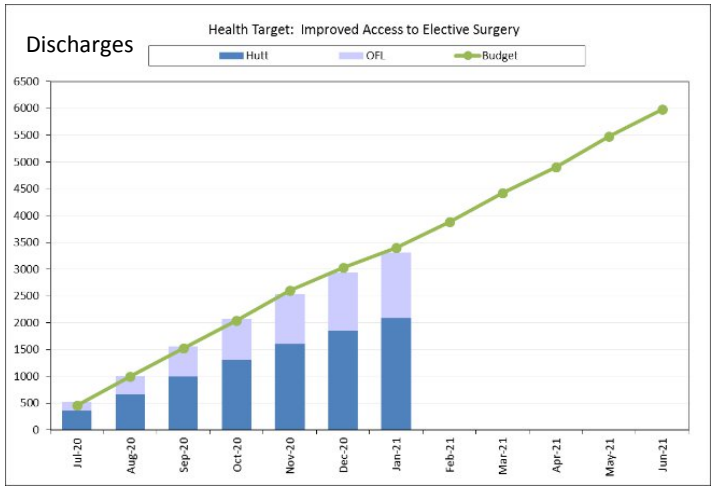




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 5% this month and the number waiting over 120 days by 22% (223)
  - The number waiting for elective surgery fell by 64 to 2,608 however the number waiting over 120 days increased by 136 to 1,251
- **What is driving performance?**
  - Principally managing inflows to our waiting list and balancing against outflows is not yet robust, however
  - Coupled with imbalance in Registered Nursing staffing levels in Recovery area (PACU) in theatre complex and an overall increase in general surgical acute demand impacts on elective service delivery – with operating theatre delays and cancellations resulting in operating theatre utilisation that is below optimum .
- **Management Comment**
  - Work on system improvements to address our waiting list management will be further progressed by our new Planned Care Manager who commences on 15 February
  - We have completed trial of increasing our acute theatres and confirmed ongoing continuation to support better planning for elective surgery across our theatre complex
  - A business case is being progressed to match PACU RN FTE establishment with the roster and this will reduce operating theatre delay times.
  - We are exploring introducing Saturday sessions x2 per month to increase General Surgical elective throughput and reduce the waiting list

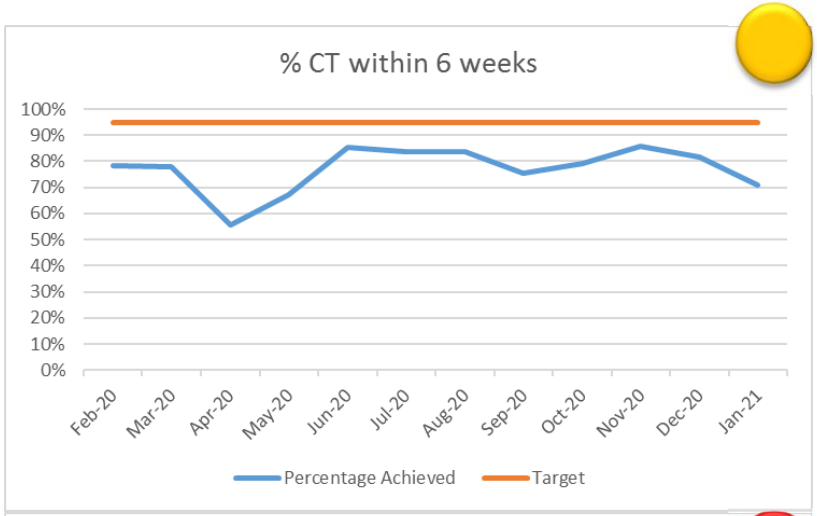
Planned Care – Inpatient discharges and Minor procedures

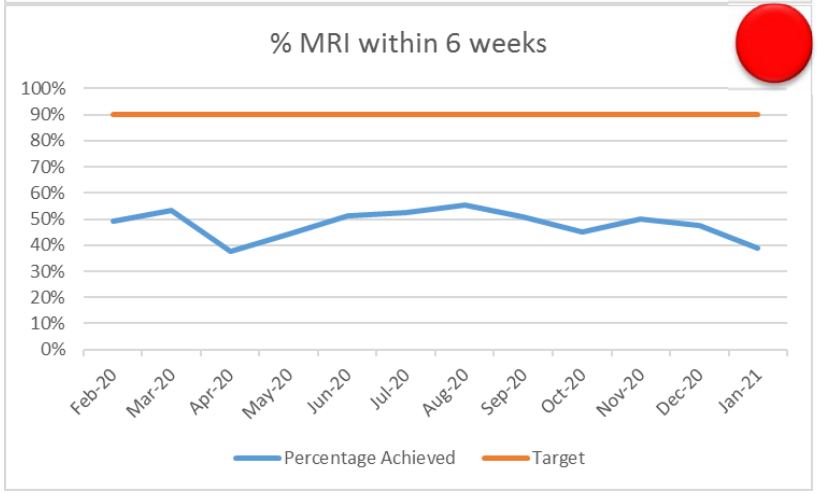




- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
- **Why is it important?**
  - It is important to ensure patients are receiving the planned care procedures required.
- **How are we performing?**
  - Phasing of budgets has been confirmed with the Ministry of Health
  - Discharges are 80 behind budget and Minor procedures has exceeded target
- **What is driving performance?**
  - Access to the operating theatre and impact of acute demand.
  - In respect of minor procedures the Dermatology vacancy at CCDHB is resulting in increased referrals. Minor procedure activity through Plastics is being supported by a locum consultant - demand continues to be high.
- **Management Comment**
  - The total January planned care target was met.
  - Recovery wait list trajectories across services are behind due to acute demand and long standing accumulative size dating back to 2019- 2020 .
  - We are monitoring delivery of our outsourcing contract : 65 cases (40 General Surgery and 25 orthopaedic) being undertaken by March 2021
  - Work continues with our SMO's on the schedule for surgery and to utilise private providers to reduce our surgical waiting list.
  - An outsourcing 2DHB RFP for a 5 year period from July 2021 has been drafted
  - The CFA for additional MoH planned care recovery funding will see additional outsourcing in place along with Hospital initiatives to meet a required reduction in ESPI2 and ESPI 5 waitlists
  - MoH additional funding of $3,922k to increase Planned Care activity:
    - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is underway. The advanced physiotherapist and MDT framework for FSAs has started with positive feedback.
    - Capital investment of $3,647k to establish a 5 room procedure suite. Awaiting final decision from the MoH on our Light Single Stage Business case. Working group in place and concept plans being finalised

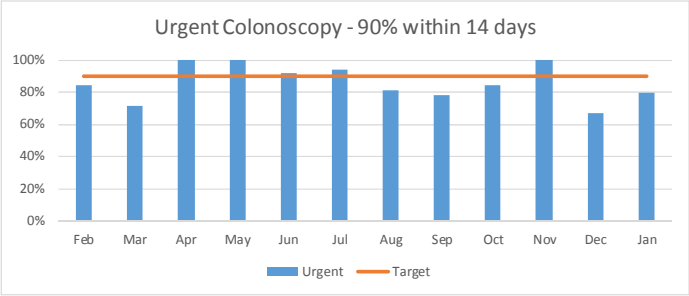
CT & MRI wait times



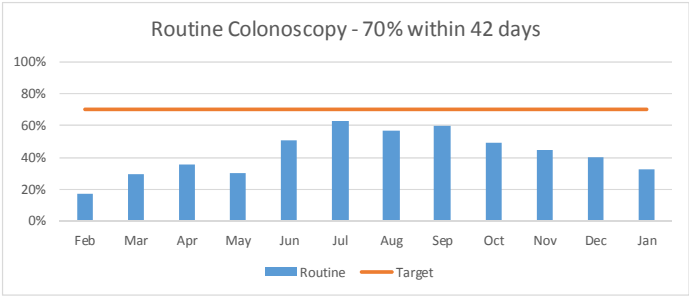


- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is steady.
  - CT wait times remain close to target but fell over last two months.
- **What is driving performance?**
  - There is insufficient radiologist capacity to meet reporting demand; resulting in outsourcing and delays. This will be partly addressed in the coming months with the successful appointment to vacancies.
- **Management comment**
  - We are currently scanning all Hutt Valley domicile patients seen by CCDHB, putting further demand on the service.
  - Actions currently underway:
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - CT guided Steroid injections are no longer being provided in house which is creating more capacity for other core business
    - Reviewing what capacity is available to report for Wairarapa reporting
    - Consultation underway for extended hours in the weekend for MRI appointments
    - Weekend CT list to manage waitlist
    - MOH Planned Care funding being used to outsource 30 MRIs per month (scan and reports) the reporting of 100 CTs per month .

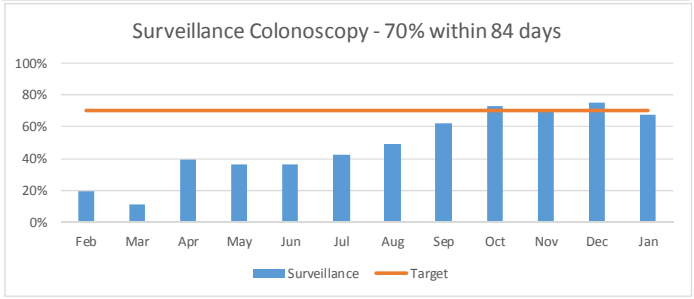
Colonoscopy Wait Times



Urgent
85% YTD



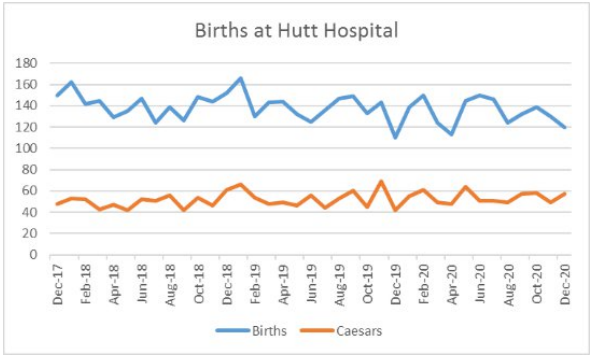
Routine
52% YTD

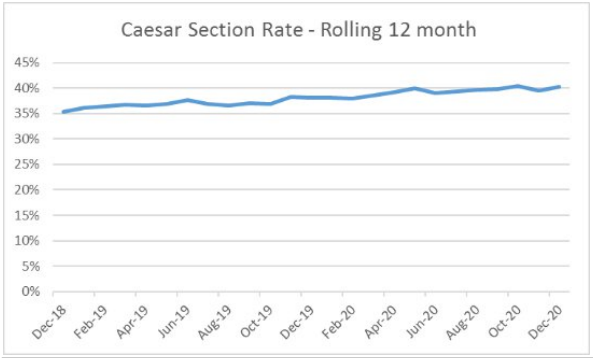


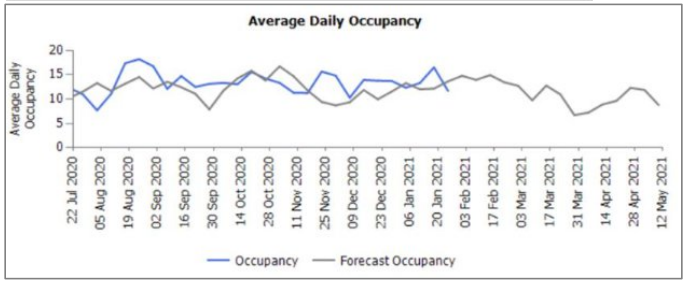
Surveil
63% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
- **What is driving performance?**
  - A growing surveillance waitlist with patients continuing to move onto this from the Bowel Screening Programme
  - A reduction in available lists in January due to leave and Public Holidays
- **Management comment**
  - A Nurse Endoscopist has been employed – due to start March 2021 – this will maintain current list numbers
  - Our Fellow will stay on at reduced FTE to continue providing lists

Maternity







- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - A deep dive review of quality activities is presented in the quality report
- **Management comment**
  - The Minister confirmed approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU).
  - The Governance Group for the facility upgrade has been formed.
  - A public announcement by the Minister is expected and we are waiting to hear this date prior to informing our community.
  - Midwifery staffing was a key recognised risk in the external review; currently Hutt Valley's inpatient antenatal and post natal ward and Delivery Suite have a combined total workforce of 35.23 FTE. The current RM vacancy at the end of January was 19.9 FTE. These vacancies do not include 6.7 FTE covered by RNs, but do include 3.2 FTE new roles that have been created by CCDM FTE calculations but not yet filled. While the service has experienced some midwife resignations, the vacancies are also the result of midwives changing roles – moving into LMC practice, or other midwifery roles within the DHB such as the community midwifery team and Women's clinics.
  - We have processes to manage demand during busy periods. We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
  - We are also developing a more regional approach as both Hutt and WRH units are similarly challenged with workforce shortages.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for January 2021

Month					Hutt Valley DHB Operating Report for the month of January 2021	Year to date					Annual	Annual				
Actual	Budget	Variance	Last Year	Variance	$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance	
					Revenue											
40,767	40,313	455	37,186	3,581	Devolved MoH Revenue	284,314	282,188	2,127	262,819	21,495	486,169	483,750	2,418	454,822	31,346	
1,920	1,569	351	1,484	436	Non Devolved MoH Revenue	13,509	11,578	1,931	11,101	2,408	22,229	20,049	2,180	19,272	2,957	
421	566	(145)	331	89	ACC Revenue	4,076	4,353	(277)	4,039	37	6,942	7,219	(277)	6,457	485	
1,307	530	777	423	884	Other Revenue	4,709	3,696	1,013	3,617	1,092	7,322	6,309	1,013	6,074	1,248	
7,964	9,229	(1,265)	8,297	(333)	IDF Inflow	65,681	64,600	1,082	60,523	5,159	111,513	110,742	771	102,288	9,225	
1,178	303	875	402	776	Inter DHB Provider Revenue	7,109	2,121	4,988	2,511	4,598	10,654	3,637	7,017	4,507	6,148	
53,557	**52,509**	**1,048**	**48,123**	**5,434**	**Total Revenue**	**379,399**	**368,535**	**10,864**	**344,611**	**34,789**	**644,829**	**631,707**	**13,122**	**593,420**	**51,409**	1
					Expenditure											
					Employee Expenses											
4,938	5,123	185	5,222	284	Medical Employees	36,376	36,993	617	34,850	(1,526)	60,686	63,310	2,623	60,010	(676)	
5,929	6,186	257	6,840	911	Nursing Employees	42,483	45,032	2,549	43,224	741	70,858	76,767	5,909	75,339	4,481	
1,768	2,768	1,000	2,427	659	Allied Health Employees	16,622	20,091	3,469	17,966	1,344	28,254	34,575	6,322	32,175	3,922	
805	668	(137)	768	(37)	Support Employees	5,508	4,860	(648)	5,030	(478)	9,056	8,394	(662)	8,676	(380)	
1,785	2,482	696	2,157	372	Management and Admin Employees	15,379	18,073	2,694	16,472	1,094	26,727	30,842	4,114	28,166	1,439	
15,224	**17,226**	**2,002**	**17,413**	**2,189**	**Total Employee Expenses**	**116,368**	**125,048**	**8,680**	**117,542**	**1,174**	**195,581**	**213,888**	**18,306**	**204,366**	**8,785**	2
					Outsourced Personnel Expenses											
618	247	(371)	223	(395)	Medical Personnel	4,107	1,730	(2,378)	2,138	(1,970)	7,365	2,965	(4,399)	3,763	(3,602)	
639	91	(548)	268	(372)	Nursing Personnel	3,647	637	(3,010)	1,158	(2,489)	7,715	1,093	(6,622)	2,002	(5,712)	
473	87	(386)	49	(425)	Allied Health Personnel	2,597	612	(1,985)	317	(2,280)	6,058	1,049	(5,008)	583	(5,475)	
10	20	10	56	46	Support Personnel	297	142	(155)	289	(8)	399	244	(155)	522	123	
442	159	(283)	155	(288)	Management and Admin Personnel	3,472	964	(2,508)	906	(2,566)	6,211	1,765	(4,446)	1,671	(4,539)	
2,183	**605**	**(1,578)**	**750**	**(1,433)**	**Total Outsourced Personnel Expenses**	**14,122**	**4,086**	**(10,036)**	**4,808**	**(9,313)**	**27,747**	**7,116**	**(20,631)**	**8,541**	**(19,206)**	2
778	697	(82)	668	(111)	Outsourced Other Expenses	5,830	4,878	(952)	5,373	(457)	9,418	8,363	(1,055)	9,845	426	3
2,288	2,374	87	2,259	(29)	Treatment Related Costs	18,249	16,525	(1,724)	17,676	(573)	31,476	28,666	(2,811)	27,169	(4,307)	4
2,262	1,468	(794)	1,700	(562)	Non Treatment Related Costs	15,669	10,676	(4,993)	11,596	(4,073)	26,822	18,465	(8,357)	37,215	10,393	5
8,515	9,151	636	7,881	(634)	IDF Outflow	64,883	64,054	(829)	57,731	(7,151)	110,660	109,807	(854)	101,298	(9,362)	6
20,094	18,907	(1,187)	17,247	(2,848)	Other External Provider Costs	134,933	132,986	(1,947)	122,820	(12,113)	231,793	227,534	(4,258)	218,583	(13,210)	7
1,822	2,376	554	2,302	480	Interest, Depreciation & Capital Charge	14,092	16,637	2,545	14,968	876	25,659	28,517	2,858	25,186	(473)	8
53,166	**52,804**	**(362)**	**50,220**	**(2,947)**	**Total Expenditure**	**384,145**	**374,890**	**(9,255)**	**352,515**	**(31,630)**	**659,157**	**642,354**	**(16,802)**	**632,203**	**(26,953)**	
390	**(295)**	**686**	**(2,096)**	**2,487**	**Net Result**	**(4,746)**	**(6,355)**	**1,609**	**(7,904)**	**3,158**	**(14,328)**	**(10,647)**	**(3,680)**	**(38,784)**	**24,456**	
					Result by Output Class											
(478)	71	(549)	68	(547)	Funder	797	(136)	934	(423)	1,220	(528)	(9)	(519)	(7,889)	7,361	
136	39	97	93	43	Governance	513	176	336	268	245	491	310	181	634	(143)	
733	(404)	1,137	(2,134)	2,867	Provider	(6,056)	(6,395)	339	(7,749)	1,693	(14,291)	(10,948)	(3,343)	(31,528)	17,237	
390	**(295)**	**686**	**(1,973)**	**2,363**	**Net Result**	**(4,746)**	**(6,355)**	**1,609**	**(7,904)**	**3,158**	**(14,328)**	**(10,647)**	**(3,680)**	**(38,784)**	**24,456**	

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $10,864k
- Personnel and outsourced Personnel unfavourable ($1,356k)
  - Medical unfavourable ($1,760k); Nursing unfavourable ($461k); Allied Health favourable $1,484k, Support Staff unfavourable ($803k); Management and Admin favourable $186k; Annual leave Liability cost has increased by $1,125k since January 2020
- Outsourced other expenses unfavourable ($952k), includes Outsourced radiology and inpatient services
- Treatment related Costs unfavourable ($1,724k)
- Non Treatment Related Costs unfavourable ($4,993k), includes Holiday Act provision.
- IDF Outflow unfavourable ($829k)
- Other External Provider Costs unfavourable ($1,947k)
- Interest depreciation and capital charge favourable $2,545k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $1,048k for the month
  - Devolved MOH revenue $455k favourable, driven by a reduction in funding for capital charge offset by PHO and COVID-19 funding.
  - Non Devolved revenue $351k favourable driven largely by the recognition of COVID-19 Revenue.
  - ACC Revenue ($145k) unfavourable.
  - Other revenue $777k favourable for the month including revenue in relation to donated assets.
  - IDF inflows unfavourable ($1,265k) for the month driven by current year wash-up payments for lower volumes.
  - Inter DHB Revenue favourable $875k, reflecting the use of shared 2 & 3DHB services, including recoveries from CCDHB for Mental Health. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result - January 2021	Funder [1] (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1][3]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	3,767	157	891	4,815
Expenditure				
Employee Expenses				
Medical Employees		2	127	130
Nursing Employees		10	290	301
Allied Health Employees		19	337	356
Support Employees		47	0	47
Management and Admin Employees		19	82	101
Total Employee Expenses	**0**	**98**	**837**	**935**
Expenses				
Outsourced - Provider	0	19	29	48
External Providers - Funder	4,429			4,429
Clinical Expenses - Provider	0	2	24	26
Non-clinical Expenses- Provider	0	212	118	331
Total Non Employee Expenses	**4,429**	**233**	**171**	**4,833**
Total Expenditure	**4,429**	**331**	**1,008**	**5,768**
Net Impact	**(662)**	**(174)**	**(117)**	**(953)**

(1) RPH COVID19 Funding now through MoH Contract - not Devovled Funding
(2) Includes funding via Whanganui DHB
(3) Excludes overhead charges
(4) Includes technology grant

- The January year to date financial position includes $5.8m additional costs in relation to COVID-19.
- Revenue of $4.8m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.95m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personnel** including outsourced favourable $424k for the month
  - Medical personnel incl. outsourced unfavourable ($186k). Outsourced costs are ($371k) unfavourable, Medical Staff Internal are $185k favourable, driven by SMO's $403k, and the MHAIDS restructure $230k.
  - Nursing incl. outsourced ($291k) unfavourable. Employee costs are $257k favourable, driven by the 3DHB MHAIDS Restructure $557k. Excluding MHAIDS the unfavourable movements were Registered Nurses ($208k), driven largely by Statutory Leave costs ($161k). In addition Senior Nurses were favourable $106k and Registered Midwives $144k, offset by Internal Bureau Nurses and Health Care Assistants ($301k), reflecting the impact of ongoing implementation of the Care Capacity Demand Management (CCDM) process and the Maternity Review recommendations.
  - Allied Health incl. outsourced $614k favourable, with outsourced unfavourable ($386k) and internal employees favourable $1,000k. Employee costs are driven by the 3DHB MHAIDS Restructure $426k, the balance is mostly due to Regional Public Health vacancies and the impact of Annual Leave taken.
  - Support incl. outsourced unfavourable ($127k), with Outsourced $10k favourable, and employee costs ($137k) unfavourable, driven by Orderlies ($44k), Cleaners ($47k), Sterile Supply Assistants ($6k), Security ($12k) and Tradesmen & Maintenance supervisors ($14k).
  - Management & Admin incl. outsourced favourable $413k; internal staff favourable $696k, Outsourced unfavourable ($283k). This reflects the transition to 2DHB services for ITS and MHAIDS and the impact of Annual Leave taken.
  - Sick leave for January was 2.0%, which is the same as this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Jan-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
278	288	10	329	51	Medical	280	287	7	290	10	287	294
721	828	107	804	82	Nursing	769	830	61	800	31	829	818
334	416	83	329	(5)	Allied Health	355	416	61	386	31	417	402
146	137	(9)	137	(9)	Support	146	137	(9)	140	(6)	137	143
303	388	85	310	7	Management & Administration	324	388	64	358	34	388	365
1,782	**2,058**	**276**	**1,908**	**127**	**Total FTE**	**1,874**	**2,058**	**185**	**1,974**	**100**	**2,058**	**2,023**
					$ per FTE							
17,741	17,765	24	15,854	(1,886)	Medical	130,056	128,857	(1,199)	120,126	(9,931)	211,310	215,094
8,221	7,472	(749)	8,511	290	Nursing	55,271	54,256	(1,014)	54,032	(1,238)	85,462	93,878
5,297	6,648	1,351	7,378	2,081	Allied Health	46,808	48,262	1,454	46,585	(222)	67,747	85,962
5,518	4,868	(650)	5,611	93	Support	37,711	35,424	(2,286)	35,892	(1,819)	66,013	58,552
5,901	6,399	498	6,966	1,065	Management & Administration	47,447	46,600	(847)	46,003	(1,443)	68,914	84,428
8,545	**8,372**	**(173)**	**9,124**	**579**	**Average Cost per FTE all Staff**	**62,108**	**60,751**	**(1,357)**	**59,547**	**(2,561)**	**95,017**	**105,731**

Medical under budget for the month by 10 FTE, driven by the MHAIDS restructure 13FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 5FTE, offset by RMO's & House Officers combined.

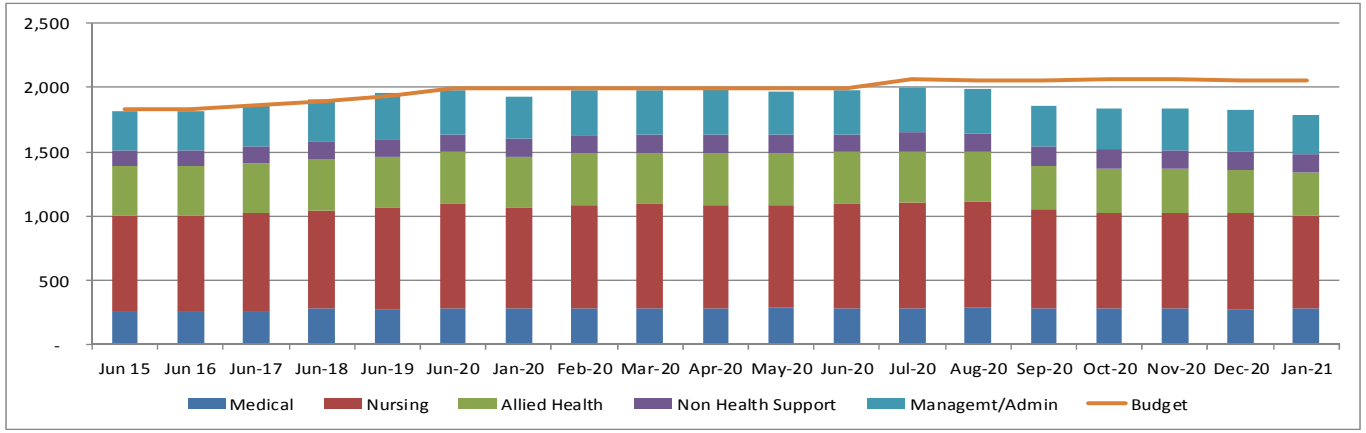
Nursing under by 107 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (8) FTE mostly driven by General Medical (5) FTE, and other variances. This is offset by Registered Nurses and Health Care Assistants under budget 5 FTE and Registered Midwives 21 FTE. This reflects the transition of changes made under both CCDM recommendations and the Maternity Review.

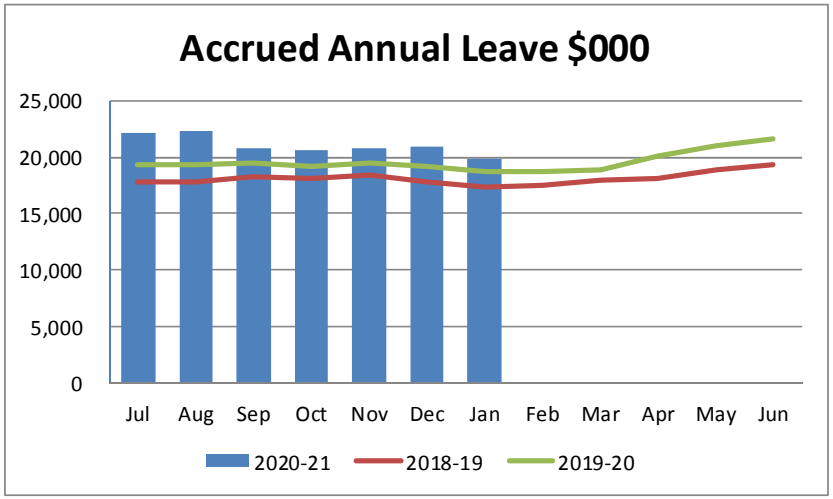
Allied FTEs are under by 83 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in Health promotion 7 FTE, Other Allied Health 5 FTE, Dental Therapists 4 FTE.

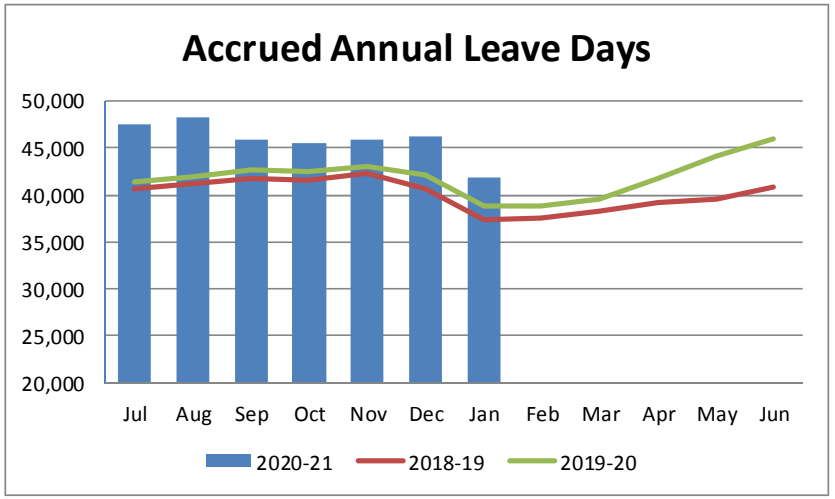
Support FTEs are (9) FTEs over budget driven by Food services (1) FTE, Cleaning (2) FTE and Orderlies (3) FTE.

Management & Admin are under budget by 85 FTEs driven by the MHAIDS & ITS Restructures 40 FTE.
Excluding MHAIDS and ITS changes favourable variance of 52FTE, other variances include; Executive Office 4 FTE, Project Management 2FTE, SPO 7FTE, Quality 2 FTE, Surgical Women's & Children's 4FTE, Regional Public Health 3 FTE and Breast Screening Programme 5 FTE.

FTE Analysis







The movement in Annual Leave Liability is driven by the MHAIDS & ITS restructures. The combined impact of this on Accrued Annual Leave was estimated to be a reduction of 3,175 days and $1,561k in respect of leave liability.

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other favourable $82k for the month.
  - Treatment related costs $87k favourable in line with the lower volumes over the Christmas period.
  - Non Treatment Related costs unfavourable ($794k) including the provision for Holidays Act Settlement ($227k) which is not budgeted as advised by MoH, non-clinical MHAIDS recoveries by CCDHB ($458k) Security ($52k) related mainly to COVID-19, Utilities ($39k), Rents ($85k) and other minor variances.
  - IDF Outflows $636k favourable for the month, driven by lower than expected volumes.
  - Other External Provider costs unfavourable ($1,187k), driven largely by COVID-19 payments to external providers.
  - Interest, Depreciation & Capital Charge favourable $554k, driven by deprecation ($1,005k) reflecting a catch-up on asset capitalisation and Capital Charge $1,559k. Capital Charge has reduced from 6% to 5% with a corresponding reduction in revenue of $727k.

Section 5

Additional Financial Information & Updates

Financial Position as at 31 January 2021

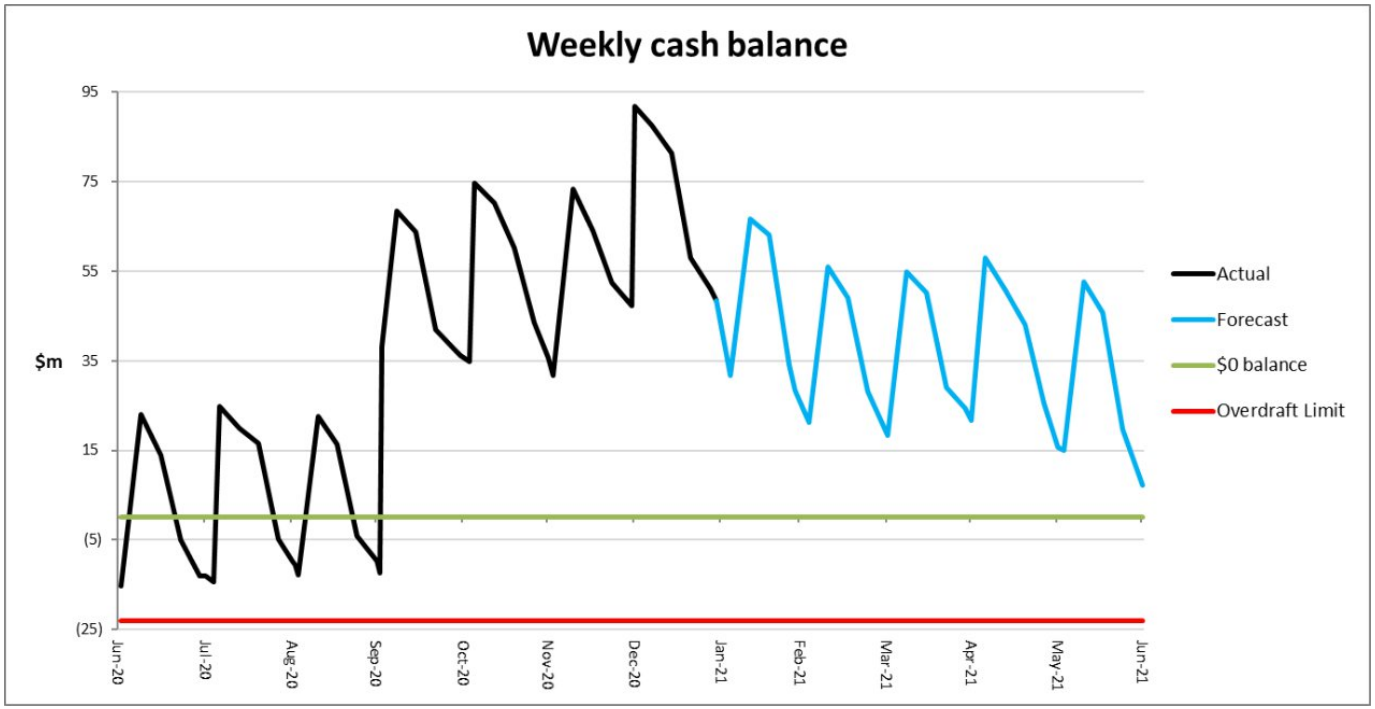
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	48,352	6,029	42,323	(10,986)	59,338	Average bank balance in Jan-21 was $71.5m ($35m equity injection received Oct-20)
Bank - Non DHB Funds *	5,336	4,927	410	4,927	410	
Accounts Receivable & Accrued Revenue	22,356	27,577	(5,221)	27,577	(5,221)	
Stock	2,289	2,200	89	2,199	90	
Prepayments	1,618	815	803	815	803	
Total Current Assets	**79,951**	**41,548**	**38,403**	**24,532**	**55,419**	
Fixed Assets						
Fixed Assets	224,567	244,848	(20,281)	229,790	(5,223)	
Work in Progress	16,303	11,001	5,302	14,001	2,302	
Total Fixed Assets	**240,870**	**255,849**	**(14,979)**	**243,791**	**(2,921)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,282	1,347	(65)	1,347	(65)	
Total Investments	**2,432**	**2,497**	**(65)**	**2,497**	**(65)**	
Total Assets	**323,253**	**299,894**	**23,359**	**270,820**	**52,433**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	89,824	69,324	(20,500)	73,615	(16,209)	Includes Holidays Act Provision of $29.1m
Crown Loans and Other Loans	17	42	24	42	24	
Capital Charge Payable	4,513	0	(4,513)	0	(4,513)	
Current Employee Provisions	27,690	26,018	(1,673)	26,518	(1,173)	
Total Current Liabilities	**122,045**	**95,384**	**(26,661)**	**100,175**	**(21,870)**	
Non Current Liabilities						
Other Loans	178	180	2	178	0	
Long Term Employee Provisions	8,972	8,972	0	8,972	0	
Non DHB Liabilities	5,336	4,927	(410)	4,927	(410)	
Trust Funds	1,246	1,347	101	1,347	101	
Total Non Current Liabilities	**15,732**	**15,426**	**(307)**	**15,424**	**(309)**	
Total Liabilities	**137,777**	**110,809**	**(26,968)**	**115,598**	**(22,179)**	
Net Assets	**185,476**	**189,085**	**(3,609)**	**155,222**	**30,254**	
Equity						
Crown Equity	158,916	164,123	(5,207)	123,916	35,000	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,955)	(27)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(4,746)	(6,371)	1,625	(38,784)	34,038	
Total Equity	**185,476**	**189,085**	**(3,609)**	**155,222**	**30,254**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 January 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	42,820	40,032	89,077	(1,303)	42,008	42,199	42,099	42,106	42,162
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	18,597	8,010	13,752	6,345	9,661	9,929	9,929	9,929	9,929
Receipts from Other Government Sources	721	778	753	770	863	669	501	750	638	677	638	750
Other Revenue	1,833	1,581	(2,392)	1,408	(60)	(202)	3,478	380	380	383	380	380
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**48,845**	**103,296**	**9,021**	**52,799**	**53,145**	**53,089**	**53,052**	**53,220**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,779)	(20,161)	(18,805)	(17,294)	(19,483)	(18,756)	(18,029)	(18,765)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(3,394)	1,140	(6,009)	(17,608)	(5,207)	(5,519)	(5,429)	(5,558)
Capital Charge Paid	0	0	0	0	0	0	0	(6,210)	(0)	(0)	(0)	(6,210)
GST Movement	(710)	75	230	1,030	(1,535)	1,310	2,098	(2,000)	(2,000)	(1,000)	(2,500)	3,350
Payment to Own DHB Provider	0	(0)	(0)	(0)	120	30	30	30	30	30	30	35
Payment to Own DHB Governance & Funding Admin	0	0	0	0	(120)	(30)	(30)	(30)	(30)	(30)	(30)	(35)
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(10,119)	(9,151)	(9,151)	(9,222)	(9,156)	(9,156)	(9,156)	(9,156)	(9,156)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,353)	(16,794)	(19,316)	(19,336)	(19,506)	(19,038)	(19,412)	(19,591)	(19,313)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(48,652)**	**(46,177)**	**(51,274)**	**(71,774)**	**(54,884)**	**(53,842)**	**(54,704)**	**(55,652)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**193**	**57,119**	**(42,253)**	**(18,975)**	**(1,739)**	**(754)**	**(1,652)**	**(2,432)**
Investing Activities												
Interest Receipts	0	0	0	28	35	39	44	21	21	21	21	21
Dividends	0	0	0	0	0	0	0	4	4	4	4	4
Total Receipts	**0**	**0**	**0**	**28**	**35**	**39**	**44**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(595)	(1,028)	(1,226)	(1,772)	(5,772)	(14,772)	(4,972)	(5,773)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	(15)	(48)	17	0	0	0	0	0
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(610)**	**(1,076)**	**(1,208)**	**(1,772)**	**(5,772)**	**(14,772)**	**(4,972)**	**(5,773)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(575)**	**(1,038)**	**(1,164)**	**(1,747)**	**(5,747)**	**(14,747)**	**(4,947)**	**(5,748)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	4,000	13,000	0	0
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**35,000**	**0**	**0**	**0**	**0**	**4,000**	**13,000**	**0**	**0**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(0)	(3)	(0)	(6)	(6)	(5)	(5)	(5)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(0)**	**(3)**	**(0)**	**(6)**	**(6)**	**(5)**	**(5)**	**(5)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(0)**	**(3)**	**(0)**	**(6)**	**3,994**	**12,995**	**(5)**	**(5)**
Total Cash In	53,100	54,861	51,678	98,624	48,880	103,335	9,065	52,824	57,170	66,114	53,077	53,245
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(49,262)	(47,256)	(52,482)	(73,551)	(60,661)	(68,620)	(59,681)	(61,430)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	35,691	91,770	48,352	27,625	24,133	21,627	15,023
Net Cash Movements	(2,150)	3,523	(60)	45,746	(382)	56,079	(43,417)	(20,728)	(3,491)	(2,506)	(6,604)	(8,185)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**35,691**	**91,770**	**48,352**	**27,625**	**24,133**	**21,627**	**15,023**	**6,838**

Weekly Cash Flow – Actual to 31 January 2021



Note

- the overdraft facility shown in red is set at $23 million as at January 2021
- the lowest bank balance for the month of January was $48.3m

Summary of Leases – as at 31 January 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses (*Lease renewal currently in negotiation)		1,149	13,787		1/11/2017	31/10/2020*	Operating
Public Trust House Lower Hutt	Community Mental Health		23,915	286,976		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		9,088	109,055		15/03/2015	14/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy		2,573	30,879		5/01/2021	31/12/2023	Operating
CBD Towers Upper Hutt	Community Mental Health		9,854	118,247		8/06/2015	7/06/2021	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			52,923	**635,067**				
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
			2,145	**25,740**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (115 Vehicles)			33,359	400,313		Ongoing	Ongoing	Operating
Custom Fleet (Nissan Leaf electrical vehicle)			556	6,671		1/10/2020	1/06/2024	Operating
			33,915	**406,984**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Diagnost R2	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
		293,188	**106,251**	**1,275,040**	**5,158,543**			
Total Leases			**195,235**	**2,342,832**				

Treasury as at 31 January 2021

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$71,514	$62,252
Lowest balance for the month	$48,332	$31,741
Average interest rate	0.72%	0.73%
Net interest earned/(charged) for the month	$44	$39

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	4
Total value of transactions	$33,391 NZD
Largest transaction	$11,378 NZD

	No. of transactions	Equivalent NZD
AUD	2	$14,476
GBP	1	$7,537
SGD		
USD	1	$11,378
Total	**4**	$33,391

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	$3,427	$303	$337	$45	$30	$198	$151	$2,363
Ministry of Health	$2,032	$1,330	$335	$18	$34	($0)	$0	$315
Accident Compensation Corporation	$629	$483	($204)	$38	($3)	$13	$15	$285
Wairarapa District Health Board	$444	$43	$0	$106	$6	$1	$10	$278
Wellington Southern Community Laboratories	$64	$2	$0	($0)	$0	($0)	$0	$62
Non Resident	$57	$0	$57	$0	$0	$0	$0	$0
Non Resident	$55	$0	$0	$0	$0	$0	$3	$52
ESR Limited	$51	$51	$0	$0	$0	$0	$0	$0
Whitireia Community Polytechnic Limited	$46	$0	$46	$0	$0	$0	$0	($0)
Oranga Tamariki - Ministry for Children	$42	$0	$0	$0	$0	$0	$0	$42
Total Top 10 Debtors	**$6,847**	**$2,214**	**$572**	**$208**	**$68**	**$211**	**$178**	**$3,397**

Board Information - Public

April 2021

Capital & Coast DHB January 2021 Financial and Operational Performance Report

Action Required

The Capital & Coast DHB Board note:

(a) The release of this report to the public.

(b) The DHB had a ($4m) deficit for the month of January 2021, being ($1.5m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003]

(c) The DHB year to date had a deficit of ($26.7m), being ($8.1m) unfavourable to budget before COVID-19 and Holidays Act [2003]

(d) In the seven months we have incurred $10.7m additional net expenditure for COVID-19 and $4.7m against provision for Holidays Act [2003]

(e) This means that the DHB has an overall YTD deficit of ($11.3m) from normal operations (excluding COVID-19 and Holidays Act) being $7.3m favourable to our underlying budget.

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

Executive Summary

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

Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the seven months to 31 January 2021 is $11.3m deficit, versus a budget deficit of $18.6m.

Additional net COVID related expenditure above funding, year to date is $10.7m.

The monthly provision for increasing Holidays Act liability is $648k and year to date the impact on the result is $4.7m

For the seven months to 31 January 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $26.7m deficit.

The DHB has submitted an Annual baseline budget of $39.8 million deficit. The DHB is working with the Ministry to have the budget and Annual Plan signed off.

Capital Expenditure was $34.9 million year to date.

We had a negative cash Balance at month-end of $16.3 million offset by positive "Special Funds" of $13 million (net $3.3 million overdraft). It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

Increasing acuity in our ED is a key feature. Over December 2020 Wellington ED experienced the fourth highest number of triage 1 presentations (59) in a single month ever. When January 2021 is compared to January 2020 despite the overall decrease the total number of triage 1 presentation increased by 23, the number of triage 2 presentations increased by 65 and the number of triage 3 presentation increased by 13. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day with the aim of freeing up beds for those being admitted from ED to move to the ward in a timelier manner.

The single major factor in our continued decline in ED wait times is the increasing LOS in ED - a symptom of inadequate bed supply. This coupled with pressures around completing of elective and acute surgical work that was delayed during our COVID response and that we now need to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients has created a perfect storm. We are supporting the project to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and in parallel exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. Production is exacerbated high number of theatre session under-utilised due to anaesthetic vacancies – sixty this month however we continue to make positive steps in terms of agreeing pricing for procedures with the greatest volume on our waitlist, so expect to meet our plan for outsourcing. SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times. We are working hard to recruit anaesthetists to our current vacancies which comprise 12% at present.

Our Maternity Units across the region are struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

The Month result was $4.9m unfavourable however outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget, the Hospital provider arm continues to have a favourable variance YTD. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave is going to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 111 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($11.3m) deficit from normal operations, against our DHB budget of ($18.6m). An additional ($10.7m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($4.7m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

3.1.1 Capital & Coast DHB January 2021 Financial and Operational Performance Report

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 January 2021

Presented in March 2021

Capital & Coast District Health Board

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

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

- Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the seven months to 31 January 2021 is $11.2m deficit, versus a budget deficit of $18.5m.

- Additional net COVID related expenditure above funding, year to date is $11.3m.

- The monthly provision for increasing Holidays Act liability is $756k and year to date the impact on the result is $4.7m

- For the seven months to 31 January 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $26.7m deficit.

- The DHB has submitted an Annual baseline budget of $39.8 million deficit. The DHB is working with the Ministry to have the budget and Annual Plan signed off.

- Capital Expenditure was $21.8 million year to date.

- We had a negative cash Balance at month-end of $29.3 million offset by positive "Special Funds" of $13 million (net $16.3 million overdraft). It should be noted that there is a significant amount of the COVID response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than was budgeted for this point in time however the equity injection of $39.8m signalled in the 2021/22 Annual Plan will be requested for the last quarter of the year.

Executive Summary continued

- Increasing acuity in our ED is a key feature. Over December 2020 Wellington ED experienced the fourth highest number of triage 1 presentations (59) in a single month ever. When January 2021 is compared to January 2020 despite the overall decrease the total number of triage 1 presentation increased by 23, the number of triage 2 presentations increased by 65 and the number of triage 3 presentation increased by 13. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day with the aim of freeing up beds for those being admitted from ED to move to the ward in a timelier manner.

- The single major factor in our continued decline in ED wait times is the increasing LOS in ED - a symptom of inadequate bed supply. This coupled with pressures around completing of elective and acute surgical work that was delayed during our COVID response and that we now need to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients has created a perfect storm . We are supporting the project to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and in parallel exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

- Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. Production is exacerbated high number of theatre session under-utilised due to anaesthetic vacancies – sixty this month however we continue to make positive steps in terms of agreeing pricing for procedures with the greatest volume on our waitlist, so expect to meet our plan for outsourcing. SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times. We are working hard to recruit anaesthetists to our current vacancies which comprise 12% at present.

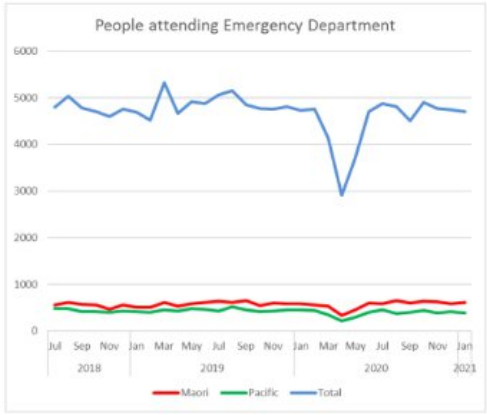
- Our Maternity Units across the region are struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

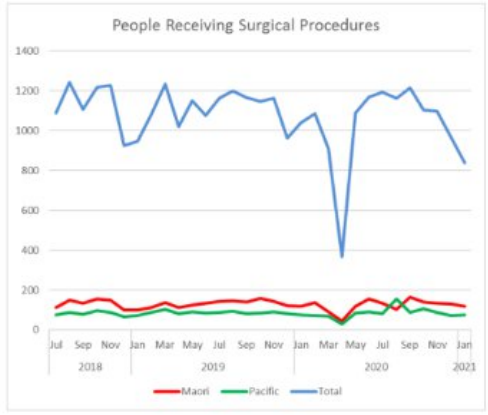
- The Month result was $4.9m unfavourable however outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget, the Hospital provider arm continues to have a favourable variance YTD. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave is going to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

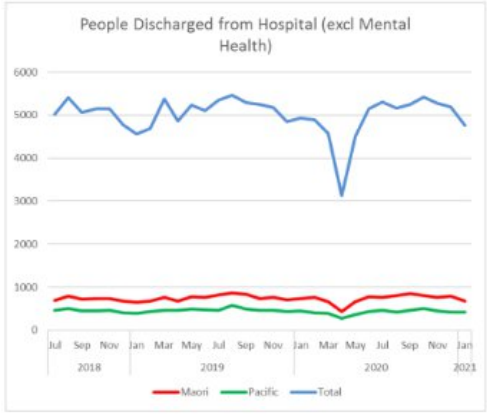
Performance Overview: Activity Context (People Served)

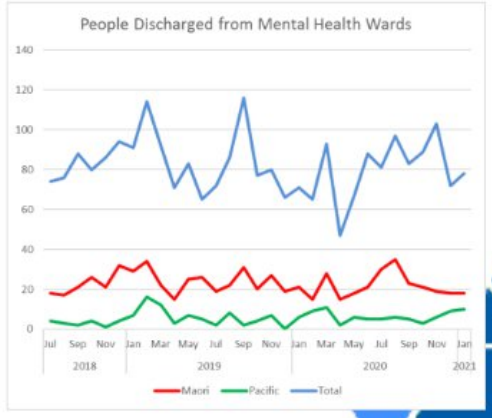
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,708**	616 Maori, 387 Pacific
People receiving Surgical Procedures (in main theatres)	**839**	117 Maori, 76 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**4,763**	685 Maori, 416 Pacific
People discharged from Mental Health Wards	**78**	18 Maori, 10 Pacific



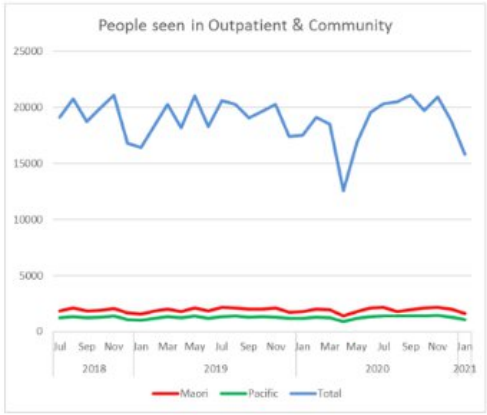


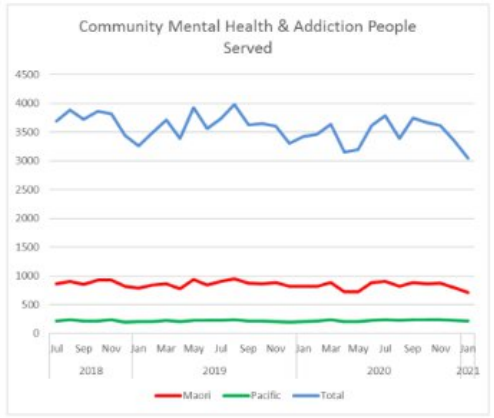


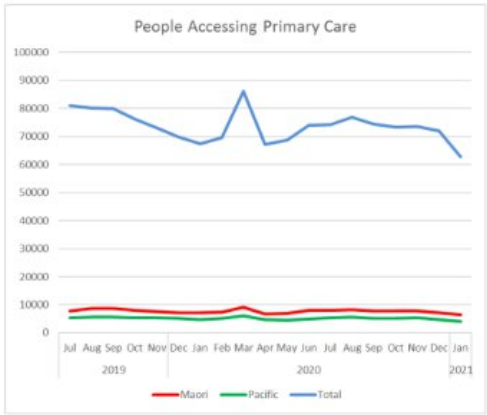


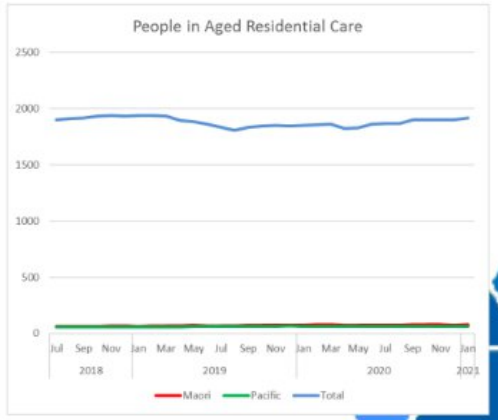
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**15,791**	1,610 Maori, 1,042 Pacific
Community Mental Health & Addiction People Served	**3,042**	715 Maori, 218 Pacific
People accessing primary care	**62,718**	6,451 Maori, 4,142 Pacific
People in Aged Residential Care	**1,918**	78 Maori, 61 Pacific









Financial Overview – January 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$26.7m deficit Incl. $10.7m COVID-19 costs Incl. $4.7m Holidays Act	$26.1m deficit Incl. $10.3m COVID-19 costs Incl. $4.7m Holidays Act	$1m deficit Incl. $.3m COVID-19 costs	$34.9m spend Incl. $19.9m strategic capex
Against a budgeted YTD deficit of $21.2m. BAU Month result was breakeven. YTD $7.2m favourable BAU variance.	Against a budgeted deficit of $21.2m. BAU Month result was $10.7m unfavourable. BAU YTD $7.3m favourable variance.	Against a budgeted deficit of $2.7m. BAU Month result was $.7m unfavourable result. YTD $3.4m unfavourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $39m. Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.19% ahead[1]	5,560[3]	($9.1m) annualised[4]
78 CWDs ahead PVS plan (153 IDF CWDs behind, but 252 Hutt ahead). Month result -630 CWDs excluding work in progress.	YTD 111 above annual budget of 5,449 FTE (budget excludes lead DHB). There is 615 FTE vacancies at end November inclusive of lead DHB transfers.	Underlying YTD annual leave taken is under by 3.3 days per FTE and Lieu leave taken for public holidays is short by 3.08 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1374 cwd outsourced (777 events) ~$7.6m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.

[3] Paid FTE ignores leave balance movement which is YTD 36 FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $4.6m adverse to budget.

CWD – Case weights (also known as WEIS for a year) WEIS – Weighted Inlier Equivalent Separations
4 – Only annual leave & Lieu excludes long service, LILO & other types, note that public holidays build up the Lieu leave in the second half of the financial year. This assumes the YTD continues for 12 months

Hospital Performance Overview – January 2021

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
68.6%	539	314**	6
26.4% below the ED target of 95% Monthly +2.7% improvement	Against a target of zero long waits a monthly movement of +232	Against a target of zero long waits, a monthly movement of -89** **January not yet available	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.19% ahead[1]	3,647[3]	$5,821*
78 CWDs ahead PVS plan (153 IDF CWDs behind, but 252 Hutt ahead). Month result -630 CWDs excluding work in progress.	YTD 28 below annual budget of 3,675 FTE. 268 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (5% above).*to Dec 2020

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1374 cwd outsourced (777 events) ~$7.6m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 36 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $753k adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- Overall the funder has a unfavourable variance of ($3.7m). Revenue is $11.9m ahead of budget most of which is mainly due to CCDHB having additional COVID accrued revenue of $10.3m. Offsetting COVID costs are ($10.5m). Recovery of all costs remains the subject of negotiations with MoH seeking a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance will continue.
- An amount of ($2m), was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Jan 2021. Additional revenue for Pharmaceuticals of $2.4m has been received to offset the effect of COVID in the unstable international market. This is offset by increased costs associated with the supply of pharmaceuticals
- Funding for community services are ($8.8m) unfavourable with Pharmaceuticals being ($7.8m) over budget. Note comment above. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also underspent reflecting the impact of COVID.
- There remains risk in the loss of inter-district flow revenue, planned care for the provider arm and pharmaceutical costs in a post-covid environment. All of these elements are being closely managed.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach:
- CCDHB is working with Ora Toa PHO, our largest iwi primary care provider; and one of our Outreach Immunisation services, to more closely monitor and increase Māori and Pacific immunisation coverage. This includes implementing a Mātua, Pepi, Tamarki service in Porirua to provide additional, proactive wraparound support for families.
- Our testing regime responds to the Government's testing strategy and our MIF staff and border workers are now being tested at higher rates, and with increased frequency.
- We are working on ED waiting times through community responses to population drivers alongside approaches to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand.

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Jan 2021	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	510,195	510,195	476,967	0	33,229
4,551	4,665	4,809	(114)	(258)	Other MOH Revenue - Funder	32,415	32,655	35,575	(239)	(3,159)
1,352	0	0	1,352	1,352	COVID Revenue from MOH	12,768	0	0	12,768	12,768
(54)	45	41	(99)	(95)	Other Revenue	1,061	317	612	744	449
3,094	2,936	2,997	158	97	IDF Inflows PHOs	21,228	20,551	19,680	677	1,548
16,804	18,517	16,210	(1,712)	594	IDF Inflows 19/20 Wash-up Prov	127,539	129,616	117,219	(2,077)	10,319
98,632	**99,048**	**92,196**	**(415)**	**6,437**	**Total Revenue**	**705,206**	**693,333**	**650,052**	**11,872**	**55,153**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	5,765	5,765	6,707	0	941
48,003	49,714	44,489	1,712	(3,513)	DHB Provider Arm Internal Costs - HHS	368,230	369,865	331,185	1,635	(37,045)
7,767	7,751	8,754	(16)	988	DHB Provider Arm Internal Costs - MH	54,372	54,261	61,344	(111)	6,971
1,612	1,942	2,118	330		DHB Provider Arm Internal costs - Corp	11,391	13,688	17,928	2,297	6,537
246	0	0	(246)	(246)	DHB Provider Arm Internal costs - COVID	1,620	0	0	(1,620)	(1,620)
58,451	**60,231**	**56,320**	**1,780**	**(2,131)**	**Total Internal Provider**	**441,379**	**443,580**	**417,164**	**2,201**	**(24,215)**
					External Provider Payments:					
7,026	5,703	5,831	(1,323)	(1,195)	- Pharmaceuticals	47,729	39,920	41,102	(7,810)	(6,628)
6,682	6,645	6,405	(37)	(277)	- Capitation	46,902	46,517	44,675	(385)	(2,227)
7,376	7,354	7,059	(22)	(317)	- Aged Care and Health of Older Persons	50,892	51,481	49,180	589	(1,712)
3,058	2,862	2,377	(196)	(681)	- Mental Health	20,866	20,034	17,202	(832)	(3,665)
867	807	719	(59)	(147)	- Child, Youth, Families	5,584	5,650	4,761	65	(823)
203	473	377	270	174	- Demand driven Primary Services	3,946	4,248	3,818	302	(128)
2,246	2,356	2,127	110	(119)	- Other services	16,859	16,495	16,029	(364)	(829)
3,735	3,725	3,256	(9)	(479)	- IDF Outflows Patients to other DHBs	26,087	26,077	23,224	(9)	(2,863)
5,280	5,240	5,040	(40)	(240)	- IDF Outflows Other	37,106	36,680	34,792	(426)	(2,314)
36,472	**35,166**	**33,192**	**(1,306)**	**(3,281)**	**Total External Providers**	**255,971**	**247,101**	**234,782**	**(8,870)**	**(21,189)**
753	0	0	(753)	(753)	- COVID in Community PHO, Pharms, ARC	8,878	0	0	(8,878)	(8,878)
95,677	**95,397**	**89,511**	**(280)**	**(5,412)**	**Total Expenditure**	**706,228**	**690,681**	**651,945**	**(15,547)**	**(54,282)**
2,956	**3,651**	**2,684**	**(695)**	**272**	**Net Result**	**(1,022)**	**2,653**	**(1,893)**	**(3,675)**	**871**

Funder Financials – Variance Explanations

Revenue

The Funder Revenue has a positive variance for YTD Jan 2021 of $11.9m. This is due to additional Ministry of Health funding received to support COVID-19 response and other new funding programmes. There are equivalent cost offsets.

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 community funding	759	8,722
COVID-19 MIQ HHS	246	1,621
COVID-19 Pharms funding	347	2,426
PHOs washup & add funding	250	1,579
Mental Health, Aged Care, Child Yth CFAs	23	1,891
Capital Chg reduced funding	(327)	(2,289)
CWD IDF 2020/21 below target	(1,712)	(2,077)
Year to Date Revenue Variances	**(415)**	**11,872**

Variance Explanations

- Funder Revenue has a positive variance for YTD Jan 2021 of $11.9m. This is due to additional Ministry of Health funding received to support COVID-19 response and other new funding programmes. There are equivalent cost offsets.
- COVID-19 community funding of $12.8m has been received from the Ministry. This supports GP Assessment testing & CBACS, Pharmaceutical costs, Quarantine Hotel staffing plus response funding for Maori and Pacific groups. There are cost offsets. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for all COVID community costs but not necessarily for all the hospital related COVID costs.
- PHO funding wash-ups and volume funding of $1.6m. There are increased costs of ($832k) offsetting this revenue. New funding for Mental Health and Child & Youth services of $1.9m has been contracted to NGO Providers.
- Provision for 20/21 IDF wash up revenue is down by ($2.1m) due to Provider Arm not achieving the targets set

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 community funding	(753)	(8,878)
Pharms increased volumes incl COVID	(876)	(4,681)
Pharms savings not achieved	(447)	(3,128)
PHOs volume variances offset	(119)	(832)
Other Community NGOs	120	(339)
CWD PVS below target	1,715	1,644
Capital Chg reduced funding	327	2,289
COVID-19 MIQ HHS	(246)	(1,621)
Year to Date Payment Variances	**(280)**	**(15,547)**

External Provider Payments:

- Community COVID-19 costs ($8.8m) mainly due to ongoing GP assessment and CBAC claims in support of the COVID-19 response as directed by the Ministry.
- Pharmaceuticals costs have been impacted by COVID-19 with increasing costs unfavourable to budget by ($4.6m). The DHB has received additional COVID funding which offsets this cost pressure. The DHB had budgeted for pharmaceutical savings in 2020/21 pre COVID. Budgeted YTD savings of ($3.1m) have not been achieved.
- PHO Capitation expenses are ($832k) unfavourable. Additional costs due to volume changes are offset by additional revenue. Effect is expected to be neutral at year end.
- Other Community NGO contracts have a net YTD variance of ($339k) Volumes are being maintained, however there are some lower volume trends due to COVID.

Internal Provider Payments:

- An amount of $1.64m, was not paid to the Provider Arm due to under achievement of the IDF targets at YTD Jan 2021. Reduced capital charge funding of $2.3m as per the Ministry has been passed through to Provider. Provider has been paid for MIQ provisional costs of ($1.6m).

Inter District Flows (IDF)

DHB of Domicile	YTD January estimated inpatient inflow wash-up
Taranaki DHB	-$1,036,804
Other under-delivered (10 DHBs)	-$1,884,344
Other over-delivered (7 DHBs)	$674,539
Hutt Valley DHB	$1,398,537
Total undelivered inpatient IDF CWD (negative is CCDHB not delivering services to other DHBs therefore unfavourable from both a patient treatment and P&L perspective)	-$848,073

DHB of Service	YTD October estimated inpatient outflow wash-up
Other over-serviced (7 DHBs)	-$205,705
Other under-serviced (11 DHBs)	$335,034
Counties Manukau	$120,559
Total unserviced inpatient IDF CWD (negative is our population being over-serviced by other DHBs therefore unfavourable from a P&L perspective but favourable from a patient treatment perspective)	$249,887

Changed Recognition:

- The DHB is back to standard recognition of IDFs from the start of the financial year rather than the COVID-19 approach taken last year.
- We have recognised non-delivery of IDF inflows with an unfavourable result of ($1.4m) YTD, a ($1.6m) decrease to last month.

IDF Inflow (revenue):

- Inpatient Caseweight IDF inflows are unfavourable by ($848k) which is driven by lower acute IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by elective inpatient lower volumes:
  - Acute: $38k: Cardiology ($1.1m), followed by Gen Med ($717k) and Oncology ($561k). Offset by Cardiothoracic $1.1m (with significant outsource earlier in the year), NICU $1m, Neuro $949k
  - Elective: ($886k); Vascular $827k offset by Cardiothoracic ($1.6m)

IDF Outflow (expense):

- Overall IDF outflows are overall unfavourable by ($435k) to Jan 21 and this will be reviewed as the IDFs for complex patients are revisited next month.
- In terms of IDF inpatient caseweight activity this was favourable by $250k to October; meaning less CCDHB domiciled patients were being treated at other hospitals than planned. 80% of this variance was from acute admissions (this $ number will be slightly lower as events are coded at other DHBs hence displaying only YTD October figures)
- This information is analysed and collated to provide the breakdown by DHB of Service to enable the services to understand service delivery change.

Commissioning: Families & Wellbeing

What is this measure?

- 95% of children fully immunised at milestone age (CW01)

Why is this important?

- Improving childhood immunisation coverage is part of our health system's early investment to lay foundations for lifelong wellbeing.
- Immunisation is one of the most cost-effective public health interventions.
- When equitable immunisation coverage is achieved, the health gains are greatest for the most vulnerable groups.

How are we performing?

- Immunisation for Māori is lower than for other ethnic groups.
- Immunisation for Pacific children has improved but remains below target.
- At 5 years of age, immunisation coverage has decreased across all groups.
- Immunisation varies by locality, although coverage is generally highest in Wellington

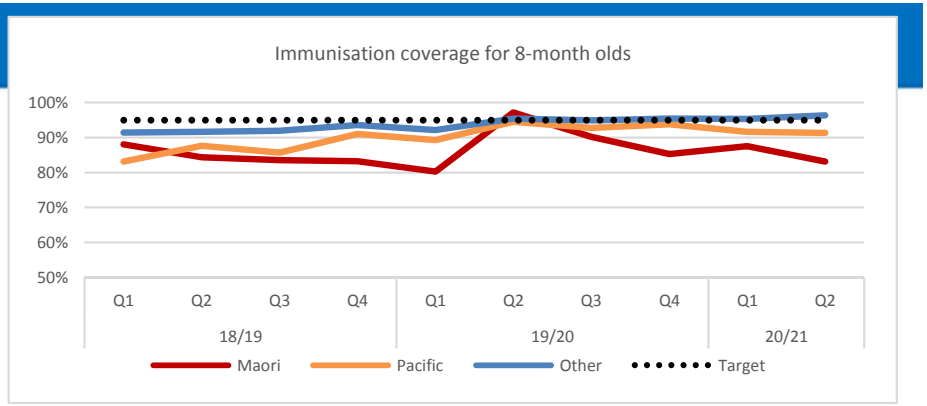
Q2 20/21	Māori			Pacific			Other		
	Wgtn	Porirua	Kāpiti	Wgtn	Porirua	Kāpiti	Wgtn	Porirua	Kāpiti
8 months	86%	85%	75%	97%	87%	100%	97%	98%	94%
2 years	85%	87%	84%	84%	94%	100%	94%	94%	94%
5 years	83%	83%	77%	87%	88%	83%	88%	90%	85%

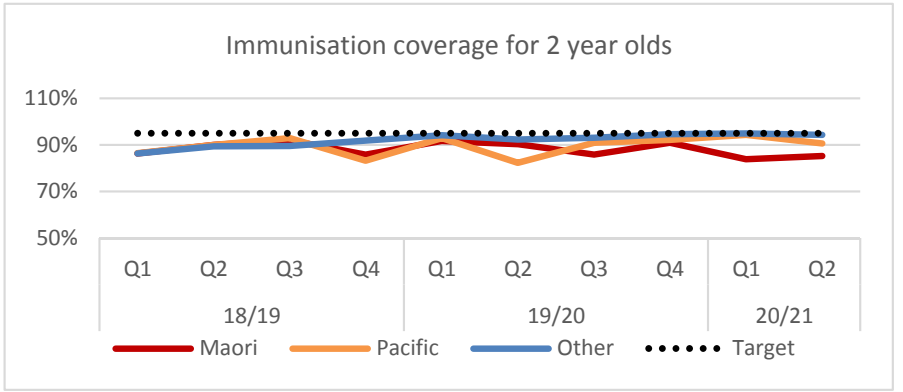
What is driving performance?

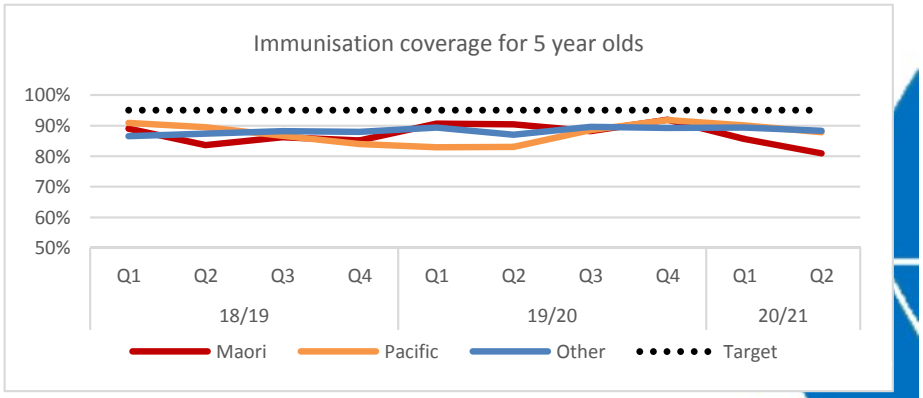
- Declines for immunisation have been a major barrier to meeting immunisation targets. We are developing a project to learn more about the factors that impact a family's decision to decline.

Management comment

- CCDHB is working with Ora Toa PHO, our largest iwi primary care provider; and one of our Outreach Immunisation services, to more closely monitor and increase Māori and Pacific immunisation coverage. This includes implementing a Mātua, Pepi, Tamarki service in Porirua to provide additional, proactive wraparound support for families.







Commissioning: Primary & Complex Care

What is this measure?

- COVID-19 testing rate per 1,000 population

Why is this important?

- The current stage in our COVID-19 response is "maintaining the elimination of disease". This requires strong surveillance to support containment of infection at the border; and robust investigation of any identified cases within the community.
- DHBs are responsible for the organisation and delivery of health services in response to COVID-19. The availability of testing facilities is important for access to testing, and supporting surveillance and contact tracing functions.

How are we performing?

- Our testing rate per 1,000 is 242 for Māori and 290 for Pacific (lower than the national average). Nationally, CCDHB has the 5th highest for testing rate for the total population (247 per 1000). We rank 8th in our testing rate for Māori and 12th for Pacific.
- CBACs have delivered high volumes of swabbing since lockdown, however, the additional swabbing capacity offered through general practices surpassed CBAC volumes until the November cases.
- Our testing volumes partly reflects the populations response to the presence of COVID-19 in their communities.

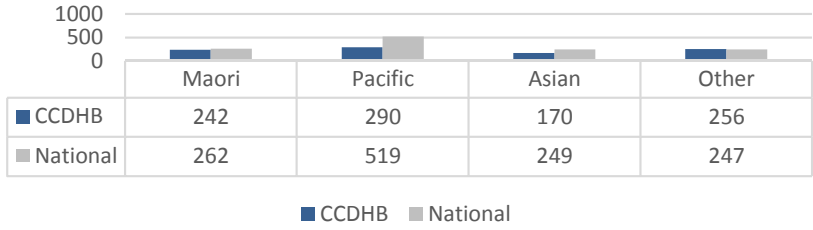
What is driving performance?

- Since November when Wellington experienced community transmission, testing at CBACs increased significantly. However, testing across the community decreased significantly over the Christmas period, and daily swabbing is still below desired volumes.

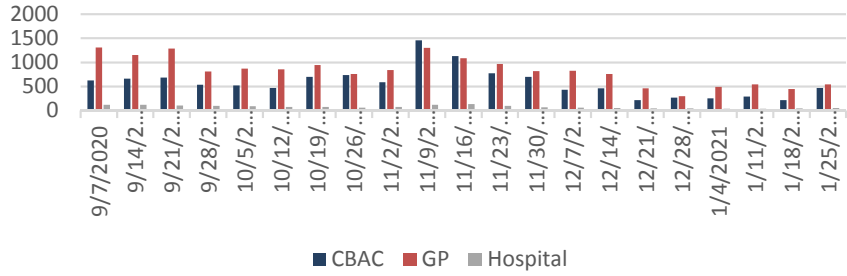
Management Comment

- Our testing regime responds to the Government's testing strategy and our MIF staff and border workers are now being tested at higher rates, and with increased frequency.
- Using our own resources and those allocated by MoH we maintain a state of preparedness in our hospitals and our Regional Public Health Response and community teams are prepared for a comprehensive response.
- Following the holiday period, we continue to look for opportunities to improve testing in the community, particularly for our Māori and Pacific communities .
- CCDHB have 3 CBACs open; 59 practices swabbing, and 1 mobile team working across our District

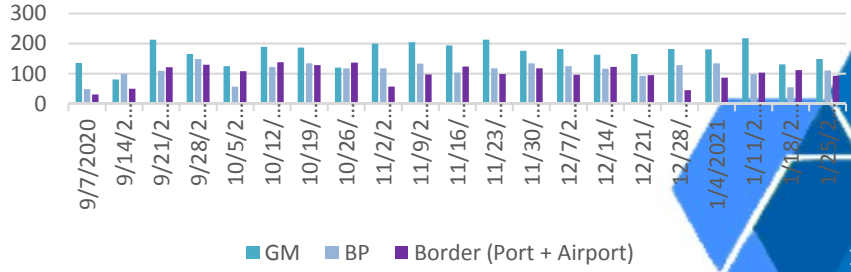
CCDHB COVID-19 testing rate per 1000



Number of COVID-19 swabs in the community, by location



Number of COVID-19 swabs for managed isolation and border surveillance



Commissioning: Hospital & Specialty Services

What is this measure?

- 95% of patients are admitted, discharged or transferred from ED in 6 hours (SS10)

Why is this important?

- This target indicates how efficiently our health system is managing patient flow
- Longer stays in ED are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients.

How are we performing?

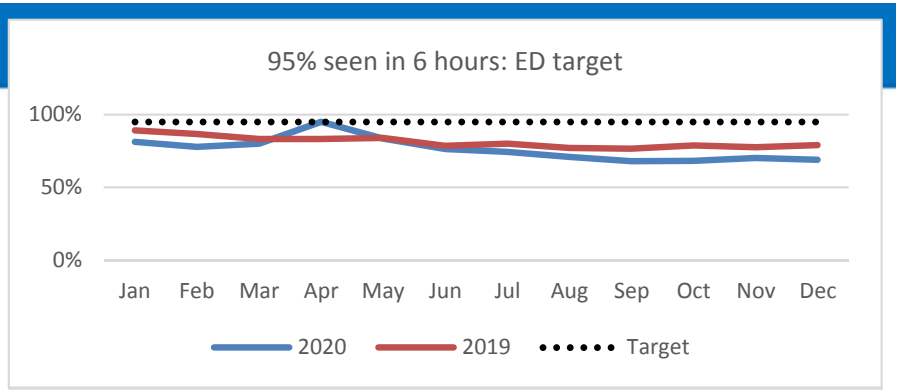
- We have not achieved this target in the last two years, except during COVID-19 lockdown.
- Performance for the last six months has been static as ED presentation volumes have returned to pre-lockdown levels.
- A small increase in people presenting to ED was experienced in October-November.

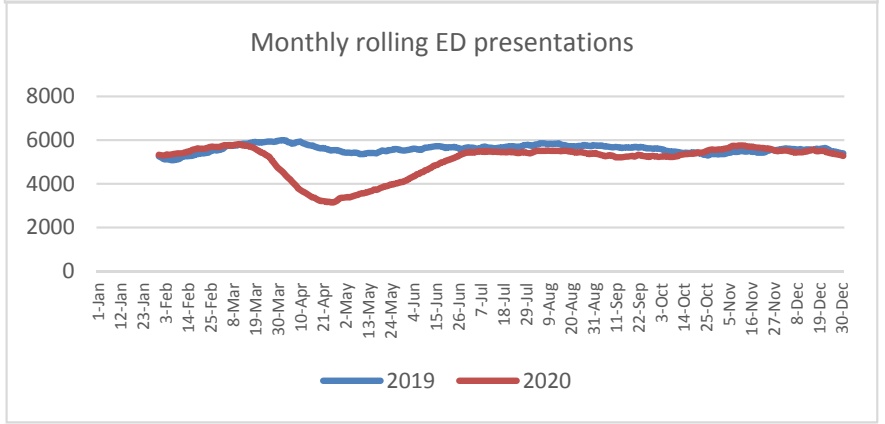
What is driving performance?

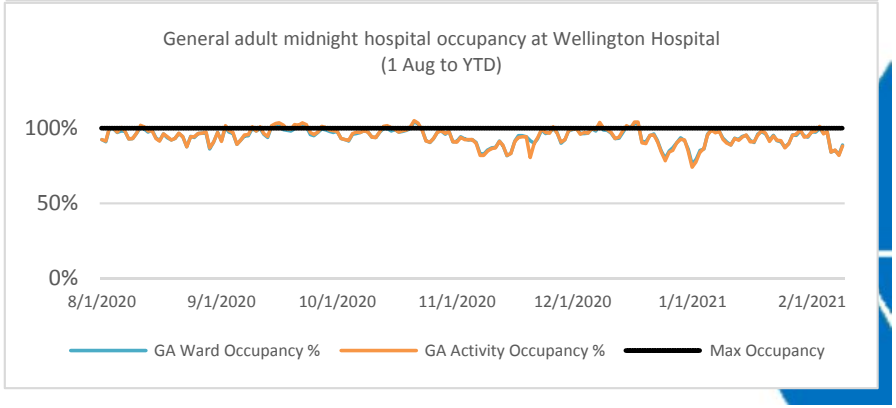
- Our acute front door (ED and acute assessment units) is undersized for the population served and not configured for contemporary models of care.
- Ensuring our patients are cared for in appropriate bed spaces means that we have reduced our number of available general adult beds by approximately 30.
- There is a recognised bed and theatre deficit on the Wellington Regional Hospital campus.
- Fewer beds in our already constrained system further reduces the speed of patient flow through the hospital. As a result patients spend longer waiting in ED for either admission or discharge which increases the likelihood of breaching the six hour target.

Management comment:

- Community initiatives to manage inflow - We are developing our community responses to population drivers alongside approaches to maximise the productivity and efficiency of our hospital system, including: ambulance diversion initiative (CARS), services that address demand for our ageing population (CHOPI, AHOP & AWHI).
- Hospital initiatives to improve in-hospital flow – We are embarking a project to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and ensure facilities are appropriately sized to meet demand. In parallel we are exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.







Commissioning: Mental Health & Addictions

What is this measure?

- Improving crisis response services (MH04)

Why is this important?

- Mental health and addiction services are under pressure with increasing demand across our communities.
- People presenting in crisis with acute and intensive needs require rapid supports. Reducing the demand on police for crisis support of known clients is an important interagency goal.

How are we performing?

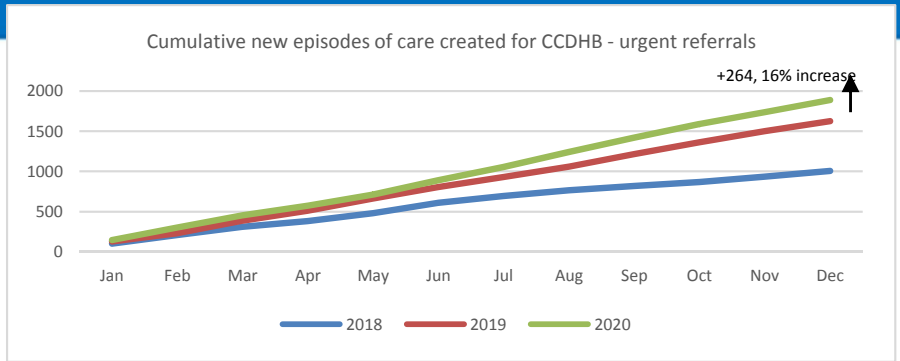
- Since lockdown, urgent referrals have been rising, while non-urgent referrals have been returning to normal volumes.
- Cumulative urgent referrals in 2020 have increased by 58% for Pacific people compared to 2019, which is significantly higher than for other groups (21% for Māori and 4% for non-Māori, non-Pacific).
- There has been a 21% increase for CCDHB Crisis Resolution Services compared to 2019.
- Although referral volumes for Crisis Resolution Services are smaller for Māori and Pacific, there has been a higher proportional increase for Pacific (+45%) and Māori (+26%) in 2020 compared to non-Māori, non-Pacific (23%).

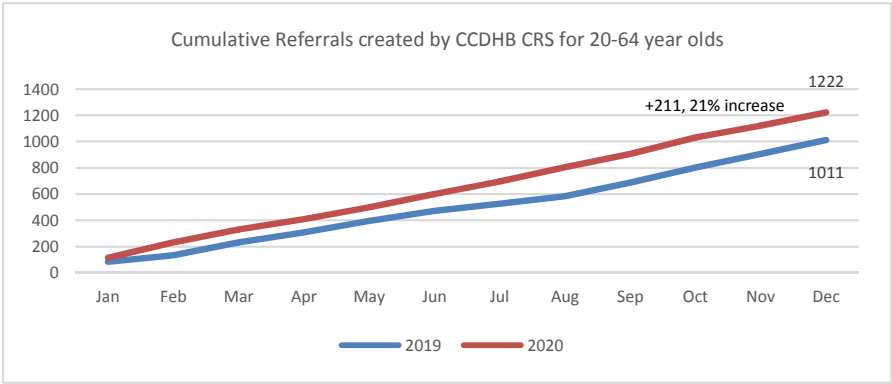
What is driving performance?

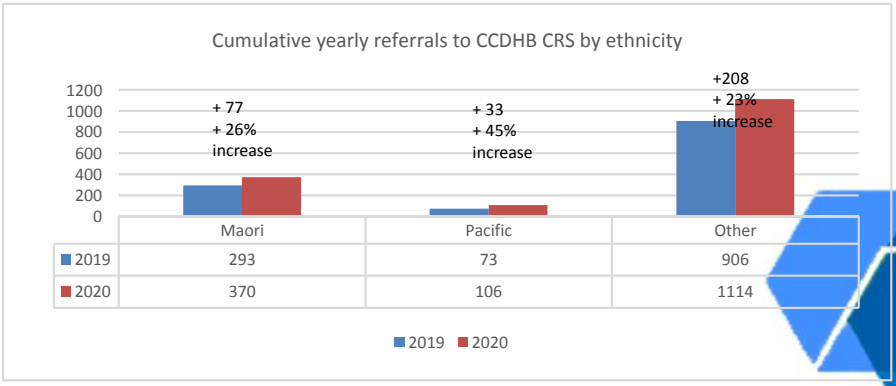
- Increases in urgent referrals, acute referrals and referrals to Crisis Resolution have increased after the initial COVID-19 lockdown period, by 16% compared to 2019.
- People are managing changing mental health and wellbeing as their social and economic circumstances are impacted and adjustment is required.

Management comment

- Services providing acute and intensive psychiatric and mental health care are under pressure, with a consistent picture of high and increasing demand.
- The acute care continuum model of care defines core services which require development and future investment to create an improved and better coordinated acute care system response







Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- Increasing acuity in our ED is a key feature. Over December 2020 Wellington ED experienced the fourth highest number of triage 1 presentations (59) in a single month ever. When January 2021 is compared to January 2020 despite the overall decrease the total number of triage 1 presentation increased by 23, the number of triage 2 presentations increased by 65 and the number of triage 3 presentation increased by 13. Our acute flow programme of work is focusing on medical teams identifying and discharging patients earlier in the day with the aim of freeing up beds for those being admitted from ED to move to the ward in a timelier manner.

- The single major factor in our continued decline in ED wait times is the increasing LOS in ED - a symptom of inadequate bed supply. This coupled with pressures around completing of elective and acute surgical work that was delayed during our COVID response and that we now need to operate parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients has created a perfect storm . We are supporting the project to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and in parallel exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

- Addressing ESPI 2 and 5 waiting lists remains a significant challenge and risk with the numbers of patients waiting more than 120 days for treatment fluctuating month on month. Production is exacerbated high number of theatre session under-utilised due to anaesthetic vacancies – sixty this month however we continue to make positive steps in terms of agreeing pricing for procedures with the greatest volume on our waitlist, so expect to meet our plan for outsourcing. SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times. We are working hard to recruit anaesthetists to our current vacancies which comprise 12% at present.

- Our Maternity Units across the region are struggling with midwifery vacancies - we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.

- The Month result was $4.9m unfavourable however outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget, the Hospital provider arm continues to have a favourable variance YTD. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual leave is going to be a major challenge. Leave hours taken as a percentage of FTE was less than the same time last year but annual leave balances are increasing –leave management plans are in place with a proactive approach being taken by managers and leaders.

CCDHB Activity Performance

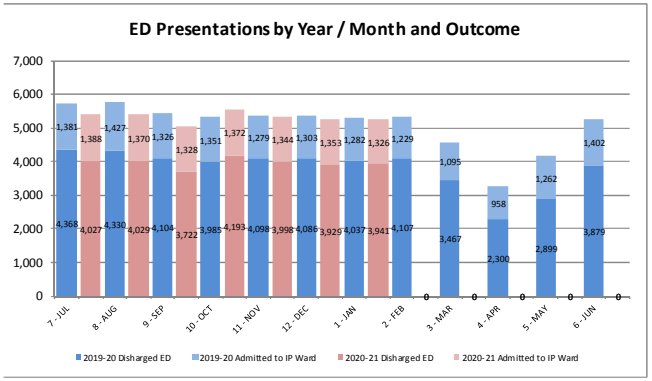
Capital and Coast DHB: January 2021

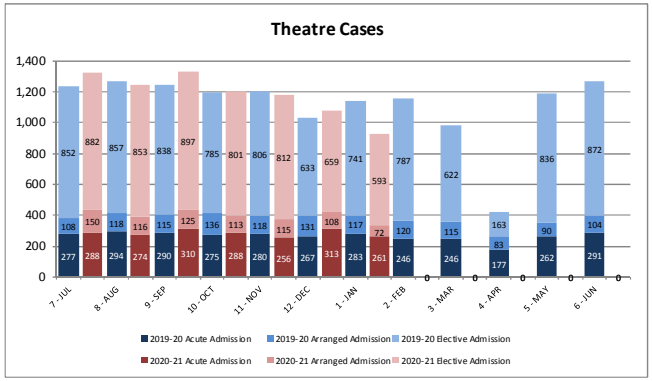
ED Presentations

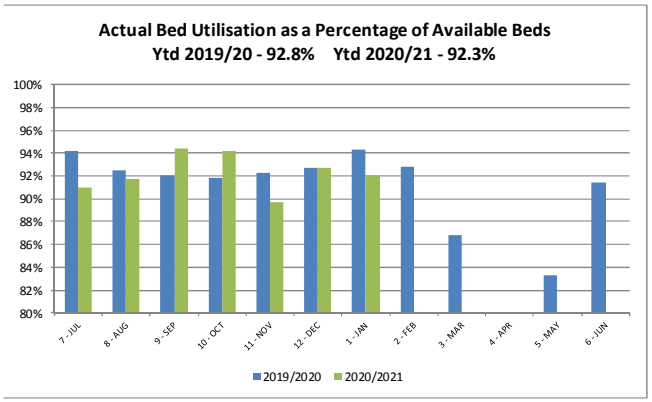
	2019/20	2020/21
YTD Totals	38,357	37,320
Change		-1,037
% Change		-3%

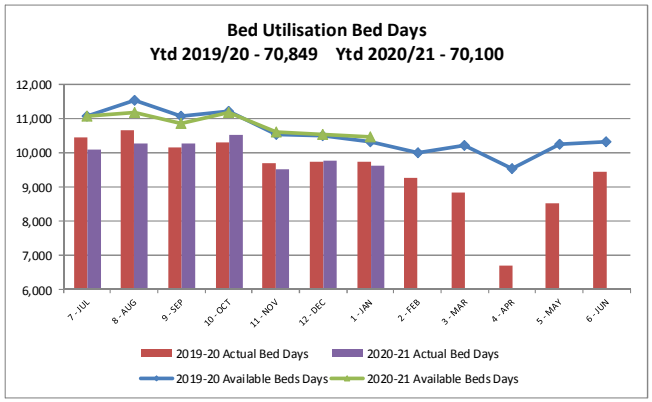
Theatre Cases

	2019/20	2020/21
YTD Totals	8,321	8,286
Change		-35
% Change		0%









- The number of ED presentations in January 2021 is lower than the number recorded in the same month in the previous financial year. The emergency department January 2021 has experienced a 1.0% decrease (52) in the number of presentations compared to January 2020, this equates to an approximate reduction of 1.7 presentations per day.
- Through the first 7 months of 2020/21 Wellington ED has experienced a significant reduction (1,051) in the number paediatric presentations compared to the same period in the previous year. The total reduction across all age groups is 1,037 compared to the previous year.
- Significantly Wellington ED in December 2020 experienced the fourth highest number of triage 1 presentations (59) in a single month ever. When January 2021 is compared to January 2020 despite the overall decrease the total number of triage 1 presentation increased by 23, the number of triage 2 presentations increased by 65 and the number of triage 3 presentation increased by 13.
- The utilisation of available of adult beds in core wards in January 2021 is 92.0% which is lower than the 94.3% rate recorded in January 2020.
- The number of Elective theatre cases has decreased for the month of January 2021 by 20.0% (148 cases) when compared to January 2020. The decreases are spread across a number of specialties in particular Orthopaedics (53), Gynaecology (26), Urology (25) and Dental (22) but countered by increases in Paediatric Surgery (16) and Cardiothoracic (7).

CCDHB Activity Performance

Capital and Coast DHB: January 2021

HSS Inpatient Caseweight Activity

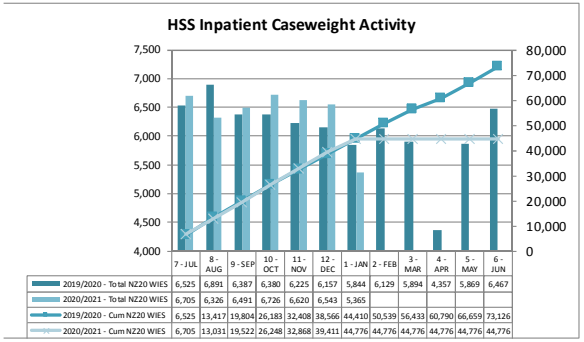
	2019/20	2020/21
YTD Totals	44,410	44,776
Change		365
% Change		0.8%

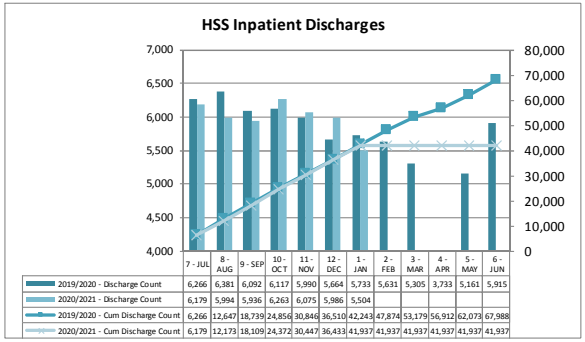
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*

HSS Inpatient Discharges

	2019/20	2020/21
YTD Totals	42,243	41,937
Change		-306
% Change		-0.7%

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



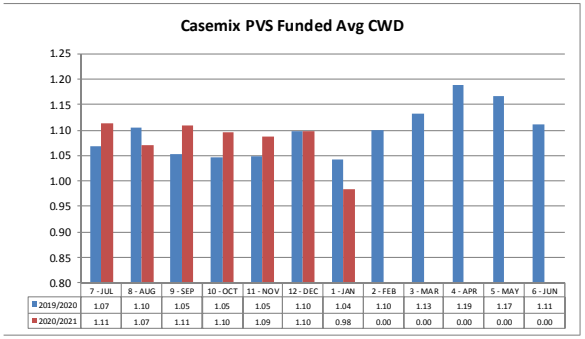


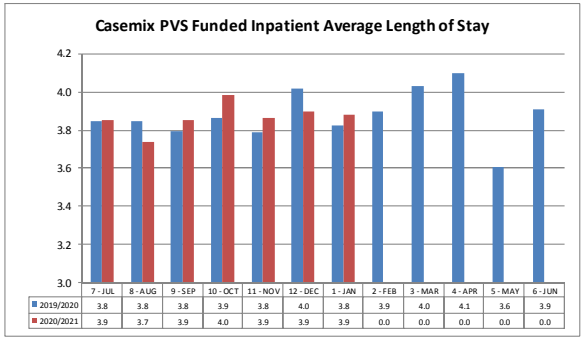
Casemix PVS Funded Avg CWD

	2019/20	2020/21
YTD Totals	1.09	1.08
Change		-0.01
% Change		-1%

Casemix PVS Funded Inpatient Average Length of Stay

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





Comparisons with same period last year:

- Local acute CWDs are lower than previous financial year (-745 CWDs) with a decrease in discharges; a lower ALOS and a similar average CWD. The discharge decrease is driven primarily by General Medicine, Paediatric Medicine and ENT. The CWD decrease is driven primarily by Neonatal, General Medicine Paediatric Medicine, Respiratory and ENT.
- Local Elective CWDs are higher than the previous financial year (174 CWDs) with a decrease in discharges; a similar ALOS and higher average CWD. The discharge increase is driven primarily by General Surgery and Vascular Surgery. The CWD increase is driven primarily by Neurosurgery, Cardiology and General Surgery.
- IDF acute CWDs are higher (281 CWDs) than the previous financial year also with an increase in discharges a higher ALOS and a higher average CWD. The discharge increase is driven primarily by Neurology and Emergency Medicine. The CWD increase is driven primarily by Neonatal, Neurology, Oncology and Haematology.
- IDF Elective CWDs are higher than the previous financial year (441 CWDs) with more discharges a lower ALOS and a similar average CWD. The discharge increase is driven primarily by Vascular Surgery, Neurosurgery and Ophthalmology. The CWD increase is driven primarily by Cardiothoracic, Cardiology and Vascular Surgery.
- In combination these four admission groups equate to an increase of 151 CWDs compared to the previous year. The services that most significantly impact this shift are Emergency Medicine (258), Cardiothoracic (254), Neurosurgery (236) and Neurology (205) but countered by deceases in General Medicine (-257), Paediatric Medicine (-247), Orthopaedics (-216) and Respiratory Medicine (-148).
- The reduction in General Medicine (-272 CWDs) will have also been impacted in the WRH AHOP counting change and Paediatric Medicine (-252 CWDs) who will be heavily impacted by the reduction in the number of presentations to the Emergency department (1,051 Ytd).

Discharges:

- Publicly funded casemix discharges for the month of January 2021 have decreased by 150
- (2.8%) in comparison to the number of discharges recorded in January 2020. The decrease in discharges is spread across a number of specialties with the decreases most evident in
- Obstetrics (28 Mother, 42 Babies), Orthopaedics (34 Acute, 33 Elective), General Medicine (41 Acute), Cardiology (32 Acute, 23 Elective) and Paediatric Medicine (31 Acute). The number of discharges was countered by increases in Emergency Medicine (187), Paediatric Surgery (2 Acute, 19 Elective) and Gastroenterology (14 Acute).
- The number of outsourced discharges in private facilities increased from 72 in January 2020 to 82 in January 2021 an increase of 10 discharge (14% increase) with CCDHB now utilising Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital

HHS Operational Performance Scorecard – period Jan 20 to Jan 21

Domain	Indicator	2020/21 Target	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan
Care	Serious Safety Events	Zero SSEs	5	11	7	8	10	5	14	6	10	4	20	6	6
	Total Reportable Events	TBD	882	1,109	1,207	724	906	1,085	1,166	1,268	1,370	1,356	1,413	1,506	1,397
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	94.3%	86.5%	92.4%	100.0%	93.5%	91.8%	86.4%	94.3%	93.9%	94.8%	92.0%	84.0%	100.0%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,319	5,336	4,562	3,258	4,161	5,281	5,415	5,399	5,050	5,565	5,342	5,282	5,267
	Emergency Presentations Per Day		172	184	147	109	134	176	175	174	168	180	178	170	170
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	80.0%	75.5%	78.7%	84.7%	82.8%	74.6%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%
	ELOS % within 6hrs - non admitted	TBD	85.8%	81.2%	84.6%	90.7%	90.4%	82.6%	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%
	ELOS % within 6hrs - admitted	TBD	63.0%	58.6%	61.8%	70.5%	66.3%	54.6%	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%
	Total Elective Surgery Long Waits	Zero Long Waits	168	148	177	400	431	348	245	105	97	182	205	307	539
	Additions to Elective Surgery Wait List		1,131	1,411	1,272	553	1,098	1,506	1,521	1,384	1,542	1,398	1,385	1,263	823
	% Elective Surgery treated in time	TBD	85.8%	86.0%	89.0%	92.7%	76.3%	71.3%	73.0%	84.2%	90.3%	89.0%	86.3%	88.5%	75.3%
	No. surgeries rescheduled due to specialty bed availability	TBD	1	8	1	1	1	12	5	9	13	14	1	6	2
	Total Elective and Emergency Operations in Main Theatres	TBD	1,067	1,101	927	378	1,103	1,202	1,237	1,192	1,254	1,130	1,118	1,002	878
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	89.0%	82.0%	89.0%	91.0%	92.0%	91.0%	93.0%	85.0%	87.0%	81.0%	85.0%	86.0%	80.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	78.0%	89.0%	97.0%	92.0%	77.0%	85.0%	94.0%	83.0%	88.0%	88.0%	83.0%	85.0%	100.0%
	Specialist Outpatient Long Waits	Zero Long Waits	238	324	488	1,079	1,286	1,450	1,076	571	314	185	225	314	Tbc
	% Specialist Outpatients seen in time	Zero Long Waits	80.4%	83.9%	82.0%	87.1%	81.0%	74.2%	74.3%	85.1%	90.1%	88.8%	92.3%	93.0%	89.1%
	Outpatient Failure to Attend %	TBD	6.9%	7.4%	7.7%	4.4%	7.1%	6.6%	7.1%	6.7%	7.0%	7.6%	7.6%	7.8%	7.3%
	Maori Outpatient Failure to Attend %	TBD	14.6%	14.2%	15.2%	8.1%	13.9%	13.7%	14.7%	13.9%	15.4%	15.4%	16.0%	16.7%	16.2%
	Pacific Outpatient Failure to Attend %	TBD	15.8%	15.6%	16.5%	7.8%	16.6%	16.0%	17.0%	14.3%	14.5%	16.4%	16.2%	18.6%	19.5%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($29.5m)	($29.5m)	($29.5m)	($47.5m)	($47.5m)	($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)
	Contracted FTE (Internal labour)		4,835	4,837	4,847	4,893	4,930	4,973	4,975	5,034	5,237	5,267	5,264	5,263	5,255
	Paid FTE (Internal labour)		5,192	5,195	5,198	5,188	5,199	5,310	5,317	5,368	5,607	5,606	5,649	5,685	5,626
	% Main Theatre utilisation (Elective Sessions only)	85.0%	82.0%	81.0%	80.0%	78.1%	82.0%	81.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	23.9%	24.3%	22.7%	19.3%	20.4%	21.9%	24.4%	23.1%	25.4%	22.2%	25.3%	22.6%	22.9%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	26	39	29	19	24	29	30	35	51	33	34	37	37
	Adult Overnight Beds - Average Occupied WLG	TBD	294	295	275	225	264	294	298	299	317	313	300	299	296
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	23	18	10	17	16	17	19	19	18	23	18	17	17
	Adult Overnight Beds - Average Occupied KEN	TBD	72	69	62	46	55	63	71	72	74	76	67	64	67
	Child Overnight Beds - Average Occupied	TBD	19	21	18	15	18	23	24	23	22	23	24	22	17
	NICU Beds - ave. beds occupied	36	32	28	34	38	30	29	28	31	38	36	33	35	38
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.82	3.90	4.03	4.10	3.61	3.91	3.85	3.74	3.85	3.98	3.86	3.90	3.88
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.7%	4.2%	3.7%	4.1%	3.3%	3.8%	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%
	Presentations to ED within 48 hours of discharge	TBD	196	225	168	133	139	203	199	201	215	254	171	170	218
Staff Experience	Staff Reportable Events	TBD	111	139	137	90	109	161	139	155	140	181	173	176	145
	% sick Leave v standard	TBD	2.1%	2.6%	3.5%	2.2%	2.5%	3.5%	4.0%	4.0%	3.6%	3.5%	3.4%	3.2%	2.0%
	Nursing vacancy	TBD	219.1	211.6	206.6	193.0	171.0	157.6	248.5	266.0	252.1	247.4	268.5	269.1	261.6
	% overtime v standard (medical)	TBD	1.6%	1.6%	1.9%	1.4%	1.4%	1.6%	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB SSIED performance for January 2021 was 69%. This result is an increase on the 66% recorded last month (December 2020) and a decrease on the 80% recorded in January 2020. The performance of patients who were seen, treated and discharged by ED for January 2021 was 78%. The performance of patients who were seen and admitted to hospital for January 2021 was 52%.
- A factor that affects our SSiED performance is the occupancy/bed utilisation in our wards. The average occupancy for January 2021 was 92%. The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in January 2021 was 338.

What is driving performance?

- The underlying causes of this are described in the " Commissioning: Hospital & Specialty Services" assessment: our acute front door (ED and acute assessment units) is undersized for the population served and not configured for contemporary models of care and recognised bed and theatre deficit on the Wellington Regional Hospital campus. The former exacerbate by operating parallel processes in our in-patient wards to manage COVID case definition vs. non-COVID patients and ensuring our patients are cared for in appropriate bed spaces and not adhoc placement.
- For January 2021, the average bed days utilised by acute admissions (233) increased by 5 beds per day compared to December 2020 (228) further compounding the issues.

Performance	NOV	DEC	JAN
2019-20	76%	77%	80%
2020-21	68%	66%	69%

Breaches	NOV	DEC	JAN
2019-20	1200	1137	997
2020-21	1594	1655	1507

ED Volumes	NOV	DEC	JAN
2019-20	4,944	5,008	5,006
2020-21	4,916	4,840	4,807

Management Comment

The following work streams continue to be progressed and rolled out including:

- During the month of January 2021 there were 5 presentations where the patient(s) was suspected of having COVID-19.
- To free up ED we continue to use Ward 6 East as our "query COVID" ward for patients who have been swabbed as part of their admission process. Once the results come back negative the patients are transferred to the ward where they will be treated for their presenting concern.
- The Acute Health of the Older Person (A-HOP) / Frailty Unit in Ward 3 continued until mid-December when the patients were then admitted under General Medicine until 1 February 2021 due to three SMOs being away on leave. The Acute Frailty Unit will be located in the 6 East Annex until 30 April 2021 while required upgrades to the facilities in Ward 3 are carried out.
- The Advancing Wellness at Home Initiative (AWHI) project is an early supported discharge for people whose level of function has declined on admission and has involved making changes to the patient care coordination service to identify potential patients needing intervention earlier in admission with the goal of reduction in the over 10 day stays for complex patients in general medicine.
- Project group to review patients who have been in hospital more than 10 days, continues to identify barriers to discharge and address these with our teams.
- Activities continue across the organisation to improve discharge processes.
- We are supporting the project to redesign the Front of Whāre (ED and acute assessment units) to facilitate delivery of contemporary models of care and in parallel exploring our short and medium term options for expansion of bed and theatre capacity. These options are being developed within the context of the Hospital Network programme.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- We are now reporting on confirmed planned care volumes for 20/21 financial year.
- Total planned care results year to date have us reporting (48) unfavourable to our planned 6,248.
- January month end result is unfavourable (207) to a plan of 837. The drivers of this result are our in-house and outsourced delivery being adverse 160 to plan. The under delivery of in-house work is driven by the high number of theatre session under-utilised due to anaesthetic vacancies – sixty this month.
- Our outsourcing volume is still being affected by contractual constraints, however we continue to make positive steps in terms of agreeing pricing for procedures with the greatest volume on our waitlist, so expect to meet our plan for outsourcing in the New Year.
- Our IDF outflow position is reported (2) and Minor procedures (7) for the month of January.

What is driving performance?

Our Outsourced and Arranged Surgical purchase unit contracts are the main contributors to our adverse year to date result.

Management Comment

- Careful planning to fully utilise all theatre sessions in Wellington and Kenepuru remains the focus. Kenepuru theatres are now planning to undertake work to install new operating lights, and are expected to close one theatre for a period of 4 months from March. Kenepuru theatre sessions will be relocated to theatre 13 in Wellington where possible to continue work during this time. Ongoing vacancies in anaesthetists continue to restrict utilisation of all sessions.
- Outsource contracts are still being negotiated but we have managed to secure an interim agreement on some procedures, we are still not outsourcing at the same capacity to meet our outsourced planned care target this year.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.
- We are working hard to recruit anaesthetists to our current vacancies which comprise 12% at present.

MRI and CT Waiting Times

What is this measure?

This is a percentage measure which shows the proportion of CT or MRI referrals that are scanned inside of a 42 day period. The clock begins at the date Radiology receives the referral for imaging.

Why is this important?

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

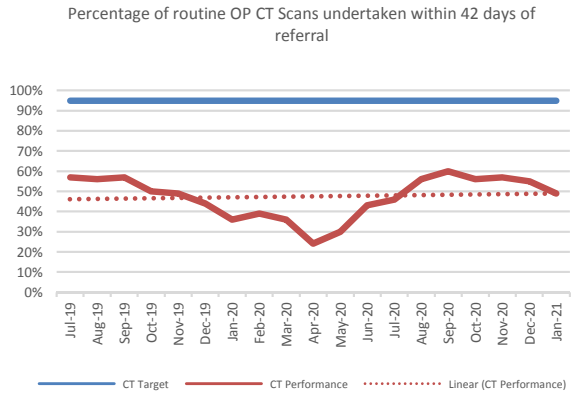
How are we performing?

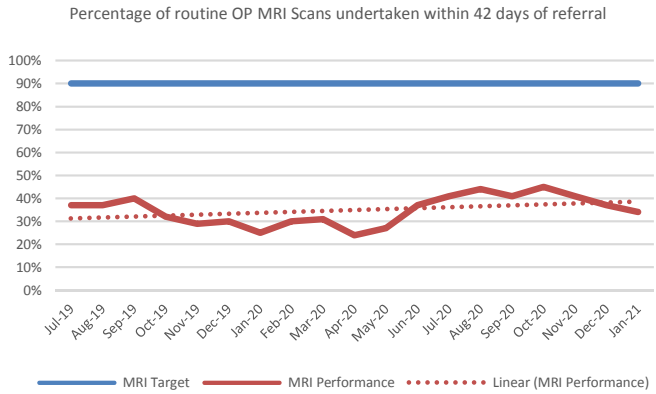
Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time.

Due to the planned care funding directly from the MOH confirmed December 2020, increased outsourcing and improved performance can be expected throughout the remainder of FY 20/21.

What is driving performance?

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





Management Comment

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

Of note, unexpected high demand for Inpatient and ED services is creating additional pressure on elective slots for CT scanning. Our demand aligns with the increased demand on ED and IP services seen across hospital services.

Actions currently underway to address waiting times:

- Upcoming planned care funding packet for CCDHB has now been approved by the MOH. Due to workforce challenges it is unlikely that we will be able to recruit and establish weekend elective lists this FY. However, increased outsourcing through the next 3 – 6 months will improve performance.
- Updated Radiology ICT management application scheduled for mid-2021 will enable clinical reporting to be outsourced. This provides some mitigation for Radiologist shortages. This option is not currently available and is a significant step towards starting weekend elective lists.

It is difficult to predict with certainty the production and demand in the next 3 – 6 months due to a variety of factors (e.g. recruitment and retention, COVID response). However, with a lot of clinical staff taking leave over Christmas the expected lower capacity and slowdown of improvement over this period has shown in the results. This should be followed by recovery through the first three months of 2021 with the increased outsourcing made possible by the MOH planned care initiative.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography has dropped to 86.6% this month.

What is driving performance?

- Remaining just below target has been influenced by SMO leave (Annual and Parental), and having to balance other procedure targets (TAVI), and the reduction in session over the Christmas/New Year Break.

Management Comment

- Significant SMO Leave was taken over the Christmas and New Year break. We currently have two consultants on parental leave, with gaps in interventional cover arrangements until staff are available. Patient cancellations or deferment related to social or medical issues (4 patients), patient seen acutely but not taken off elective list (1 patient) are included in those breaching the target. Others missed the 90 day target by a short time - likely due to availability of elective sessions over Christmas/New Year break.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

1. 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0'):
    a. Door to cath. <= 3 days October results (Target is 70%):

National Performance	76.8% (111/142)
Central Region	78.2% (111/142)
CCDHB	92.6% (25/27)
Hawkes Bay	65.2% (15/23)
Hutt Valley	81.3% (13/16)
Mid Central	75% (24/32)

As a region we achieved the Target. Hawkes Bay dropping below target this month

What is driving performance?

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

Management Comment

- Increased lab capacity resulting from the new SMO Roster and redistribution of interventional lab sessions, has allowed better lab utilisation, although staffing has been a challenge this month due to two SMO's on Parental leave and an increase in Operators taking Annual Leave around the Christmas break. The underlying issue remains access to beds, increased by Cardiology having access to short stay beds reduced. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. Trans-oesophageal Echocardiograms and CTCA patients have been moved out of the IRW space, utilising the Transit Lounge and Clinical Management Unit for this work to free up bed space in IRW and Ward 6 South to help mitigate this issue.

Faster Cancer Treatment

What is this measure?

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

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

Why is this important?

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

How are we performing?

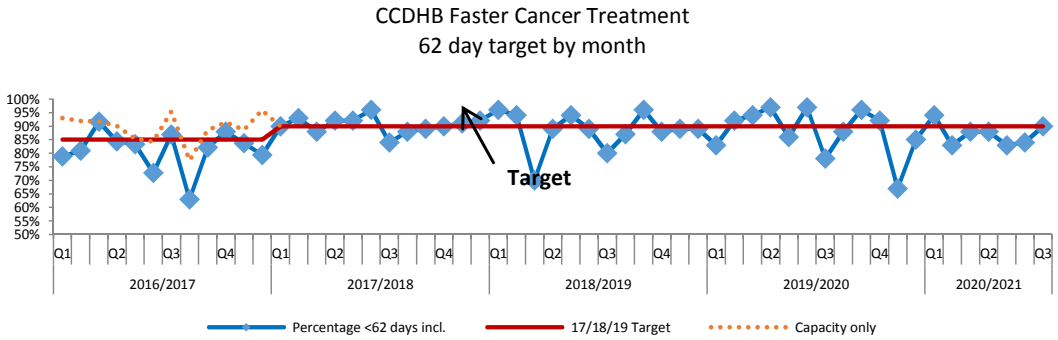
- CCDHB is marginally compliant with the 62 day target for January at 90% which equates to the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer. CCDHB was last compliant in July 2020 and has struggled since early 2020 to consistently achieve the target.
- CCDHB is non-compliant with the 31 day indicator for January at 82% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.
- Patient numbers for the 31 day indicator is 40% lower than expected (62 patients' vs 107) and is a significant drop over previous months. It likely indicates reduced services over December/January and incomplete data finalising due to public holidays January/February. The total number of patients reported under the 62 day target remains 20% lower than the expected average (19 vs 27 average). The major reason for this lack of coverage is that many patients were not flagged as having a high suspicion of cancer. An audit will be undertaken to clarify if this is an issue with referral information, triaging priority or a process issue in not using the FCT button.
- With low patient numbers, one or two breaches are sufficient to reduce compliance below 90%.

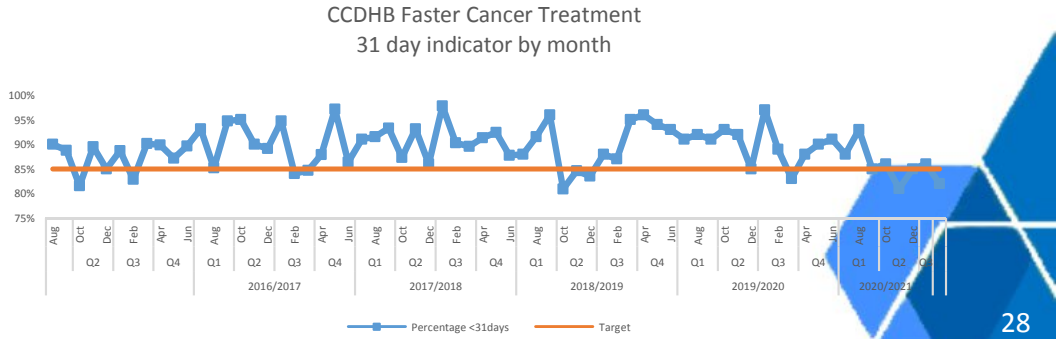
What is driving performance?

- With low patient numbers, one or two breaches are sufficient to reduce compliance below targets.
- Breaches in the 62 day target were those who experienced a delay in the front end of the pathway i.e. delay to FSA or delay in diagnostic procedures. The two breaches occurred in the breast and haematological tumour streams with surgery and non-intervention being first treatment.
- Four of the eleven breaches in the 31 day indicator was due to patient reasons – an increase we often see Dec/Jan. Four breaches were also for clinical reasons, mainly related to co-morbidity assessment and management prior to surgery. Three breaches were for capacity constraints related to staff leave or reduced services prior to radiation treatment. For this month more patients breached who had radiation or chemotherapy than surgical treatments and may reflect reduced services to linac outages.
- Capacity constraints (3 patients) related to Urology, Head and Neck and Haematological tumour streams. Average delay for all 31 day breach patients was 56 days (range 32-94 days) a reduction from Decembers 65 days.

Management Comment

- The reduction in services over the Christmas/New Year break did, as anticipated, result in some patients having experienced increased delays.
- There was also some constraints in radiation treatment services due to equipment unavailability.
- Tracking patients prospectively through their cancer journey is a manual process and is highly reliant on identifying patients early who are likely to have a cancer diagnosis. An audit will be conducted to identify if clinicians are utilising the outlook Faster Cancer Treatment button at triage. Our internal benchmark is for 85% of all appropriate referrals are identified and prioritised as High Suspicion of Cancer Urgent 2Weeks or confirmed cancer using the Outlook FCT Button.





Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

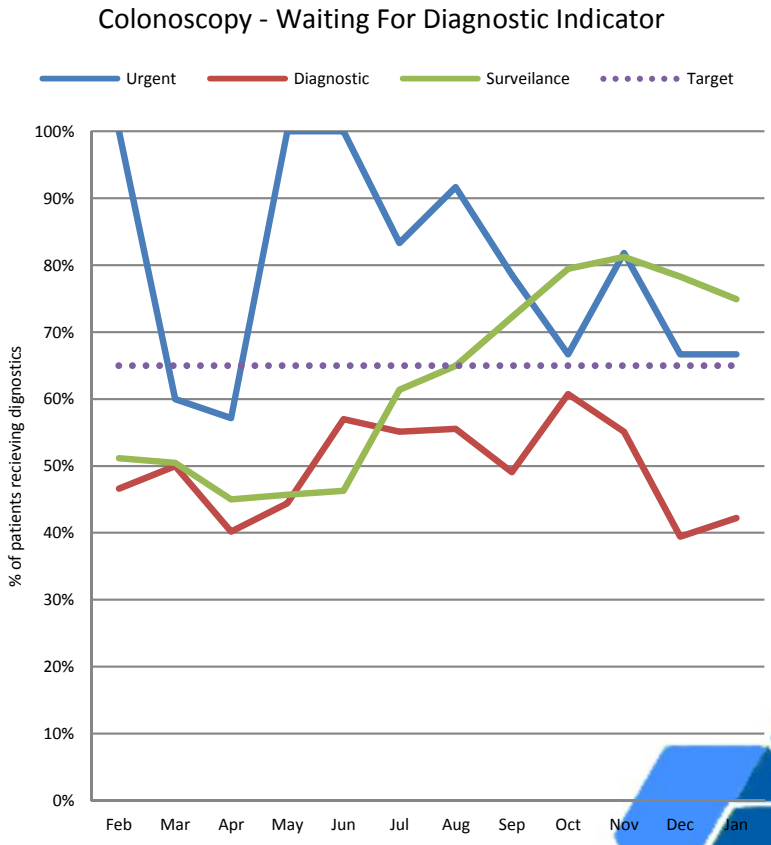
- CCDHB did not meet the Ministry of Health target for urgent and diagnostic colonoscopies achieving 67% and 42 respectively against targets of 90% and 60%. The previous month we were 67% and 39% respectively.
- We did meet the Ministry of Health target for surveillance achieving 74%.

What is driving performance?

- At the end of January there were 185 patients who had either a diagnostic or surveillance colonoscopy compared to 125 the previous month. At the end of January there were 475 patients waiting for either a diagnostic or surveillance colonoscopy compared to 415 the previous month.

Management Comment

- There was a reduction in the number of available lists in January which has contributed to the performance. Work is ongoing in-house to improve the number of patients per list and capital was approved to order replacement endoscopes to ensure a fully operational fleet for the department.
- The limitations to maximising the capacity are attributed to the layout of the department, which is inconsistent with contemporary standards for an endoscopy unit. Plans are being developed for a design team to scope out the work required.



Section 2.3

Mental Health Addiction & Intellectual Disability

Executive Summary – Mental Health Performance

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

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

Indicator	2020/21 Target	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan
Access Rate	3%	3.6%	3.6%			3.7%			3.8%					
Shorter waits for non-urgent Mental Health services <= 3 weeks (Younger Persons Community & Addictions Sector)	80%	51.8%	51.4%	32.7%	29.8%	43.8%	46.7%	46.3%	46.3%	48.3%	54.2%	44.9%		
Shorter waits for non-urgent Mental Health services <= 3 weeks (Adult Community & Addictions Sector)	80%	61.0%	63.2%	57.7%	47.1%	63.8%	57.2%	55.7%	50.8%	52.9%	49.3%	57.4%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Younger Persons Community & Addictions Sector)	95%	93.8%	76.5%	48.5%	74.0%	88.1%	82.1%	80.9%	80.3%	81.0%	86.7%	89.3%		
Shorter waits for non-urgent Mental Health services <= 8 weeks (Adult Community & Addictions Sector)	95%	90.1%	86.5%	72.4%	77.2%	93.9%	92.3%	91.0%	88.7%	89.2%	87.5%	88.1%		
Community service users seen in person in last 90 days	95%	77.9%	76.4%	68.8%	54.8%	56.1%	62.9%	76.7%	82.9%	83.8%	81.9%	83.4%	80.8%	77.3%
Community DNA rate	<= 5%	7.4%	7.8%	7.0%	4.0%	5.1%	6.6%	6.9%	6.6%	7.4%	7.3%	8.3%	7.2%	6.7%
Maori under Section 29 CTO (Rate per 100,000 population) 2019/20 Target: 10% reduction of rate of previous year (405)		404	404			395			415					
Wellness Plan Compliance	95%	43.1%	43.1%			47.3%			45.9%					
Wellness Plans - Acceptable Quality	95%	78.9%	78.9%			79.3%			82.5%					
Community Services Transition (Service Exit) Plan Compliance	95%	47.6%	47.6%			53.4%			49.6%					
Community Services Transition (Service Exit) Plans - Acceptable Quality	95%	61.9%	61.9%			71.6%			71.2%					

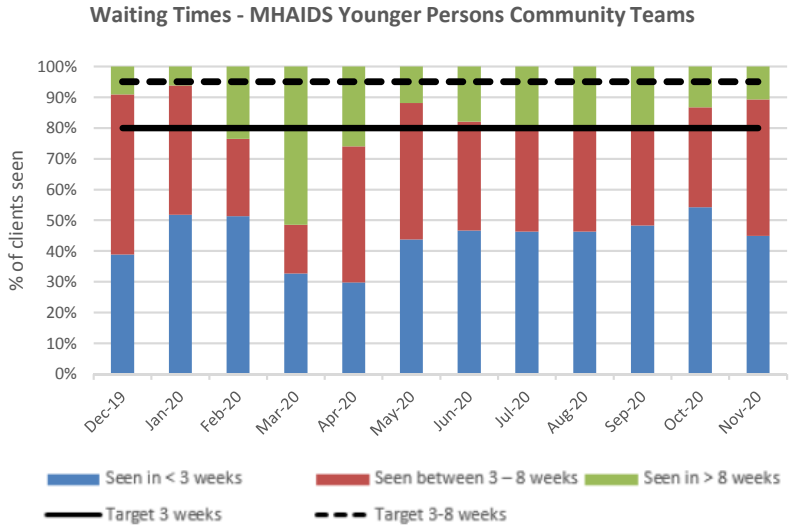
Adverse Performance requiring immediate corrective Action	Performance is below target, corrective action may be required	Performance on or better than Target / Plan

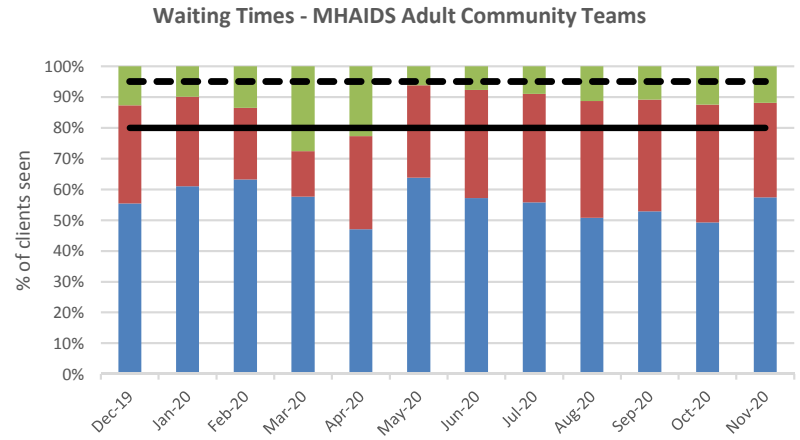
Mental Health, Addictions and Intellectual Disability Service - Monthly Performance Report (2 of 2)

Indicator	2020/21 Target	2020-Jan	2020-Feb	2020-Mar	2020-Apr	2020-May	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan
Pre-Admission Community Care	75%	60.4%	75.5%	70.7%	76.3%	70.2%	76.6%	85.0%	65.3%	81.4%	75.5%	80.4%	78.9%	72.1%
Post-Discharge Community Care	90%	77.9%	88.9%	80.7%	81.5%	89.6%	95.7%	86.8%	72.7%	86.6%	79.5%	82.5%	66.3%	88.3%
Acute Inpatient Readmission Rate (28 Day)	<= 10%	7.6%	7.9%	3.1%	11.9%	8.5%	5.1%	5.0%	4.7%	6.4%	7.5%	3.2%	8.9%	11.0%
Inpatient Services Transition Plan	95%	70.5%	70.5%			72.4%			74.1%					
Inpatient Services Transition Plan - Acceptable Quality	95%	82.7%	82.7%			74.4%			82.4%					
Clinically Safe Acute Inpatient Occupancy Rate Te Whare Ahuru		100.9%	102.4%	98.1%	78.1%	77.8%	99.7%	94.6%	97.7%	98.8%	94.0%	99.0%	72.6%	84.4%
Clinically Safe Acute Inpatient Occupancy Rate Te Whare O Matairangi		102.9%		101.1%	100.0%	93.2%	106.2%	108.2%	109.3%	105.1%	95.6%	107.9%	96.4%	96.1%
Seclusion Hours	Aspirational goal of zero seclusion by 31 December 2020	458	622	995	733	632	965	590	878	295	383	868	1,007	201
Seclusion Hours - Māori		265	254	682	317	282	620	133	294	85	281	128	267	125
Seclusion Hours - Pacific Peoples		3	289	74	136	116	195	91	72	10	0	229	47	0
Seclusion Events		16	21	32	29	28	27	20	37	27	28	30	23	13
Seclusion Events - Māori		8	13	15	13	14	12	7	12	7	16	12	8	7
Seclusion Events - Pacific Peoples		1	4	4	3	4	9	3	3	1	0	4	3	0

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

KPI Spotlight - Wait Times from Referral to First In-person Contact





What is this measure?

Ministry of Health waiting times measure (MH03) - Shorter waits for non-urgent mental health and addiction services for 0-19 year olds. We replicate the measure for adult community teams internally also. This measure is calculated from the date the referral is received to the date of the first In-person contact with the client (face to face or Zoom). Referrals without a face-to-face recorded are not included. Monthly data for the past 12 months is shown (time delay required in order to allow clients to fall into the over 8 week group). The MOH has set targets that 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks.

Why is it important?

Mental health consumers experiencing distress should have faster access to receive therapeutic intervention.

How are we performing?

The 80% 3 week target has proved difficult to achieve, consistent with national results. Teams are managing to see around 90% of people referred within 8 weeks, close to the 95% target. CAMHS teams have struggled with this measure in recent months post COVID lockdown due to the surge in urgent referrals. Some teams have focused on this measure with successful results – the Wairarapa Adult CMHT have surpassed both targets in each of the last 8 months.

What is driving performance?

- robot technology is now being utilised to automate intake referrals. This together with associative improvements in efficiency as part of this project has yielded positive results with community teams receiving referrals quicker from Te Haika and Hutt Intake teams.
- improving processes to reduce DNA rates for initial assessments.
- using the Intake Assessment document for all clients.
- regular community caseload reviews to ensure clients still require secondary mental health input – this in turn creates space for new clients to be seen earlier.

Barriers:

- Teams carrying vacancies struggle to meet the 3 week target especially.
- The increase in acute presentations which has impacted CAMHS teams recently means significantly less clinical time is available for non-urgent choice assessments.

Quality & Safety Monthly Update - January 2021

- **HVDHB Hospital Certification Surveillance Audit.**

  The MoH has confirmed with HVDHB that the MHAIDS services that sit on HVDHB campus with not be included in the upcoming (March 2021) HVDHB Hospital Certification Surveillance Audit. All MHAIDS services at HVDHB will now come under CCDHB Hospital Certification Surveillance Audit which will be undertaken in May 2021.

- **CCDHB Hospital Certification Surveillance Audit.**

  Preparation is underway for CCDHB Hospital Certification Surveillance Audit which will be undertaken in May 2021. Initial meeting with QIPS. Awaiting the self-assessment notification from the Auditors (DAA). Data collection underway. Following up with teams on progress against corrective actions.

- **HQSC - Learning from Adverse Events Project**

  New Sponsor to be appointed following the resignation of MHAIDS Allied Health Director

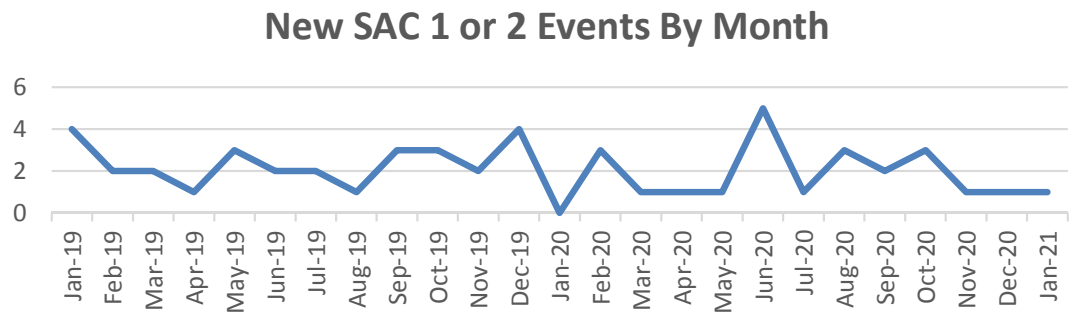
- **Risk Register**

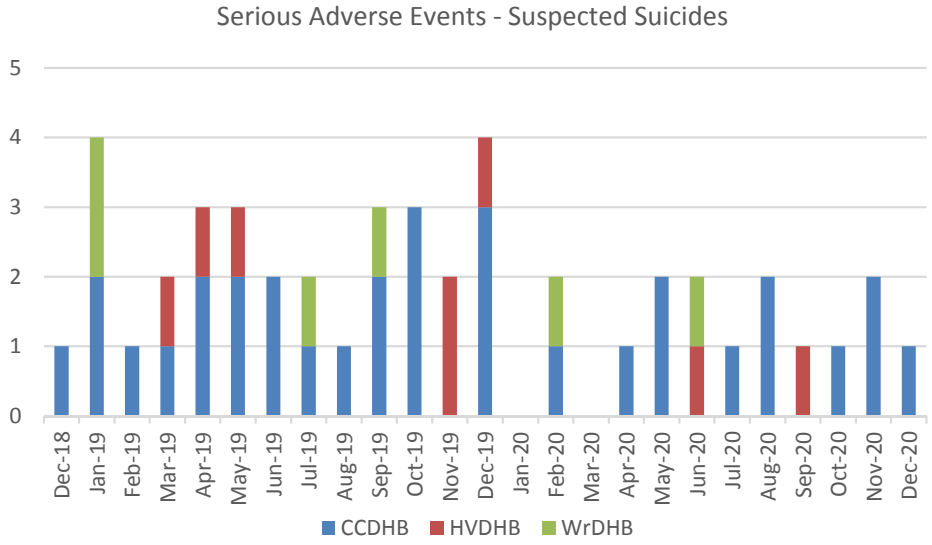
  No new risks added or closed. Updates to current risks not completed by risk owners in December/January. Process to facilitate updates to be discussed at Clinical Governance and Leadership meeting.

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Serious Adverse Events

Key Points:
1 new SAC 2 event (HVDHB)
- serious self harm
3 Closed with HQSC
43 Open Reviews

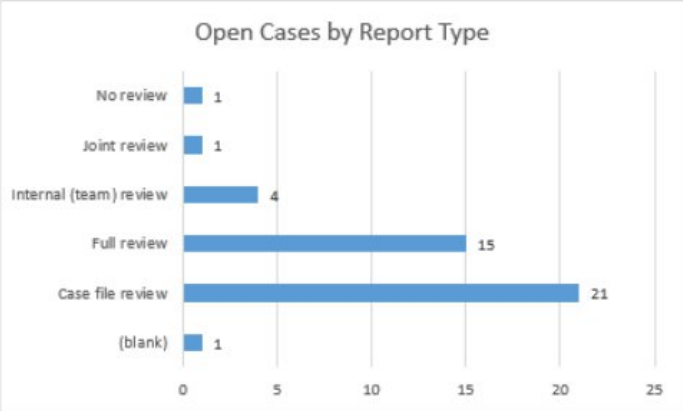


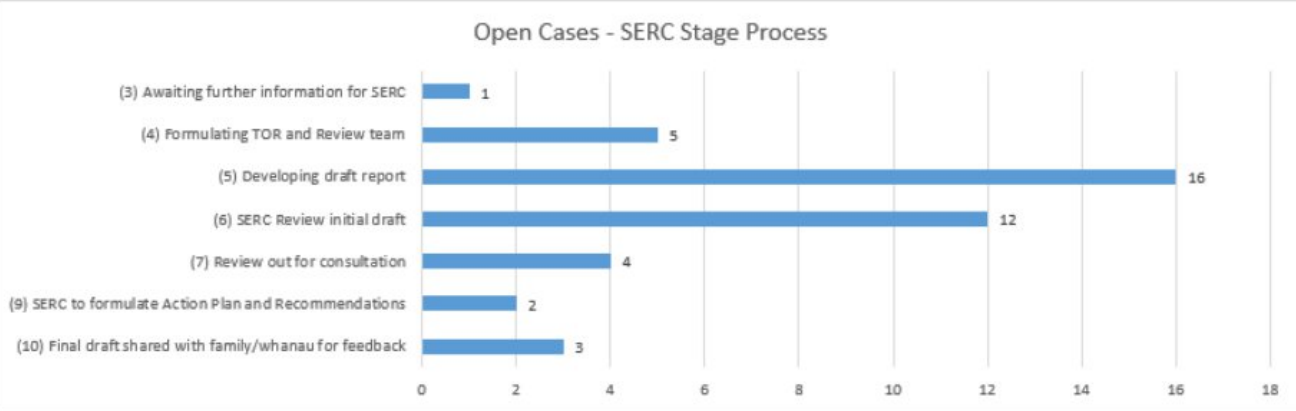


New SER Cases – January 2021	
RE Number	**SAC Rating**
101279	SAC 2
Closed SER Cases – January 2021	
73738	SAC 2
79406	SAC 2
99199	SAC 2
89118	Non-SAC rated
Opened and Closed SER Cases – January 2021	
99901	Non-SAC rated
100836	Non-SAC rated

Current Open Cases	SAC 1	SAC 2	SAC N/A or Awaiting Clarification
43	4	24	15

Cases Awaiting Triage	Cases Awaiting Further Info for SERC	Suspected Suicides
0	1	23

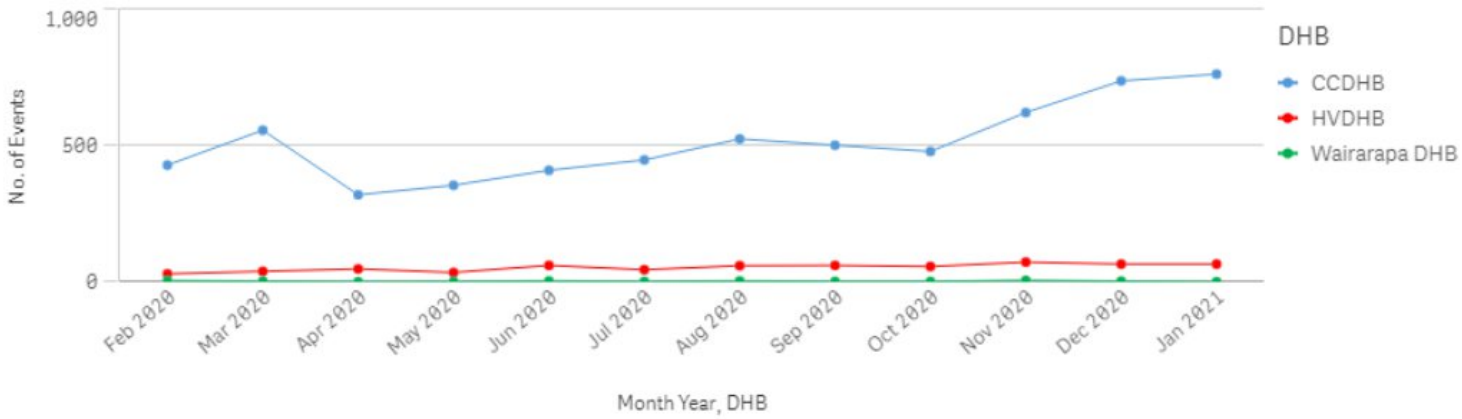




EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

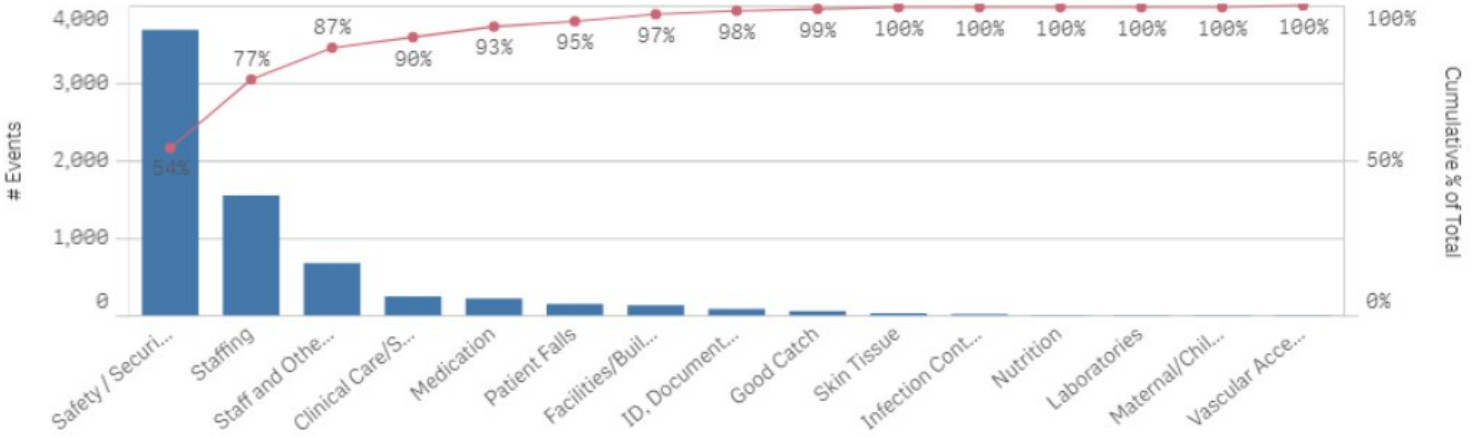
Reportable Events

Line Chart of Reportable Events



Pareto Chart Showing Incident Types / Specific Incident Types

Click on an Incident Type bar to drill down to Specific Incident Types



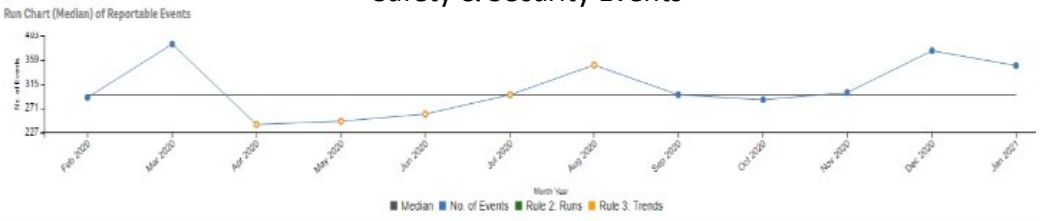
Key Points:

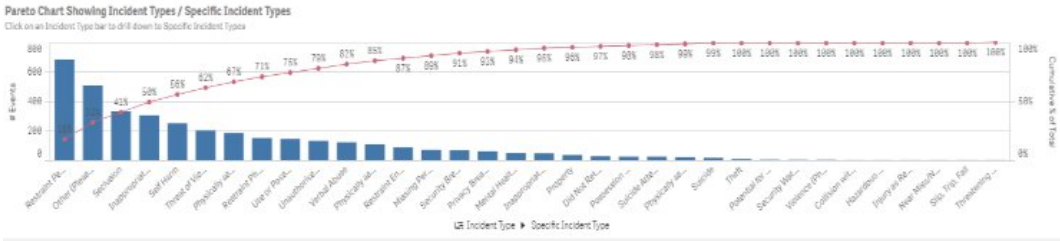
- Staffing events continue to increase and accounted for overall increase in reportable events this month.

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

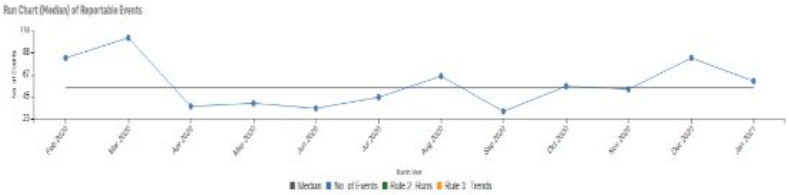
Reportable Events

Safety & Security Events

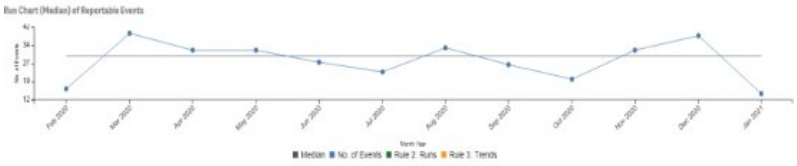




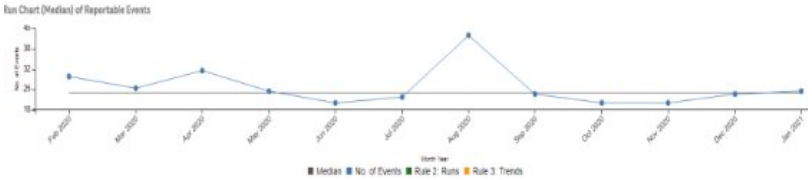
Restraint (Personal) Events



Seclusion Events



Inappropriate Behaviour Events



Run Charts of six top Safety & Security events.
Note x axis does not commence at zero on the run charts.

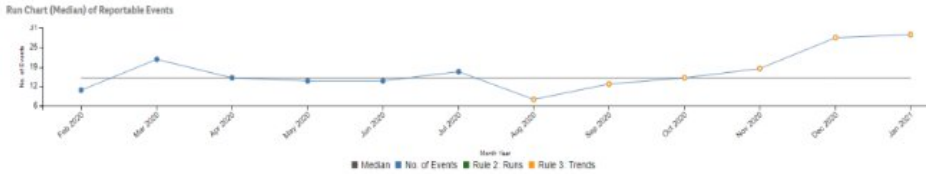
Restraint Events – 60 (drop from 83 previous month)
37 Intensive Recovery Sector -34 in RRAIS*
17 Forensic Sector - 15 of these in Youth Unit
6 Intellectual Disability Sector

Self harm events – 50 (increase from 18 previous month)
48 in Intensive Recovery Sector – 39 in RRAIS

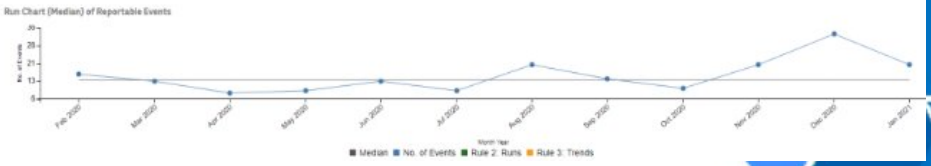
*Note RRAIS is now in Younger persons sector but still recorded under IRS in Qlik.
Ops Manager and Quality Coordinator are meeting weekly with senior RRAIS staff to develop action plan to address issues.

Self Harm Events

Threat of Violence



Physically assaulted Staff

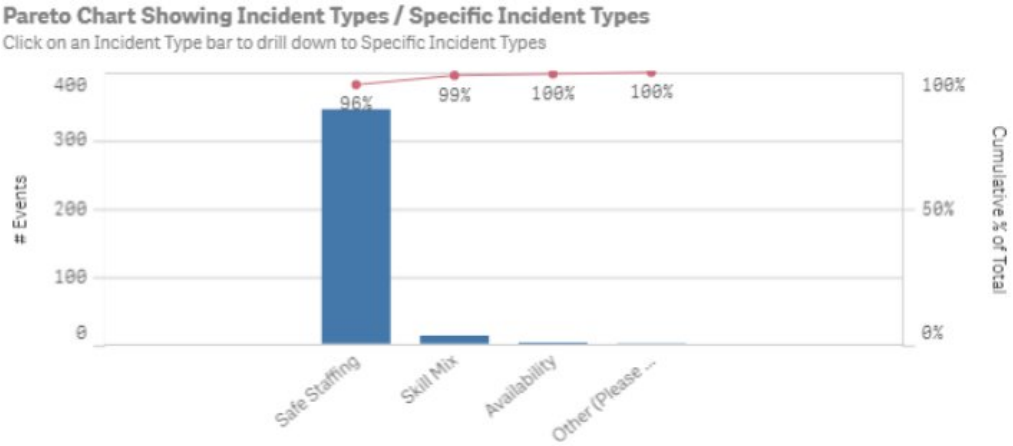


EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Reportable Events Continued - Staffing

Staffing Events Monthly Comparison last 12 months

Staffing Events by Type for Jan 2021



Key Points:

- Staffing events was top event type reported this month 361 events (43%) outnumbering safety and security events 349 (42%)

- Intellectual Disability Sector accounted for 249 events 72% of all staffing events
- Intensive Recovery Sector 49 events – 29 of these for Te Whare Ahuru
- Forensics and Rehab Sector 45 events – 32 of these for Tane Mahuta

EFFECTIVE SAFETY SYSTEMS TO RECOGNISE RISK AND REDUCE HARM

Health and Safety Events Monthly Comparison last 12 months

Reportable Events Health and Safety Measures – Jan 2021

All Staff and Other Health and Safety Events

60

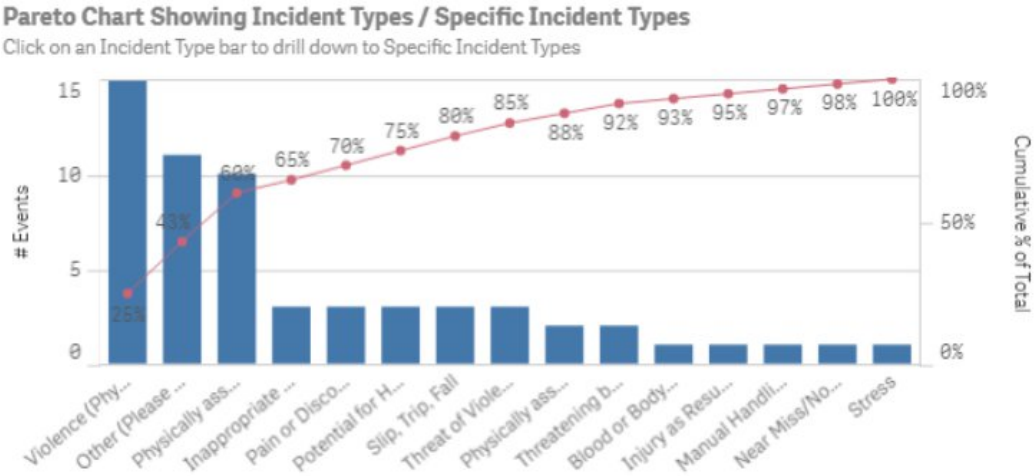
BBFE Events: 1	Slips, Trips and Falls: 4
All Manual Handling Events: 1	Manual Handling Patient: 1
Manual Handling Object: 0	Physical Assaults on Staff: 28

Physical assault on staff events - **28** *down from 47 in Dec*

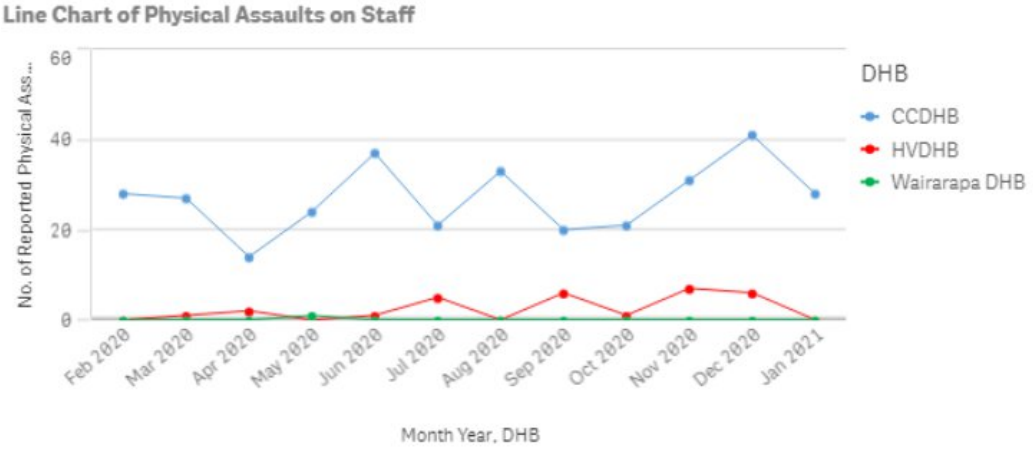
14 Intensive Recovery Sector -12 in Psychogeriatric Unit.
10 Forensic Sector - 8 of these in Youth Unit
4 Intellectual Disability Sector

Reportable Events Continued – Health & Safety

Health and Safety Events by Type for Jan 2021



Physical Assaults on Staff Monthly Comparison last 12 months



41

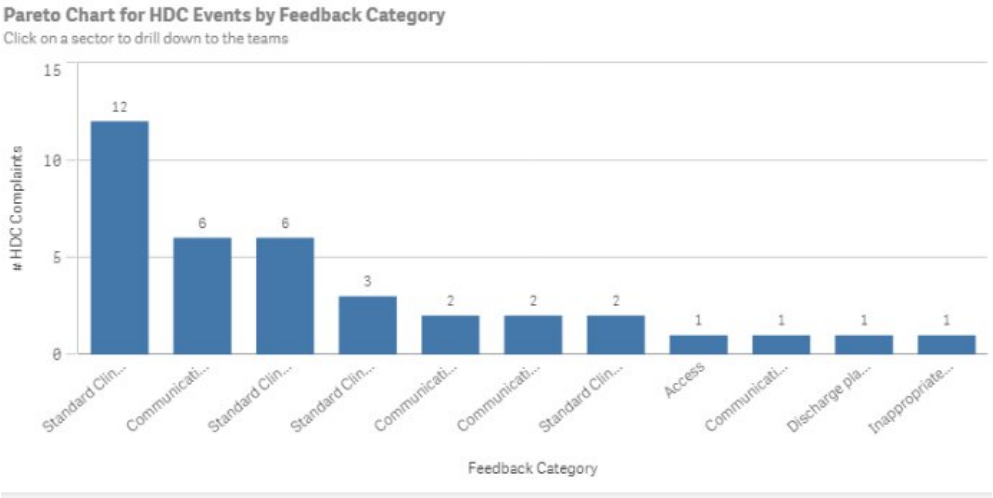
PERSON & WHĀNAU CENTRED CARE

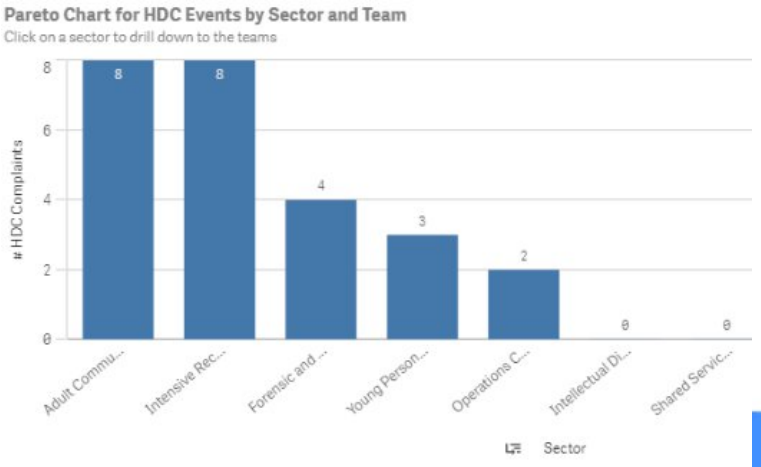
HDC Complaints

HDC Complaints

Total received in January 2021 = 0

Closed by HDC in January = 1
Responses sent to HDC = 2



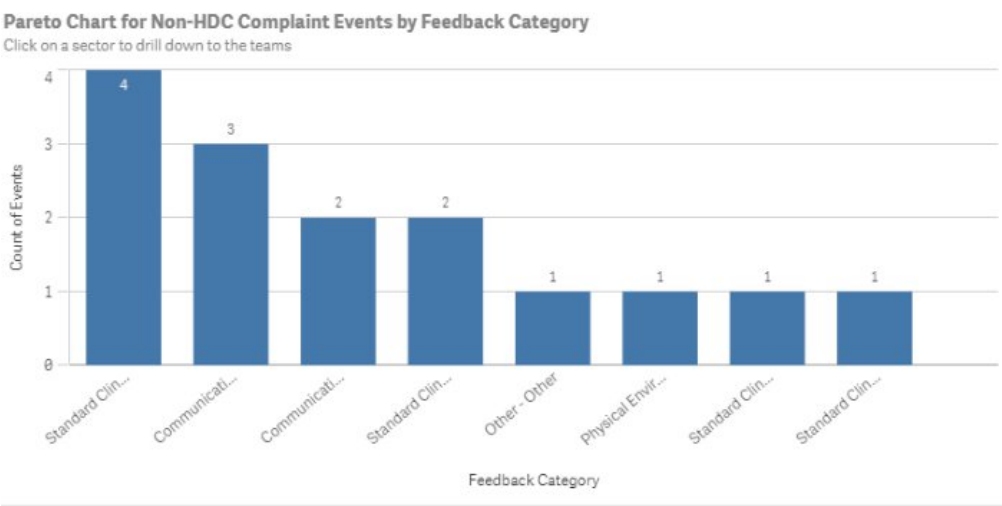


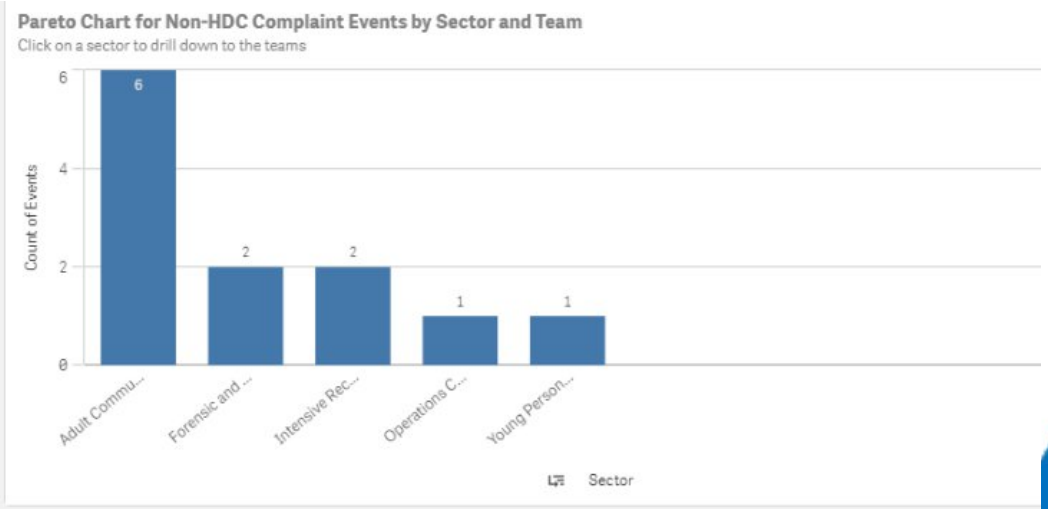
PERSON & WHĀNAU CENTRED CARE

Non HDC Complaints

Non HDC Complaints

Total received in January = 12
Down from 25 previous month





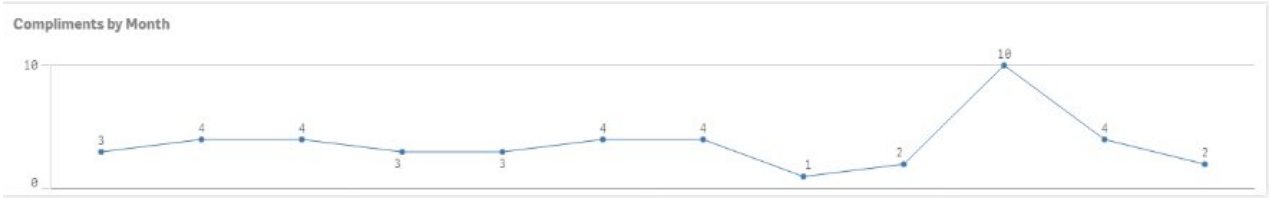
Note that correspondence can contain information about an event that is allocated to multiple feedback categories, sectors and teams. The sum of the numbers for the pareto charts may therefore exceed the totals shown in the time-based chart at the top of this sheet.

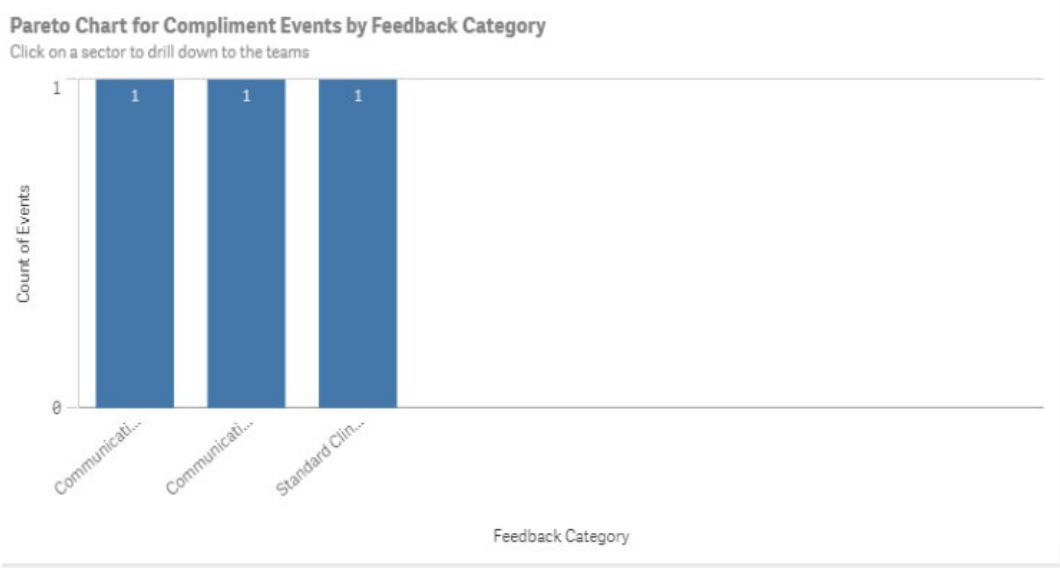
PERSON & WHĀNAU CENTRED CARE

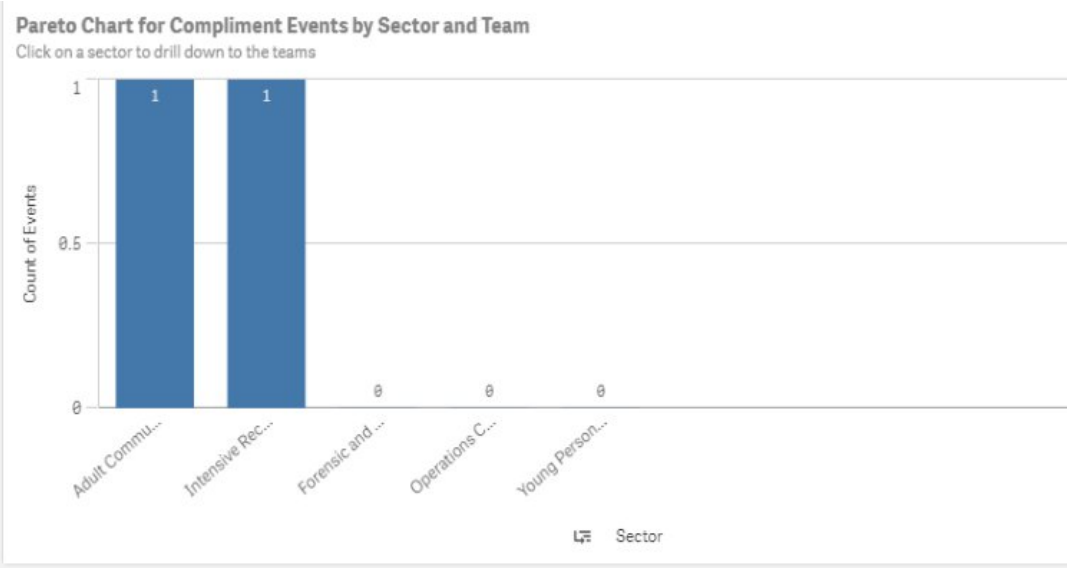
Compliments

Compliments

Total received in January = 2





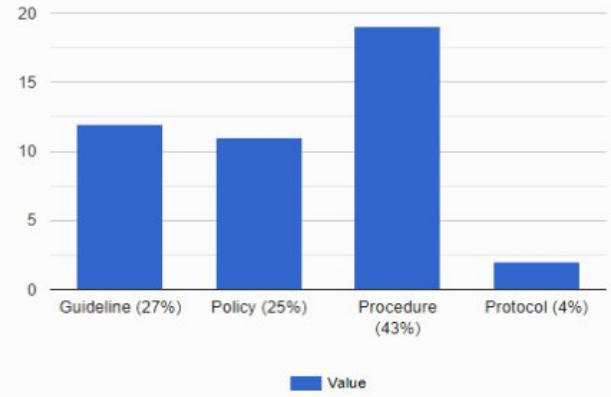


Note that correspondence can contain information about an event that is allocated to multiple feedback categories, sectors and teams. The sum of the numbers for the pareto charts may therefore exceed the totals shown in the time-based chart at the top of this sheet.

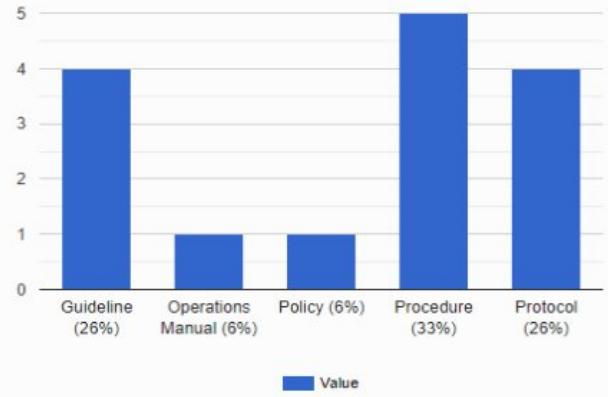
Controlled Documents Committee.

Compliance reporting on MHAIDS Policies, Procedures, Guidelines, Protocols and Operations Manuals

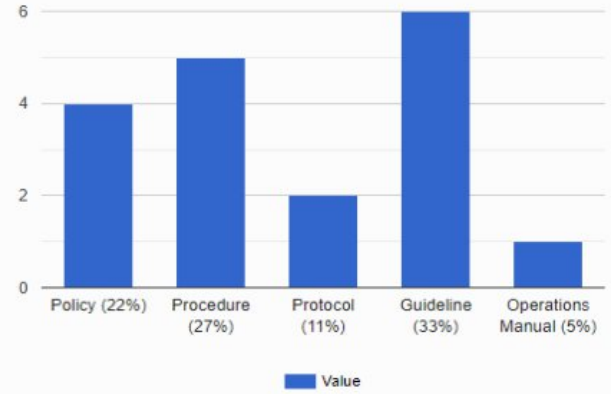
Documents in Date



Documents out of Date



Current Documents coming up for review - next 3 months



MHAIDS Committee Updates

Audit Committee

Audits due in February:

Long Acting Injection Medication Chart
Inpatient Ligature
Environment Cleaning and Maintenance

SharePoint Governance Group

The SharePoint Governance committee are working to standardise and update the current MHAIDS SharePoint site. Current actions include redesigning the homepage, combining the quality pages, developing processes for requesting a new page and instigating a 'report a problem' function. Once these issues have been completed, the plan is for the SharePoint Governance group to set up a roadshow for all MHAIDS staff and present the changes.

Improvements Committee

Report next month

Project Updates

HQSC - Learning from Adverse Events
Progressing four PDSA cycles aimed at increasing staff awareness of learnings from serious event reviews. Establishing a SharePoint site for all things Serious Event, testing case studies as a tool for learning about SERs, introducing the SER process to staff through presentations, and evaluating the introduction of a mentor programme for new reviewers.

HQSC - Connecting Care Transitions Project
The National Programme has now concluded, however work will continue within MHAIDS. Work is underway with Hutt Community Teams focusing on transitioning service users back to Primary Care.

HQSC - Toward Zero Seclusion
– Project teams continue to work on testing the following change ideas:
- recruitment of Maori staff to acute inpatient services (3 Maori NESPs joining each of the acute units, transfer of Maori RN to Te Whare Ahuru)
- weekly education sessions on working in a culturally safe manner due to commence in April
- use of headphones to distract, soothe and access mental health and wellbeing apps
- post seclusion reviews with service users and staff involved in the event
- activity packs on admission
- audit of prescribing for acute behavioural disturbance

HQSC QIA - MDT Review Process
Completed co-design elements of the project with clients and EIS care managers, used the baseline survey to design intervention. PDSA for intervention starting Monday 15th, aiming to increase client awareness of and participation in MDT process.

Talking Therapies Project
Talking Therapies training sessions have been implemented through ConnectMe and are well attended.
RPDS have expanded the Emotion Regulation training to 2-days in 2021, staff are applying for Post-Grad study this year, ELT have given provisional approval for funding training for DBT Consultation Groups.

Te Ara Oranga (Client Pathway) and Digital Client Record
The Project lead has now left to take up a new position and replacement is yet to be appointed.
The working group continues to meet weekly. Recent changes include the addition of a Consent flag. This is to be added to notes anytime there is a discussion about consent to treatment, therapy or sharing of information. This includes conversations when people withdraw consent.

Sensory modulation working group
The group have drafted terms of reference and are finalising its membership. The group is developing a stocktake survey which will go out to all teams; the information gathered will inform the work plan. Organising attendance at the Te Pou sensory modulation train the trainer workshop in April to increase the pool of SM training facilitators in MHAIDS.

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit YTD was $7.3m favourable against budget.
- Two extraordinary items exist which are not included within the budget, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($10.7m); COVID-19: additional costs during COVID-19
  - ($4.7m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position, $20.7 million relates to our YTD from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m some of which are still due to start within the year.
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of December was already ($44.7m) in overdraft, offset by $13m in special fund balances. Moving to ten day payment of creditors as required has had an estimated impact of around $8m on the DHB cash balance.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD January 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(8,317)		Devolved MoH Revenue	(1,621)	(11,489)		(21,426)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	667			2,704	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue			(44)	0	(44)
2,037	**(8,317)**	**0**	**Total Revenue**	**(953)**	**(11,489)**	**(44)**	**(18,722)**	**(44)**
			Personnel					
(1,610)		(2,049)	Medical	(3,674)		(1,393)	(5,284)	(25,530)
(1,620)		(9,145)	Nursing	(3,107)		(2,283)	(4,727)	(41,849)
		(1,370)	Allied Health			(380)	0	(6,966)
		32	Support			(102)	0	(1,869)
		168	Management & Administration			(437)	0	(7,905)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(6,781)**	**0**	**(4,594)**	**(10,011)**	**(84,119)**
			Outsourced Personnel					
(51)			Medical	(224)		(16)	(275)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(224)**	**0**	**(16)**	**(275)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(1,488)			1,346	0
(1,952)			Treatment related costs - Outsourced	(699)			(2,651)	0
(1,921)			Non Treatment Related Costs	(2,105)		(134)	(4,026)	(134)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(11,820)		(21,737)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(4,292)**	**(11,820)**	**(134)**	**(27,068)**	**(134)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(11,297)**	**(11,820)**	**(4,743)**	**(37,354)**	**(84,269)**
6,357	**1,600**	**12,365**	**Net result**	**10,343**	**332**	**4,699**	**18,632**	**84,225**

- The year to date financial position includes $10.3m additional costs in relation to COVID-19.
- Revenue of $11.5m has been received to fund additional costs for community providers however this has not been sufficient for these costs
- Additional personnel costs of $4.6m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – January 2021

Month - January 2021									Capital & Coast DHB Operating Results - $000s	Year to Date									
			Variance		Adjustments			Variance					Variance		Adjustments			Variance
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD January 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget
78,788	77,550	72,947	1,238	5,841	977		77,811	261	Devolved MoH Revenue	555,379	542,850	512,541	12,529	42,837	13,109		542,269	(581)
3,515	3,559	3,523	(44)	(8)			3,515	(44)	Non-Devolved MoH Revenue	25,701	25,019	24,459	683	1,242			25,701	683
2,410	2,843	3,247	(433)	(838)	0		2,410	(433)	Other Revenue	35,384	20,265	23,438	15,119	11,946	(667)		36,051	15,786
19,898	21,452	19,207	(1,554)	691			19,898	(1,554)	IDF Inflow	148,766	150,167	136,899	(1,400)	11,867			148,766	(1,400)
3,924	770	672	3,154	3,252			3,924	3,154	Inter DHB Provider Revenue	21,696	5,432	5,041	16,264	16,656		44	21,696	16,264
108,535	**106,174**	**99,597**	**2,361**	**8,938**	**977**	**0**	**107,558**	**1,383**	**Total Revenue**	**786,927**	**743,732**	**702,378**	**43,194**	**84,549**	**12,442**	**44**	**774,485**	**30,752**
									Personnel									
15,005	14,932	14,663	(73)	(341)	111	192	14,702	230	Medical	108,825	107,241	100,183	(1,584)	(8,641)	3,674	1,393	103,758	3,482
22,634	19,999	20,229	(2,635)	(2,405)	(609)	314	22,929	(2,930)	Nursing	147,887	134,913	129,423	(12,974)	(18,464)	3,107	2,283	142,498	(7,584)
5,840	5,742	5,035	(97)	(805)		52	5,788	(45)	Allied Health	43,364	39,968	35,734	(3,395)	(7,630)		380	42,984	(3,016)
893	1,042	910	150	17		14	879	164	Support	6,153	6,413	6,082	260	(71)		102	6,051	362
6,241	6,952	6,383	712	142		60	6,181	771	Management & Administration	46,972	46,111	42,818	(861)	(4,154)		437	46,535	(424)
50,611	**48,668**	**47,220**	**(1,944)**	**(3,391)**	**(498)**	**631**	**50,478**	**(1,811)**	**Total Employee Cost**	**353,201**	**334,647**	**314,241**	**(18,555)**	**(38,960)**	**6,781**	**4,594**	**341,826**	**(7,180)**
									Outsourced Personnel									
915	439	657	(476)	(257)	143	0	771	(333)	Medical	5,409	3,095	4,099	(2,314)	(1,309)	224	16	5,169	(2,074)
59	25	16	(34)	(43)			59	(34)	Nursing	359	175	153	(185)	(207)			359	(185)
127	114	120	(13)	(7)			127	(13)	Allied Health	820	796	921	(24)	101			820	(24)
34	22	12	(12)	(22)			34	(12)	Support	249	153	198	(96)	(51)			249	(96)
286	78	112	(207)	(173)			286	(207)	Management & Administration	2,576	568	1,374	(2,008)	(1,202)			2,576	(2,008)
1,420	**677**	**917**	**(743)**	**(502)**	**143**	**0**	**1,277**	**(600)**	**Total Outsourced Personnel Cost**	**9,413**	**4,786**	**6,745**	**(4,627)**	**(2,668)**	**224**	**16**	**9,174**	**(4,387)**
9,966	10,466	9,387	500	(579)	273		9,692	773	Treatment related costs - Clinical Supp	77,636	77,614	73,696	(22)	(3,940)	1,488		76,149	1,465
1,421	2,038	1,150	617	(271)	135		1,285	752	Treatment related costs - Outsourced	14,205	15,789	13,272	1,584	(933)	699		13,506	2,283
7,277	6,851	5,587	(426)	(1,689)	528	18	6,731	120	Non Treatment Related Costs	61,681	48,368	44,642	(13,313)	(17,039)	2,105	134	59,442	(11,074)
9,015	8,965	8,300	(50)	(715)			9,015	(50)	IDF Outflow	63,193	62,757	58,051	(435)	(5,142)			63,193	(435)
28,211	26,201	24,895	(2,010)	(3,315)	1,092		27,119	(918)	Other External Provider Costs (SIP)	201,656	184,344	176,770	(17,313)	(24,886)	11,820		189,836	(5,492)
4,605	4,780	4,757	175	152			4,605	175	Interest Depreciation & Capital Charge	32,630	33,977	34,471	1,346	1,841			32,630	1,346
60,493	**59,300**	**54,076**	**(1,193)**	**(6,417)**	**2,029**	**18**	**58,446**	**854**	**Total Other Expenditure**	**451,002**	**422,849**	**400,904**	**(28,153)**	**(50,098)**	**16,113**	**134**	**434,756**	**(11,906)**
112,524	**108,645**	**102,214**	**(3,880)**	**(10,311)**	**1,675**	**648**	**110,201**	**(1,557)**	**Total Expenditure**	**813,616**	**762,282**	**721,889**	**(51,334)**	**(91,727)**	**23,117**	**4,743**	**785,756**	**(23,473)**
(3,989)	**(2,470)**	**(2,617)**	**(1,519)**	**(1,372)**	**(697)**	**(648)**	**(2,643)**	**(173)**	**Net result**	**(26,689)**	**(18,550)**	**(19,511)**	**(8,140)**	**(7,178)**	**(10,675)**	**(4,699)**	**(11,271)**	**7,279**
2,955	3,650	2,684	(695)	271					Funder	(1,022)	2,653	(1,893)	(3,675)	871				
132	(0)	168	132	(36)					Governance	463	(0)	507	463	(44)				
(7,076)	(6,120)	(5,469)	(956)	(1,607)					Provider	(26,130)	(21,202)	(18,125)	(4,928)	(8,005)				
(3,989)	**(2,470)**	**(2,617)**	**(1,519)**	**(1,372)**					**Net result**	**(26,689)**	**(18,550)**	**(19,511)**	**(8,140)**	**(7,178)**				

Note two adjustments are made for

1. COVID-19 and
2. Holidays Act.

These two items form part of the DHB deficit; as revenue from MoH/Government has not been received to offset these costs, but is excluded from our responsible deficit and was excluded from our budget submission.

Executive Summary – Financial Variances

- The DHB deficit year to date is ($26.7m)
- Included within this result is recognition of the adjustment to the holiday act provision ($4.7m) and an estimated impact of COVID-19 of ($10.7m).
- Excluding the two items above brings the deficit for the year into deficit of ($11.3m) being $7.3m favourable to budget.
- Revenue is favourable by $29.2m YTD, after excluding COVID-19, lead DHB changes this decreases to a $.1m favourable variance. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($1.4m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($23.2m) YTD, excluding the Holidays Act provision ($4.6m) and the COVID-19 related costs of ($7m) incurred the net unfavourable variance is ($11.6m). This ($11.6m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($10.9m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $504k unfavourable YTD, the overspend in blood products ($2.3m) unfavourable were offset by favourable variances across other categories, such as; dispensed drugs, prostheses, grafts and outreach clinics.
- Outsourced clinical services is favourable YTD by $1.6m; favourable movement due to outsourced surgical service delayed compared to budget plan, however this is offset by the increase in MRI, CT Scans and other radiology services.
- Non treatment related costs ($13.3m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and settlement this was a $3.2m favourable variance; which is due to lower spend on asset maintenance, and new investment initiatives not yet commenced.
- The funder arm is unfavourable YTD due to additional spend requirements for our community COVID-19 response which are not all funded. Some new programmes in the NGO space have commenced alongside increased revenue to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is on budget YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($1.4m)
- The variance is due to revenue for special funds/research of $711k, Interest due to overdraft situations ($309k), Donations ($588k) MHAIDS non-lead DHB revenue of $623k. The funder arm is also unfavourable by $1.2m revenue however with offsetting community cost.

Personnel (inc outsourced)

- Medical Personnel is ($549k) unfavourable for the month, YTD unfavourable by ($3.9m). The unfavourable position for the month is due to transfer of costs to CCDHB for MHAIDs services (~$548k), Holidays Act provisions ($191k) and the year to date exc MHAIDS, Holidays Act was a favourable variance of $.2m is driven by vacancies across other services, most notably surgery and Women's and Children's services offset by COVID expenditure.
- Nursing Personnel is ($2.7m) unfavourable to budget for the month, YTD ($13.2m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is ($111k) unfavourable to budget for the month, YTD ($3.4m) unfavourable to budget. $2.5m of the YTD variance results from the transfer of staff from other DHBs to CCDHB.
- Support Personnel labour month position is favourable by $163k, YTD favourable by $138k.
- Management/Admin Personnel is favourable in the month by $504k, YTD unfavourable by ($2.9m). $2.5m YTD of this variance has corresponding offsetting revenue within ICT, the remainder is spread across the organisation and driven largely by the use of outsourced contractors.

Section 4

Financial Position

Cash Management – January 2021

Month : Jan 2021						Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance							Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD Jan 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
32,633	111,708	102,254	(79,075)	(69,621)		Receipts	800,396	781,957	746,896	18,439	53,501
						Payments					
53,216	45,974	48,365	(7,242)	(4,852)		Payments to employees	350,144	321,818	324,194	(28,326)	(25,950)
52,360	62,377	70,525	10,018	18,165		Payments to suppliers	434,476	444,300	414,890	9,824	(19,586)
0	11,365	12,297	11,365	12,297		Capital Charge paid	12,110	23,465	12,297	11,354	186
14,815	(137)	(6,546)	(14,952)	(21,361)		GST (net)	(2,364)	957	420	3,321	2,784
120,391	119,579	124,640	(812)	4,249		Payments - total	794,366	790,539	751,800	(3,826)	(42,565)
(87,758)	(7,871)	(22,386)	(79,887)	(65,372)	6	Net cash flow from operating Activities	6,031	(8,582)	(4,905)	14,613	10,935
						Investing Activities					
0	75	177	75	177		Receipts - Interest	151	525	643	374	493
0	0	0	0	0		Receipts - Other	0	0	500	0	500
0	75	177	75	177		Receipts - total	151	525	1,143	374	993
						Payments					
0	0	0	0	0		Investment in associates	0	0	0	0	0
5,271	5,511	1,765	240	(3,506)		Purchase of fixed assets	34,875	38,576	21,774	3,701	(13,100)
5,271	5,511	1,765	240	(3,506)		Payments - total	34,875	38,576	21,774	3,701	(13,100)
(5,270)	(5,436)	(1,588)	315	(3,329)	7	Net cash flow from investing Activities	(34,724)	(38,051)	(20,631)	4,076	(12,108)
						Financing Activities					
0	0	0	0	0		Equity - Capital	0	0	0	0	0
4,410	0	0	4,410	4,410		Other Equity Movement	7,382	0	10,650	7,382	(3,268)
0	0	0	0	0		Other	0	0	(55)	0	(55)
4,410	0	0	4,410	4,410		Receipts - total	7,382	0	10,594	7,382	(3,213)
						Payments					
0	0	0	0	0		Interest payments	8	0	0	(8)	(8)
0	0	0	0	0		Payments - total	8	0	0	(8)	(8)
4,410	0	0	4,410	4,410	8	Net cash flow from financing Activities	7,374	0	10,594	7,374	(3,221)
(88,618)	(13,307)	(23,974)	(75,162)	(64,290)		Net inflow/(outflow) of CCDHB funds	(21,320)	(46,633)	(14,941)	26,062	(4,393)
85,535	(15,090)	17,116	(100,625)	(68,419)		Opening cash	18,236	18,236	8,083	0	(10,153)
37,043	111,783	102,431	(74,590)	(65,034)		Net inflow funds	807,929	782,482	758,633	26,195	51,281
125,662	125,090	126,405	(572)	744		Net (outflow) funds	829,248	829,115	773,574	(133)	(55,674)
(88,618)	(13,307)	(23,974)	(75,162)	(64,290)		Net inflow/(outflow) of CCDHB funds	(21,320)	(46,633)	(14,941)	26,062	(4,393)
(3,084)	(28,397)	(6,858)	25,313	3,775		Closing cash	(3,084)	(28,397)	(6,858)	25,313	3,775

Capital and Coast DHB
RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD Jan 2021		
	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating	**6,031**	**(8,582)**	14,613
Non operating financial asset items	**(50)**	-	(50)
Non operating non financial asset items	**(2,158)**	**(1,785)**	(374)
Non cash PPE movements			
Depreciation & Impairment on PPE	(19,108)	(18,913)	(195)
Gain/Loss on sale of PPE	0	-	0
Total Non cash PPE movements	**(19,108)**	**(18,913)**	**(195)**
Working Capital Movement			
Inventory	507	-	507
Receipts and Prepayments	33,899	12,100	21,799
Payables and Accruals	(45,808)	(1,369)	(44,440)
Total Working Capital movement	**(11,402)**	**10,731**	**(22,133)**
Operating balance	**(26,688)**	**(18,549)**	(8,139)

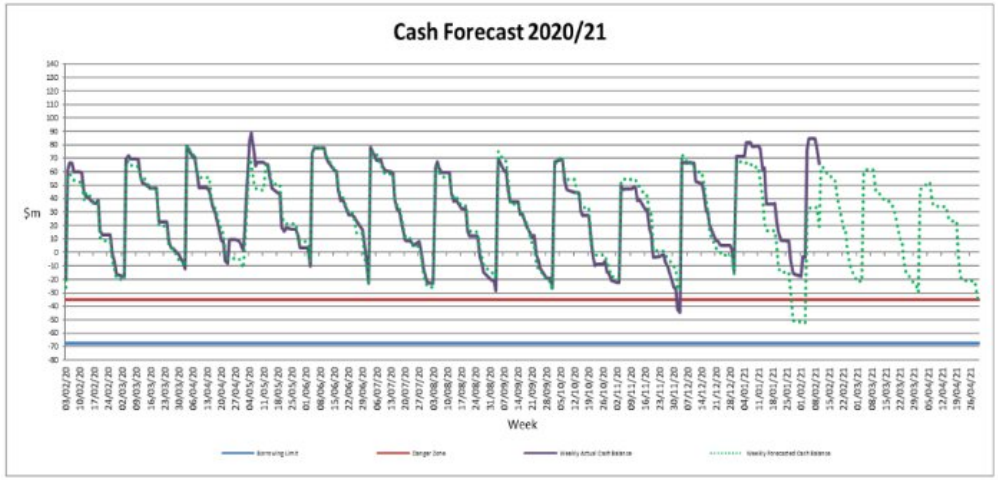
Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
DHB's current ratio is 0.44 (November 20: 0.35);

Debt to Equity Ratio – This ratio determines how the DHB has financed the asset base.
DHB's total liability to equity ratio is 49:51 (Nov 20 46:54)

Debt Management / Cash Forecast – January 2021

Accounts Receivable
31-Jan-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	6,407	4,661	93	-	(2)	1,655	11,974
Other DHB's	22,442	3,815	5,087	4,169	5,818	3,553	18,506
Kenepuru A&M	233	28	25	23	157	-	227
ACC	(82)	1,026	(1,061)	(279)	3	229	(99)
Misc Other	4,186	1,825	443	130	63	1,725	3,366
Total Debtors	33,186	11,355	4,587	4,043	6,039	7,162	33,974
less : Provision for Doubtful Debts	(2,500)						(2,486)
Net Debtors	30,686						31,488



Cash Management

- During COVID-19 we have moved to immediate payment terms in line with treasury advice, this has caused increased payments due to the timing lag that usually exists (i.e. 20th of following month)

Debt Management

- **Ministry of Health:** The MOH overdue is for invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.
- **Other DHB's:** Single largest debtor outstanding is Hutt Valley DHB at $15.7m, mostly Salary recovery
- **Kenepuru A&M:** Includes significant number of low value patient transactions. Provision of the overdue debts is $136k
- **Misc Other:** Includes non-resident debt of approx. $1.9m. About 82% of the non-resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Balance Sheet / Cashflow – as at 31 January 2021

Dec 2020	Month : Jan 2021				Variance			Capital & Coast DHB Balance Sheet
Actual	Actual	Budget	At Jan 2020	At Jun 2020	Actual vs Budget	Actual vs Jan 2020	Notes	YTD Jan 2021
71,766	31	31	32	31	0	(1)	1	Bank
881	106	(0)	0	6,523	107	106	1	Bank NZHP
12,889	13,046	11,683	12,104	11,683	1,363	942	1	Trust funds
62,299	64,008	49,375	45,189	46,342	14,633	18,819	2	Accounts receivable
9,491	9,502	8,995	10,127	8,995	507	(624)		Inventory/Stock
10,191	10,025	6,257	7,971	6,257	3,768	2,054		Prepayments
167,516	**96,718**	**76,341**	**75,422**	**79,831**	**20,377**	**21,296**		**Total current assets**
512,500	511,453	540,857	527,228	522,978	(29,404)	(15,776)		Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988		Work in Progress - CRISP
76,889	80,429	54,096	48,515	57,317	26,333	31,914		Work in progress
604,236	**606,729**	**609,799**	**585,603**	**591,921**	**(3,071)**	**21,126**	3	**Total fixed assets**
0	0	0	0	0	0	0		Investments in New Zealand Health Partnership
1,306	1,150	1,150	1,150	1,150	0	(0)		Investment in Allied Laundry
1,306	**1,150**	**1,150**	**1,150**	**1,150**	**0**	**(0)**		**Total Investments**
773,058	**704,597**	**687,290**	**662,175**	**672,901**	**17,307**	**42,422**		**Total Assets**
0	16,266	40,111	18,995	0	23,845	2,729		Bank overdraft HBL
174,555	94,888	64,504	67,659	76,604	(30,384)	(27,228)	4	Accounts payable, Accruals and provisions
0	0	0	0	0	0	0	7	Loans - Current portion
9,483	11,102	1,642	1,766	(252)	(9,460)	(9,336)	6	Capital Charge payable
593	593	593	593	593	0	0		Insurance liability
18,070	10,776	36,144	21,185	36,144	25,368	10,409	5	Current Employee Provisions
166,769	168,163	140,857	118,159	140,857	(27,305)	(50,004)	5	Accrued Employee Leave
7,242	10,448	7,299	9,901	7,299	(3,148)	(547)	5	Accrued Employee salary & Wages
376,711	**312,235**	**291,150**	**238,258**	**261,245**	**(21,084)**	**(73,977)**		**Total current liabilities**
0	0	0	0	0	0	0		Crown loans
104	107	95	79	95	(12)	(29)		Restricted special funds
605	605	605	605	605	0	0		Insurance liability
6,564	6,564	6,564	6,296	6,564	0	(269)		Long-term employee provisions
7,274	**7,277**	**7,264**	**6,980**	**7,264**	**(12)**	**(297)**		**Total non-current liabilities**
383,985	**319,511**	**298,415**	**245,237**	**268,510**	**(21,097)**	**(74,274)**		**Total Liabilities**
389,073	**385,085**	**388,875**	**416,938**	**404,391**	**(3,790)**	**(31,853)**		**Net Assets**
812,712	817,122	812,773	797,172	813,224	4,349	19,950		Crown Equity
0	0	0	0	(3,484)	0	0		Capital repaid
4,410	0	0	0	0	0	0		Capital Injection
130,659	130,659	130,660	131,395	130,659	(1)	(736)		Reserves
(558,709)	(562,697)	(554,558)	(511,630)	(536,008)	(8,140)	(51,066)		Retained earnings
389,073	**385,085**	**388,875**	**416,937**	**404,392**	**(3,791)**	**(31,852)**		**Total Equity**

Balance Sheet

1. The DHB's cash overdraft balance at the end of January is favourable to budget.
2. Accounts receivable is high than budget due to timing differences. The main customer HVDHB paid $14m in February 2021;
3. Accounts payable, accruals and provisions is higher than the budget mainly due to timing differences
4. Employee liabilities is high than budget due to unbudgeted employee costs (MHAIDs) approx. $3m per month;

Cash flow

1. The net cash flow from operating activities is unfavourable to budget. This is mainly due to more than expected Crown funding received in December and other timing differences;
2. The net cash flow from investment activities is almost line up to budget;

Capital Expenditure Summary January 2021

		Actual spend on live projects					Forecast spend on approved projects					
Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	September Quarter actual spend	December Quarter actual spend	January actual spend	Actual YTD Spend	Actual LTD Spend	To spend	Feb-21	Mar-21	Jun 21 Quarter	Forecast cash spend to Jun 21*
Buildings	8,565,209	-	225,088	820,879	135,756	1,181,723	1,181,723	7,383,487	690,658	1,064,224	1,681,544	4,618,148
Clinical Equipment	7,699,770	-	643,250	1,506,284	101,992	2,251,526	2,251,526	5,448,244	879,492	1,427,083	2,456,377	7,014,479
ICT	1,517,117	-	41,960	142,786	35,647	220,394	220,394	1,296,724	158,687	157,685	467,143	1,003,908
2020-21 projects	**17,782,096**	-	**910,298**	**2,469,950**	**273,395**	**3,653,642**	**3,653,642**	**14,128,454**	**1,728,837**	**2,648,992**	**4,605,063**	**12,636,535**
Buildings	17,711,763	8,814,096	1,395,429	934,819	427,755	2,758,002	11,572,098	6,139,665	1,166,963	951,442	2,353,312	5,635,001
Clinical Equipment	43,874,614	21,222,465	7,018,217	5,846,681	787,826	13,652,723	34,875,188	8,999,426	1,465,395	900,131	2,362,682	16,127,711
ICT	9,238,081	6,711,200	1,266,724	348,068	135,497	1,750,289	8,461,489	776,592	206,110	178,673	475,562	2,269,027
Prior Year projects	**70,824,458**	**36,747,760**	**9,680,370**	**7,129,568**	**1,351,078**	**18,161,015**	**54,908,775**	**15,915,683**	**2,838,468**	**2,030,246**	**5,191,555**	**24,031,739**
Total	**88,606,554**	**36,747,760**	**10,590,667**	**9,599,517**	**1,624,472**	**21,814,657**	**58,562,417**	**30,044,137**	**4,567,305**	**4,679,239**	**9,796,619**	**36,668,274**

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

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

- The development of business cases from the 2020/21 Capital Plan are at various stages. It is anticipated that $3m-$4m be presented for approval each month. $17.8m in projects have been approved to the end of January 2021
- Total spend to the end of January 2021 was $21.8m which mostly related to prior year approved projects
- The forecast cash spend for the year is $41m-$43m funded from depreciation ($37m), Crown Equity, donations and leases. This is based on an average monthly spend of $3.5m-$4m. It presumes a steady flow of business cases approved, lessened disruption on workforce and supply chain logistics from COVID-19
- The January actual spending was lower due to a shorter working month for most non clinical & corporate staff

Board Information - Public

April 2021

2DHB MĀORI HEALTH STRATEGIES (TAURITE ORA & TE PAE AMORANGI) PROGRESS & PERFORMANCE REPORT (2020/2021 QUARTER 3)

Action Required

Both Boards note:

(a) The release of this report to the public.

(b) This report was submitted for discussion to the Health System Committee.

(c) The appended updates in relation to Taurite Ora and Te Pae Amorangi.

(d) This paper also provides a response to requests for information from Board members at the 3 March Board meetings.

Strategic Alignment	MoH Whakamaua: the Māori Health Action Plan 2020-2025 CCDHB Health System Plan 2030 (the 2030 Plan) HVDHB Our Vision for Change 2017-2027 CCDHB Taurite Ora Māori Health Strategy 2019-2030 HVDHB Te Pae Amorangi, Māori Health Strategy 2018-2027
Presented by	Arawhetu Gray, Director Māori Health Services, 2DHB
Purpose	As above.
Contributors	Māori Health Services and Strategy, Planning and Report teams.

Executive Summary

The 2DHB Director Māori Health Services role was appointed in late November 2020. Since then our focus has been on transforming the Māori Health Services teams to ensuring fucntionality within a 2DHB operating environment. Our immediate priorities are:

- Supporting the Māori Health Service workforce at both HVDHB and CCDHB's to deliver the tailored programmes of work that are specific to their Māori population and communities (outlined in Te Pae Amorangi and Taurite Ora), and developing a 2DHB approach to the remainder of their function.
- Supporting the formation of a new Māori governance structure that retains independence from 2DHB and continues to represent the interests of mana whenua.
- Obtaining approval for the transfer ofthe HVDHB and CCDHB Māori Health Strategy implementation funds to the baseline operating fund for the 2DHB Māori Health Service.

Strategic Considerations

Service	Continued delivery of the tailored programmes of work highlighted in Te Pae Amorangi and Taurite Ora to address the impact of inequity on Māori health outcomes.
People	Māori Health Service staff prioritise delivery of Te Pae Amorangi and Taurite Ora as the primary function of their role.
Financial	Reprioritise project funding in 2021/22 (Taurite Ora - $500k and Te Pae Amorangi $350k) to Māori Health Service Baseline funding for 2021/22 and out years
Governance	The system-wide transformation to achieve health equity by 2030 requires strong partnership between our new Māori governance Board and 2DHB.

Engagement/Consultation

Patient/Family	
Clinician/Staff	
Community	

Identified Risks

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

Attachment/s

1. 2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi) Progress & Performance Report (2020/2021 Quarter3).
2. Health Literacy Project Report.

1. Introduction

This paper:

- Responds to the request for more information regarding the plan for Māori governance (the Partnership Boards) and for engagement at the governance level with the two DHB Boards.
- Responds to questions from Hutt Valley DHB Board members regarding the Memorandum of Understanding currently being developed with iwi leaders.
- Asks the Committee to note that the 2DHB Director Māori Health is seeking Board approval to for the transfer of the HVDHB and CCDHB Māori Health Strategy implementation funds to the baseline operating fund for the 2DHB Māori Health Service.

2. Background

In November 2020, the Director, Māori was appointed to lead Māori Health Services at both HVDHB and CCDHB. Previously, each DHB operated independently with its own Director and Service team, they also developed and published separate Māori Health Strategies aligned to the data profile of their regional Māori population. In the case of Hutt Valley DHB: Te Pae Amorangi, and at Capital & Coast: Taurite Ora.

As part of our transition into a single service serving all of Te Upoko o te Ika a Māui, we are combining our reports on both Māori Health Strategies. This is possible because they identify the same five priority focus areas: Equity; Workforce; Commissioning; Mental Health and Addictions and First 1000 days/Maternal, Child and Youth Health.

3. 2DHB Māori Governance and Engagement

3.1 Amalgamation of Māori relationship boards

At a meeting held on 3 December 2020, the Māori Partnership representatives from HVDHB and CCDHB reached agreement in principle to amalgamate into a new entity, to be known as *Te Upoko o te Ika Māori Council (Tui MC).*

An agreement and terms of reference have been drafted and at this stage it is proposed that Tui MC will comprise up to two representatives from each of the following iwi entities:

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

The Chair shall be appointed by the TUI MC members. Once the agreement and terms of reference have been signed by all parties, it will be presented to the 2DHB Board at the next meeting on 7 April 2021.

3.3 Wainuiomata service delivery

The Strategy, Planning and Performance and Māori Health Service Directorates will work with the Wainuiomata community to determine their needs.

2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report (2020/2021 Quarter 3)

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

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

Contents

1. Background

While indicators and their status recorded later in this document. We will continue to maintain separate supporting narratives against Te Pae Amorangi and Taurite Ora here.

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

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

2. Te Pae Amorangi

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

2.1.1 Outcome One – HVDHB has clearly defined and transparent recruitment and retention policies and procedures to pro-actively recruit Māori across all positions

A small working group to drive a collective approach across the two DHBs has been developed. Scope and explicit actions/outcomes have been defined. There is much work to be done in this area as the project team is working through the wide list of commitments made by the 20 DHB CEOs and Te Tumu Whakarae. As 2DHBs we are behind on the reporting requirements and are working through how to collect this information from our current systems, as well as how we develop training specific to hiring managers.

2.1.2 Outcome Two – HVDHB is a preferred employer for Māori Health Professionals

Our Māori Workforce Lead and Communications Advisor are in the very early stages of scoping a project to develop a Hutt Valley DHB Māori marketing profile and action plan aimed to attract and retain Māori into our workforce.

2.1.3 Outcome Three – HVDHB will be a supportive environment for further growth and development of our Māori workforce

2.1.3.1 Te Aka Kūmara Pānui

A pānui especially designed for kaimahi Māori has been developed to ensure all HVDHB kaimahi are kept up to up to date with the activity within the Toi Ora Māori Health Team. This pānui is also a vehicle for us to communicate and stay connected and engaged with our kaimahi. Feedback from all

staff has been positive with Māori employees stating that they feel empowered by the work being done in the Māori Workforce area.

2.1.3.2 Te Wānanga Mō Ngā Kaimahi Māori

On Thursday 4 March a rōpū of HVDHB Māori Employees came together for a wānanga at Koraunui Marae. The wānanga was an opportunity for the DHBs Māori employees to come together to grow our whakapapa, enhance our whanaungatanga and access mātauranga Māori (Māori knowledge), as well as korero how we can work together as a collective to deliver on Te Pae Amorangi in our own areas.

The day started with a Raranga (Māori weaving) workshop and ended with a workshop. There are three noho marae planned for the rest of the year.

Some feedback from the wānanga was:

Thank you for organising this kaupapa and I'm sure you are well aware it is definitely needed in our space of mahi at the DHB. This is just the start of what we can overcome and achieve to rebuild our own identity and our workforce. Ka pai e hoa! Looking forward to the next one.

Thank you for organising yesterday's wānanga I found it really lovely just to be able to ground myself and breathe after a very busy start to the year. I especially enjoyed he practical side of the day making the putiputi with Aroha and Ariana, meeting other kaimahi who work in the DHB. A good start of things to come.

2.1.4 Outcome Four – HVDHB are supporting and developing young Māori into Health workforce

2.1.4.1 Rangatahi ki te Aō (Rangatahi into the World)

This year will see the Hutt Valley DHB officially launch the Rangatahi ki te Aō Programme that was successfully piloted in 2020.

Last year we had a very successful start to the programme with our rangatahi Imajyn and Tyla-Jade. The pair learned about various medical services they might one day want to make into a career here at the DHB.

Imajyn, who was in her final year at Naenae College, particularly enjoyed learning about dentistry in the community, the hospital's audiology department, and the role of theatre nurses. Imajyn has since enrolled at Whitireia as part of the Bachelor of Nursing Māori Programme.

Tyla-Jade Robb, who was in Year 12 at Te Ara Whānui in Alicetown, said she was initially interested in pharmacy but found she more enjoyed learning about the role of an anaesthetic technician after getting to watch a surgical operation.

The internships are funded by Kia Ora Hauora and managed by the DHBs Māori Workforce Lead, Director Midwifery, Associate Director Allied Scientific and Technical and Associate Director Nursing.

This year we will run the programme for a week of each school holidays and will open the applications up to six rangatahi from Te Ara Whānui Kura Kaupapa Māori, Naenae College, Taita College and Wainuiomata High.
As a direct result of this pilot Imajyn is now studying towards her Bachelor of Nursing Māori at Whitireia Polytechnic.

2.1.4.2 Hutt Valley DHB Mahi Exposure Day

On Friday 21 May Hutt Valley DHB will hosts its very first Mahi Exposure Day. Attendance by Māori and Pacific rangatahi will be prioritised and a focus will be on ensuring we have strong representation of our Māori and Pacific Workforce.

2.2 Māori Health Unit Operational Work

2.2.1 Equity tool driving change

Originally developed for use in Ministry of Health-funded workshops, the Health Equity Assessment Tool (HEAT) aims to promote equity in health in New Zealand.

Our Māori Health Unit organised a training day for staff from across Hutt Hospital earlier this year after looking at opportunities to help staff when planning, trialling and implementing initiatives to ensure they address inequity for Māori.

HEAT consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities.

The questions cover four stages of policy, programme or service development:

1. Understanding health inequalities;
2. Designing interventions to reduce inequalities;
3. Reviewing and refining interventions; and
4. Evaluating the impacts and outcomes of interventions.

Presenters included Māori research leader Bridget Robson (Ngāti Raukawa) who is the director of Te Rōpū Rangahau Hauora a Eru Pōmare; the head of the university's Department of Public Health Louise Signal, and PhD student Eloise Pollard whose thesis is titled Planning for equity: Evaluating the application of the Health Equity Assessment Tool (HEAT) to promote health equity for Māori from Otago University.

HEAT is a flexible tool that can be used in its entirety or, alternatively, selected questions or groups of questions can be asked for specific purposes. For example, questions one to three can promote the consideration of health inequalities and their causes, while question five can assist with assessing a policy, service or programme's responsiveness to Māori.

The HEAT questions can be used to provide a quick overview of potential issues and gaps in policies, services and programmes, such as gaps in information or stakeholder involvement. Alternatively, more in-depth responses to the HEAT questions can assist in developing an evidence base for policy, service and programme development and/or evaluation.

2.2.2 Feedback from workshop attendees:

What are the main messages you got from the workshop?

- Equity should be on top of everyone's agenda, we need to change and engage communities, redirect services
- Be braver with equity-based ideas
- To utilise the HEAT tool across projects
- Equity is achievable, this has to be a priority throughout the organisation, HEAT tool facilitate changes

The strengths of the workshop?

- Presenters knowledge base and commitment to topic +++
- The people presenting it
- Great networking. Clear presentation, great examples of HEAT - especially breastfeeding
- Lots of group work, excellent presenters and presentations
- Connecting with others from the DHB, framework to work through systematically

What supports do you need to assist you to tackle inequalities for Māori in your work?

- Regular communications with like-minded staff. Support from managers to put equity as priority;
- Colleague and management support, a HEAT expert to provide consult and advice;
- Mandated focus on equity, training for staff on Te Tiriti, cultural practise etc. Support to use HEAT in strategic planning. Training and monitor change; and
- More staff understanding HEAT and a management commitment to invest. Monitoring to initiate an organisational wide approach.

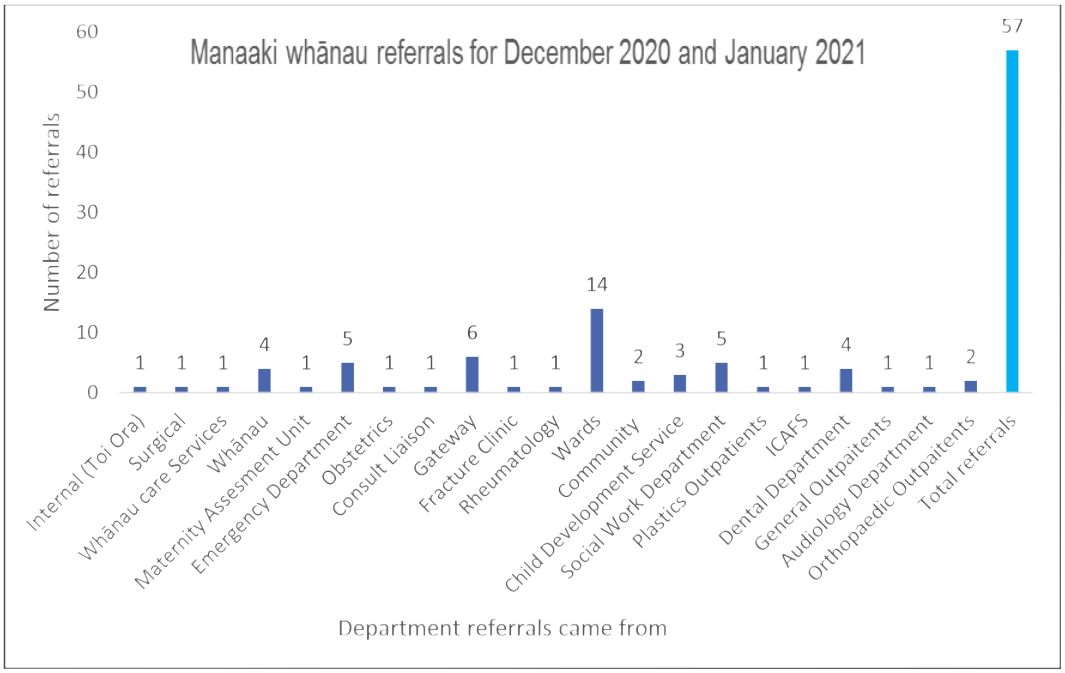
Any other comments:

- Appreciate the clarity that we have in permission to do this work;
- Amazing I think you should have this workshop often;
- I am always cautious that pushing some things towards equity too hard may get me into strife; and
- Thank you for organizing and facilitating a very useful day of conversation, networking and learning. It would be useful to have this repeated and added into a day of training.

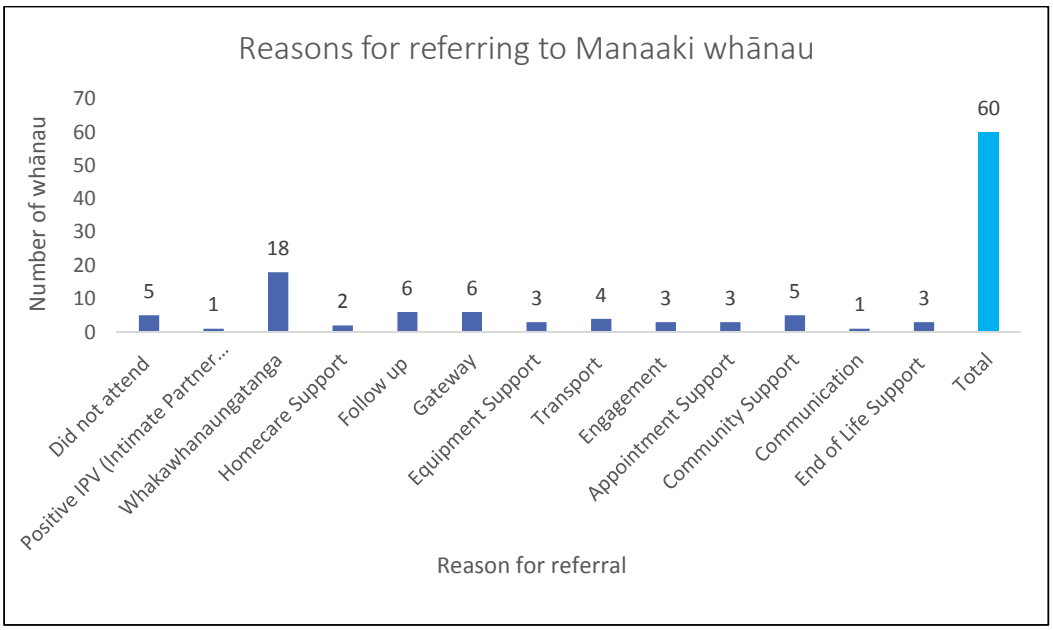
2.3 Manaaki Whānau Update

2.3.1 Manaaki Whānau Referrals

Manaaki Whānau receive internal referrals from across the hospital and a number of external agencies and providers. Referrals are received by email, phone call, the internal e-referral system or face to face (i.e. stop into Toi Ora Office).

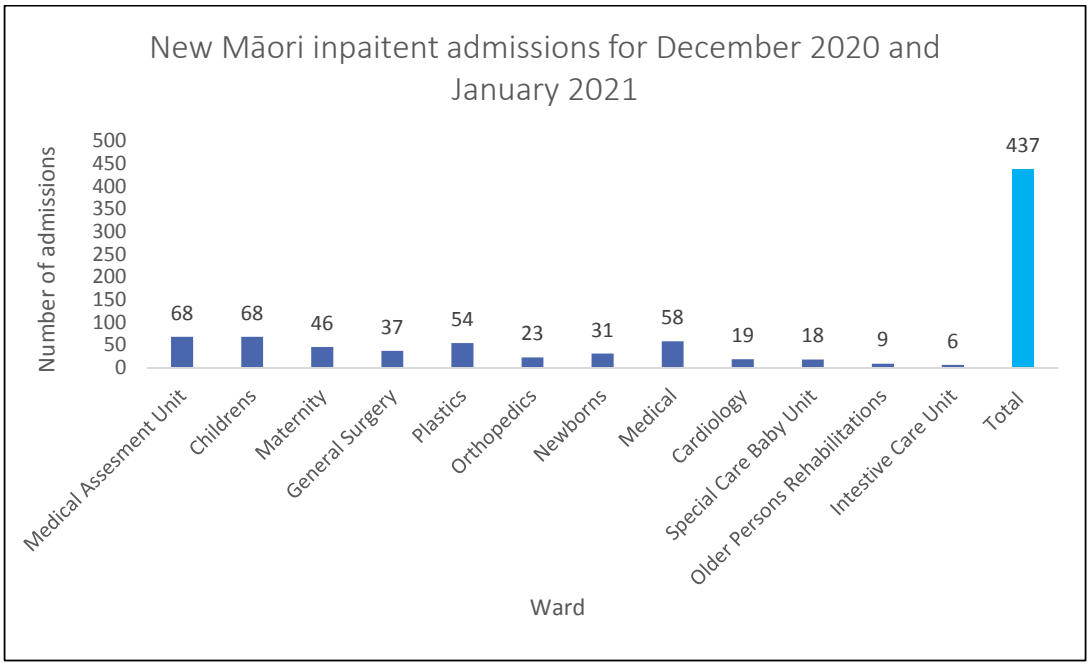


The following graph shows the reasons for referring to the Manaaki Whānau team.



2.3.2 Whānau Māori Inpatients

Every morning, our Manaaki Whānau print a list of newly admitted inpatients that identify as Māori. The aim is for every whānau Māori to be visited by our Manaaki Whānau however it must be noted that this is not always possible due to workload demands, particularly if one of the two are away on leave or sick.



3. Taurite Ora

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

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

3.1 Becoming a Pro-Equity Organisation

On 3 March 2021 the Board approved the Equity goal and directions and the set of equity principles that were first approved by the Health Safety Committee in November 2020. From here, our next step is to develop a Pro-Equity Policy Framework. Strategy, Planning and Performance (SPP) and the Māori Health Services Directorate (MHS) will work together to develop a performance framework supported by advanced analytics and insights into our investment choices.

We will also develop a phased communications and engagement strategy, it will be a continual and consistent campaign to embed equity principles into our whole service.

MHS will co-lead to safeguard our Treaty obligations and promote the unique position of Māori to be at the forefront of equity discussions and decisions. To support our discussions, we have recently appointed a 2DHB position of Senior Insights Advisor, Māori to our team. This new position spans both Hutt Valley and Capital & Coast DHB's, and is responsible for developing and managing an equity focussed information base that reflects a strong Matauranga Māori perspective. His employment began with us at the end of February 2021.

Members of ELT are augmenting our workforce with appointments in their service areas that have an equity focus and an indirect reporting line to the MHS Director. These include:

- Māori Cancer Nurse Coordinator (Provider Services);
- Project Manager (Provider Services);
- Principal Advisor – Equity (People, Culture & Capability); and
- Principal Advisor – Equity (Allied Health, Scientific & Technical).

It is expected that our equity and Taurite Ora work programme will pick up pace with the addition of these committed resources.

Chief Information Officers (CIOs) are taking this kaupapa forward to Chief executives. General Manager Māori are to consult with their partnership boards and feedback to the CIO.

3.1.1 Communications

#ProtectOurWhānau

Māori Health Development Group has been developing a Māori communications programme in collaboration with the 2DHB Communications team.

The #ProtectOurWhānau, #TiakiWhānau reflects the elements of whānau, pepi, tamariki, taiohi, matua, kaumātua. The messages, premised on Māori korero, are about wellbeing and family connection speak to the whānau collective as well as members of a whānau or hapori (community).

The new campaign has been launched on CCDHB social media channels, encouraging whānau to be well, stay well and live well.

Pātaka Miraka

MHDG has been working with NICU in their development of the Pātaka Miraka (Mothers Milk Bank) initiative. A draft image is being considered for use in marketing the programme

3.2 Information Technology Initiatives

3.2.1 Ethnicity Data working party

While this group has not convened yet, we have made progress by updating ethnicity data collection across the projects that we are already involved in, this means that ethnicity coding will be applied to all Reports of Concern (ROCs) entries and for all referrals to the Maternal Wellbeing Group. Tis project is a priority in terms of measuring our performance against the workforce targets agreed between DHB's and Tumu Whakarae (the national body representing Māori executive directors across the 20 DHB's).

3.2.2 Tumu Whakarae - National Māori General Managers for all District Health Boards

As reported above we have engage a new position that spans both Hutt Valley and Capital & Coast DHB's, and is responsible for developing and managing an equity focussed information base that reflects a strong Matauranga Māori perspective. His employment began with us at the end of February 2021. His primary focus so far has been:

- performing a data audit of better understand our data landscape and how well it currently serves our specific data requirements;
- engaging our key data stewards & data consumers to better understand our specific research questions, data requirements going forward & what data silos are out there; and
- using our CC & HV Structured Query Language databases (SQL) to start performing deeper data dives on currently reported metrics to explore the more subtle behaviours within our Māori & Pasifika patient universe.

District Health Boards hold a wide range of data from patient specific data, whole of community data as well as corporate level information relating to everything from finance, human resources through to strategic direction. A paper on Māori Data sovereignty, with consideration to Te Tiriti o Waitangi, was tabled at the Central Region Māori Managers forum.

The paper noted that the following needed consideration with regard to Māori data sovereignty:

1. Māori data governance needs to be considered as it applies to Article One of Te Tiriti o Waitangi.

2. Article Two of Te Tiriti o Waitangi is required to be upheld, in particular the acknowledgement and active recognition of Rangatiratanga and Taonga in relation to Māori data.

3. Data projects, systems, policies, legislation; the principles of Te Tiriti o Waitangi require Co-Governance, Co-Design and Co-Innovation, particularly:

    a. Partnership: interactions between the Treaty partners must be based on mutual good faith, cooperation, tolerance, honesty and respect;

    b. Participation: this principle secures active and equitable participation by tangata whenua;

    c. Protection: government must protect whakapapa, cultural practices and taonga, including protocols, customs and language.

4. It should be noted that when the concept of Taonga and Whenua (wenua) are applied, as described in Article Two, Māori custom does not see a difference. Māori data, as a Taonga, has the same sort of connections as a land does, but it is just a different format.

5. To protect Māori data we need to recognise that it is collectively owned by whanau, hapū, iwi and Māori organisations. Not one individual can own our data, or should own our data.

6. No non Māori individual or group can own Māori data.

3.2.3 Whānau Care Services

Whanau Care Services continues to provide clinical and cultural support to whānau in hospital. As part of this we are working with Maraeroa to develop a whare ki whare contract to strengthen the

link between primary and secondary care. The intention is to have patients with Long Term Conditions (LTC) being successfully managed in the community and reducing hospital admissions. The service also continues to provide services in coronary care; this includes working with patients in the wards and outpatients as well as following up with those who do not attend their outpatient appointments.

The team is evolving to align the services with the priorities identified in Taurite Ora. This has included working with the Decision Support Unit (DSU) to develop easy to use reports such as Figure 1 - Whanau Care by ward. The colours identify the frequency of admission and the words Identify which patients have previously had Whānau care involvement. This chart is updated daily and sent to the Whānau Care team who use it to follow-up the high priority patients and, subject to workload, see other patients as well.

Figure 1 Whānau care by Ward

The Whānau Care team has been working with the Patient care facilitator to find ways to capture the informal feedback the team get from the whānau they work with. Often whānau do not want to make a formal complaint and the opportunity for the DHB to learn is lost. We have discovered the SQUARE information collection system enables these to be recorded which will improve reporting on Māori Patient experiences of health care.

The Whānau Care team manager has also become involved with a number of CCDHB Provider services. This is to ensure Whānau Care services are aware of and contribute to initiatives within the hospital services. This includes:

- Monthly Hospital Health Services (HHS) management meeting. The purpose of this meeting is to discuss operational issues and decisions for the Hospital services;
- Choosing Wisely - This is a CCDHB group that considers and implements improvement initiatives such as Wound Stewardship, CHRISP Clinic, Pharmaceuticals – Oversight group Bariatrics;

- Perioperative Mortality Review. This is a joint programme sponsored by the Choosing Wisely group and ED. The aim of this group is to take the research on perioperative mortality and change practice on the assessment and treatment of Māori patients who present with abdominal pain are managed; and
- Did not attend committees (DNA). There are a number of service initiatives to address the DNA rates for Māori

4. Strengthening our commissioned services

4.1 Māori and Pacific Midwifery

CCDHB have contracted a Māori and Pacific Midwifery Continuity of Care team aimed at:

- Retaining and attracting Māori and Pacific midwifery expertise to work in the Porirua community and ensuring a high percentage of their caseload are Māori or Pacific babies;
- Enhancing the health experience and outcomes of Māori and Pacific pregnant women and their whānau/families. This includes providing flexible, culturally responsive midwifery care to women during their entire pregnancy including antenatal, intrapartum and postnatal periods; and
- Partnering with other kaupapa Māori services, such as wahakura wānanga, and the DHB to improve health outcomes for Māori and Pacific women and their babies.

4.2 Māori and Pacific breastfeeding

CCDHB has contracted a breastfeeding education specialist service to develop and deliver a programme of specialist breastfeeding education that will build a community of support for Māori and Pacific women on their breastfeeding journey. This programme will work along Māori and Pacific communities to provide breastfeeding education in a cultural appropriate and community context, involving the wider family/ whānau. CCDHB is also supporting 4 women, including 2 Māori women, to complete their Lactation Consultant qualifications, to increase the Māori Lactation Consultant workforce in the community.

4.3 Taineke Mobility Programme

CCDHB are in the process of funding a mobility wellness service that prioritises Māori and Pacific Island people, and people with community services cards (CSC holders) that are living with a musculoskeletal health condition.

The service aims to assist people at all stages of their condition. However, the main focus is on people who need advice and support to manage their symptoms before they have deteriorated to the extent that they may need hospital level care/surgery, for example a hip or knee replacement.

The service is about working with people and whānau to understand their situation, discussing the options available so they can make more informed decisions and; together developing the most appropriate care for their needs. Through this process the service will target investment to those who most need it, and create a model of care that reflects the clinical needs, cultural needs and preference of individuals and whānau. The service will focus on areas where there are pockets of inequitable outcomes; most commonly for Māori, Pacific Island people and; whānau living in areas of high deprivation, particularly in Porirua.

4.4 Whare to Whare Kaiarahi – Navigation service

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

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

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

This will be done by supporting individuals and their whānau to navigate the health system from their Whare back to their Whare in a way that meets their needs and accesses the right resources at the right time. The overall goals of the Service will be to:

- Support Māori who are primarily based within Cannons Creek and Waitangirua, it can extend further across Porirua;
- Embeds a Whānau Ora model of support;
- Supports whānau to stay healthier at home;
- Provide navigation and support into hospital, where required, and improves the follow out from hospital for whānau to their home; and
- Provide effective and efficient integration and linkages with providers and other agencies.

4.5 Māori Influenza and Measles Vaccination Programme (Insert 4.5, Indicator 2)

In response to the Ministry of Health's announcement, CCDHB have been invited to, and MHDG are developing a funding application for the Māori Influenza and measles vaccination programme. This is an extension to the Māori influenza programme from last year. The goal of this integrated immunisation kaupapa is to increase immunisation among whānau and address inequities between Māori and non-Māori rates of immunisation.

The Government has made available up to $8.4 million in 2021 for DHB and Māori health providers to deliver services that increase access to the influenza and measles, mumps and rubella (MMR) vaccines for Māori who meet the eligibility criteria, especially:

- Kaumātua over 65 for the influenza vaccine; and
- Rangatahi, 15-30-year olds for the MMR vaccine.

This funding enables providers to implement clinically safe, culturally responsive and community-centric influenza and MMR vaccination approaches that achieve the greatest possible outreach across their Māori population. Services may include pop-up clinics, drive-through vaccine stations, 'door to door' or other innovative services.

This programme of work will run in collaboration with the current DHB Measles immunisation programme targeting Māori.

It is planned that services for the 2021 MIMVP will run from 14 April to 31 August 2021.

5. Maternal, Youth & Child

5.1 Increase Māori engagement with the Maternal Wellbeing & Child Protection group and review processes and structure

To be updated.

5.2 Childrens Hospital website

MHS co-led the review of the Health Literacy: Communications and information activity. As part of the activity we reviewed the wellington children's hospital webpage. We based the review on the perspective of a caregiver bringing a child to an outpatient appointment at a children's clinic – we found that the webpage could be improved by providing more information about location, parking and parking costs, specific information about clinics and how to reschedule appointments. We also wanted to update it with photographs of children that reflected the diversity of our population and move the contact information to the top of the page to make it immediately accessible.

To help us do this, we engaged a Māori Communications expert to provide advice and recommendations. The page is live and we will review user data after 12 months to consider whether further improvements are needed. Figure 2 is a snapshot of the contact information is here:

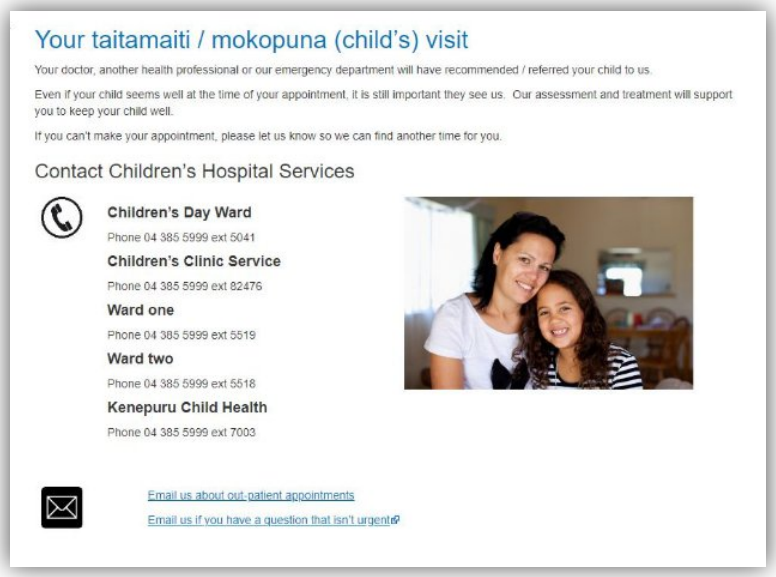


Figure 2

5.3 Health Literacy Project

Low health literacy is a contributing factor to Māori health disparities identified in Taurite Ora. Improving communication of key health messages in ways that meet the needs of those with the lowest health literacy and ensuring these patients and whānau leave appointments knowing what to do, how to do it and why they need to do it, is expected to be an enabler of improved health for Māori and other groups within our population, and result in more efficient spending of the health dollar.

Working with the Maternal, Youth & Child service, we carried out a mini –review which was completed in November 2020 – figure 3 shows the front page of the report

The main goals of the review were:

- Establish current health literacy capability of the Children's health workforce;
- Conduct a basic health literacy assessment for a sample of patients/whānau attending children's clinics (including Māori patients/whānau);
- Identify effective communication strategies for patients and whānau; and
- Use the review findings, in combination with previous review findings, to develop a health literacy education approach tailored for the Children's health workforce.

The next steps of implementation and a wider post-implementation review are planned for the next quarter once a Provider Services project manager has been appointed to work with MHS.

A copy of the Health Literacy project report is appended to this report:

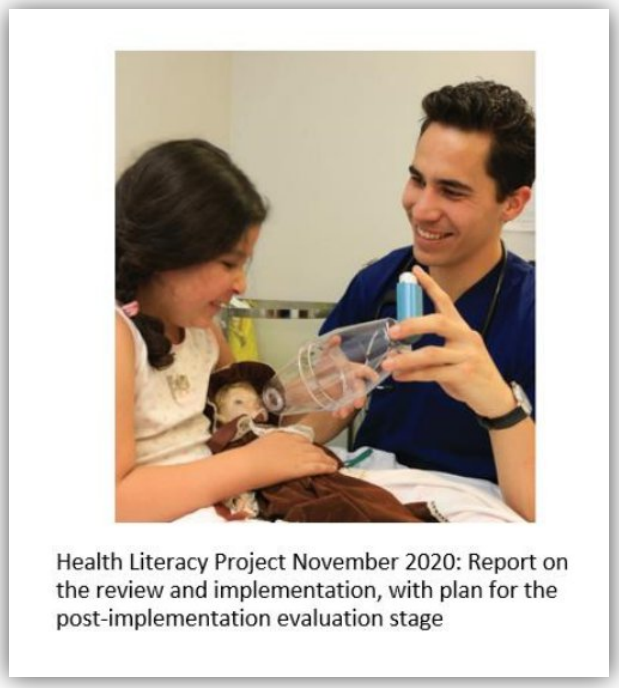


Figure 3

6. 2DHB Māori Health Dashboard: Measures of Equity

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

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

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

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

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

7. Appendix One: 2DHB Māori Health Dashboard

Systemic changes enable equitable health outcomes for Māori

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

Areas of focus

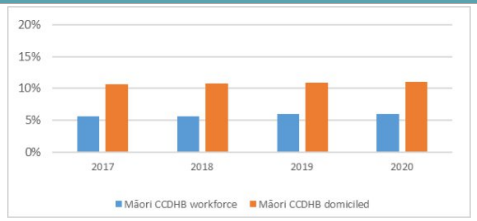
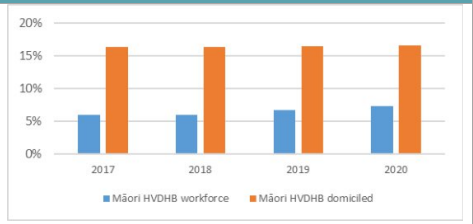
- DHBs as pro-equity health organisations
- Growing and empowering our workforce to have a strong Māori health workforce, and a workforce equipped to improve Māori health
- Strengthening commissioned services
- Accessible appointments

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

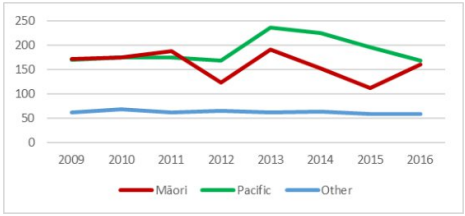
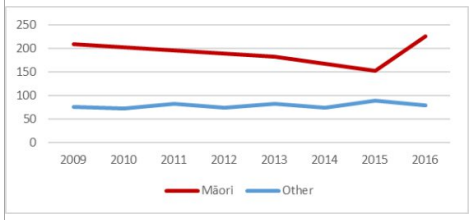
- Developing and committing to an Equity Policy
- Māori stakeholder engagement plan and enhanced partnership board engagement (MPB / MWRB)
- Māori workforce plan and recruitment strategy
- Cultural competency workforce plan
- Equitable commissioning policy

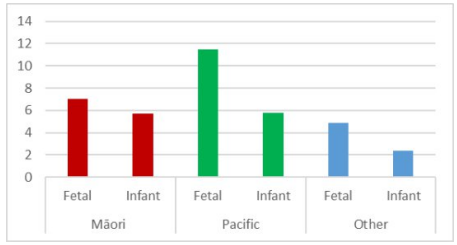
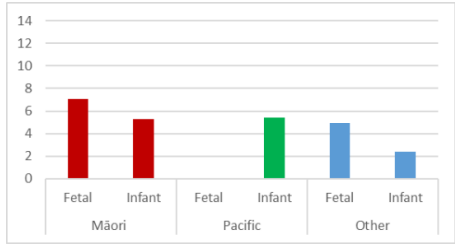
Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
Indicator 1: Māori workforce is proportional to the regional working population	An increase in Māori workforce is expected to improve cultural safety in the by both Māori and non-Māori staff, for both Māori staff and patients.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

Māori live longer lives

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

Areas of focus	**Sub-regional initiatives (2DHB)**
• Amenable mortality • Maternal, child and youth • Mental Health and Addictions **Links to Whakamaua: Māori Health Action Plan 2020-2025** • Objective 3: Reduce health inequities and health loss for Māori • Objective 4: Strengthen system accountability settings	• Wahakura wānanga programmes to hapū māmā and whānau, including focused messages around safe sleep, immunisation, breastfeeding, and smoking cessation • Co-designing MHA programmes with Māori • Long-term conditions

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

Indicator 3: Lower rates of Māori infant and foetal mortality	A healthcare system that provides equitable outcomes should not show differences in foetal/infant mortality rates for different ethnicities.	Māori infant and foetal mortality rates are equal to or lower than non-Māori rates per 1,000 (2017)			This is connected to initiatives on breastfeeding, immunisations, smoke-free homes, and safe sleep devices.

Māori have fewer avoidable hospital admissions

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

Areas of focus

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

Links to Whakamaua: Māori Health Action Plan 2020-2025

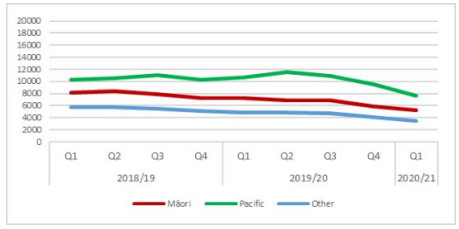
- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 3: Reduce health inequities and health loss for Māori

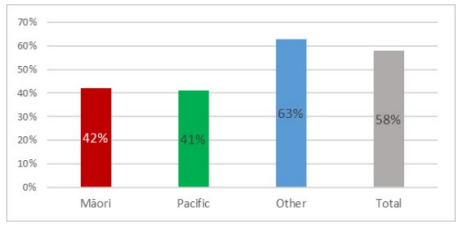
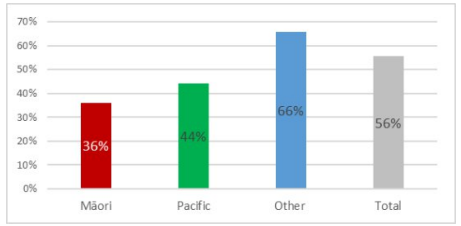
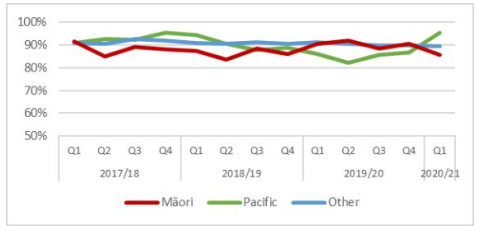
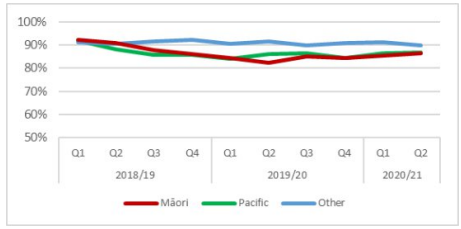
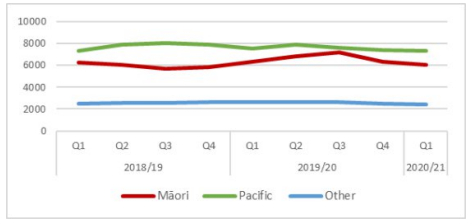
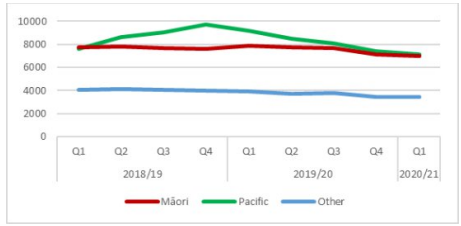
Sub-regional initiatives (2DHB)

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

Local initiatives

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

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

Indicator 2: Māori babies live in smoke-free homes	Babies living in smoke-free homes are expected to have greater health outcomes and reduced rates of hospitalisation.	At least 70% of Māori babies live in smoke-free homes			
Indicator 3: Māori babies are immunised	Children who receive immunisations can be protected from some illnesses that might result in hospitalisation. Māori tamariki are currently less likely to be fully immunised by age 5 than non-Māori children.	95% of Māori tamariki are immunised by age 5			WellChild data also includes data on breastfeeding and smoke-free homes and a range of other indicators by DHB.
Indicator 4: ASH rates (ages 45-64)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care intervention and Māori have been found to have higher rates than non-Māori, pointing to inequitable healthcare outcomes.	Reduction in Māori ASH rates by 6%			ASH data is not available for ages 5 to 44. While ASH rates may reduce comparatively for ages 5-44, we do not know how Māori are impacted in this age range. Acute hospital bed days data can be found here. Average inpatient length of stay data available here.

Māori have greater access to appointments

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

Areas of focus

- Accessible appointments
- Did Not Attend (DNA) rates

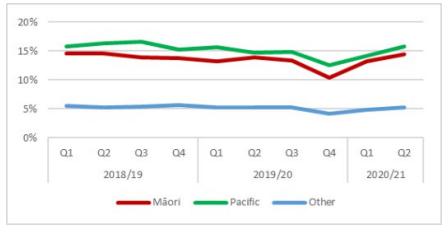
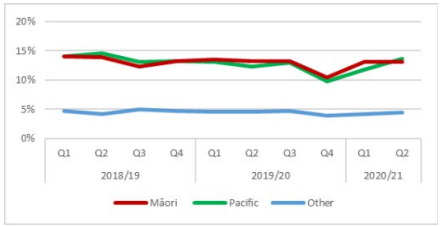
Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments

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

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

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

Areas of focus

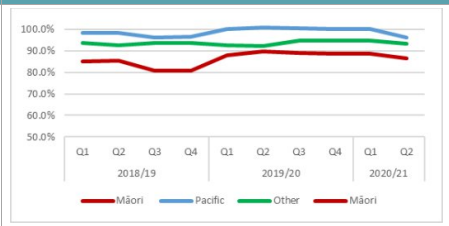
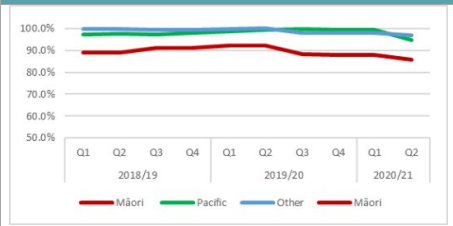
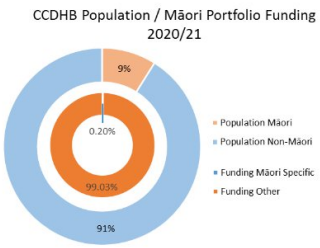
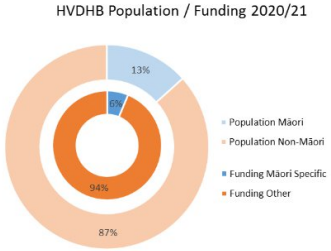
- Primary care and Māori health providers
- Community health services
- Co-design and partnership-based approaches

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

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

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

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

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Health Literacy Project November 2020: Report on the review and implementation, with plan for the post-implementation evaluation stage

Report prepared by Gayle Ryan

(Project Manager - Surgical Women and Children's Directorate)

File location: G:\CCDHB\Surgery, Womens and Childrens' Directorate\Quality Improvement\Projects 2019 20\Taurite Ora\Health literacy\Project docs

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Manakotanga - Acknowledgements

The author of this report would like to thank Mal Joyce, Andrew Marshall, Karen Bridge, Laura Ellis, Jeanette Harris, Arawhetu Gray, Melita MacDonald, Victoria Hollier, Ann Newby, Joe Zhou, Sony Indrawan, Cheryl Goodyer, Elizabeth Solomona, Rachel Noble, Louise Goosens, Sylvia Reyners and the many Children's Health staff who participated in the project – without your support the project would not have been possible.

"Ehara taku toa I te toa takitahi, engari he toa takitini – success is not the work of one but the work of many"

- Whakatauki author unknown

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Introduction to the Children's Health Services health literacy project

Health literacy can be defined as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions' (Selden et al, 2000). In practice, this requires that patients and their whānau leave every health appointment:

"knowing what to do, how to do it and why they need to do it"

In Aotearoa New Zealand 56% of adults are estimated to have poor literacy skills, with as many as 75-80% of the Māori population having poor literacy (MoH, 2010). Low health literacy is associated with poor health choices, less adherence with medical advice, increased hospitalisation rates, poor control of chronic disease and disease relapse (Connelly & Turner, 2017).

Low health literacy is a contributing factor to Māori health disparities identified in Taurite Ora, CCDHB's Māori health strategy 2019-2030. Improving communication of key health messages in ways that meet the needs of those with the lowest health literacy and ensuring these patients and whānau leave appointments knowing what to do, how to do it and why they need to do it, is expected to be an enabler of improved health for Māori and other groups within our population, and result in more efficient spending of the health dollar.

The Taurite Ora project mandate

Review progress and complete activities across the two work streams of the Children's Clinics Service Improvement Project:

Communication – information needs are identified and information is shared with consumers in ways that improve health literacy; information is developed and evaluated with consumers

Workforce – the health workforce are encouraged and supported to develop effective health literacy practices, their development needs are identified and performance evaluated

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Background to the Children's Health Services health literacy project

In 2014/15 CCDHB Children's Clinics participated in a Ministry of Health led health literacy review focusing on reasons for appointment non-attendance. The review highlighted the multiple health literacy demands placed on patients/whānau during a child's journey through the outpatient clinic at CCDHB (appendix 1) that contribute to non-attendance.

The review identified health literacy challenges for patients and whānau including; communication, navigation/access and unmet health needs. The review produced a set of recommendations, many of which were implemented.

The 2019/20 project began with a review of the 2014/15 review focusing on those recommendations with a status of incomplete or not started across the communication and workforce workstreams. What was discovered through this process was:

- Staff turnover and the four year time period had resulted in loss of documentation and organisational knowledge related to the activities
- Health Literacy training within Child Health Services was developed but not delivered widely or embedded within the service
- There has been no review of the impact of the completed activities within Child Health Services
- Other parts of the organisation have picked up some of the activities i.e. the SIP plain English letter re-design project
- Other priorities have developed for directorates, including PAS investment of resources in electronic patient communication and Child Health Service investing resources in development of the new children's hospital (limiting resourcing for this project).
- There were no specific actions related to improving health literacy for Māori

Due to the significant time period since the original review and some of the factors noted above, it was decided that a mini review was required to understand the current situation and obtain a baseline for improvement.

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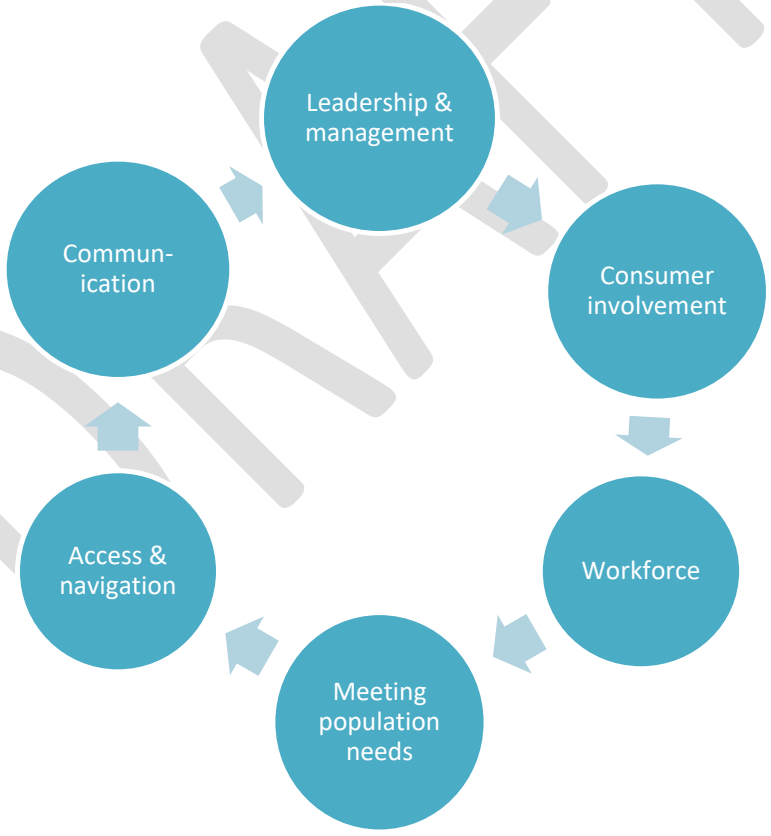
Part 1. Health Literacy Review Approach & Measures

Health Literacy Review: A quality framework within a Māori health equity context

A review of the Children's Clinics in Wellington and Kenepuru was carried out in March 2020. This consisted of clinic waiting room interviews with patient whānau and clinic observations. During February and March, Child Health Staff were invited to complete an online Health Literacy survey to assess their self-reported health literacy competence.

The review was planned and carried out using health literacy review guidelines (MoH, 2015). These guidelines draw from international best practice and form a quality framework for health literacy reviews. The New Zealand quality framework is based on the Six Dimensions of a health-literate organisation

Figure 1. Six Dimensions of a health literate organisation (MoH, 2015)



He Matapihi kit e kounga o ngā manaakitanga ā-hauora o Aotearoa 2019: A window on the Quality of Aotearoa New Zealand's Health care 2019 (HQSC, 2019) was also used as a guiding document to understand Māori health inequity and health literacy in the national context. This document highlighted that improving health literacy and communication is just one factor contributing to improved health literacy and health equity within the community.

Figure 2. HQSC view of equity & Māori health (HQSC, 2019)

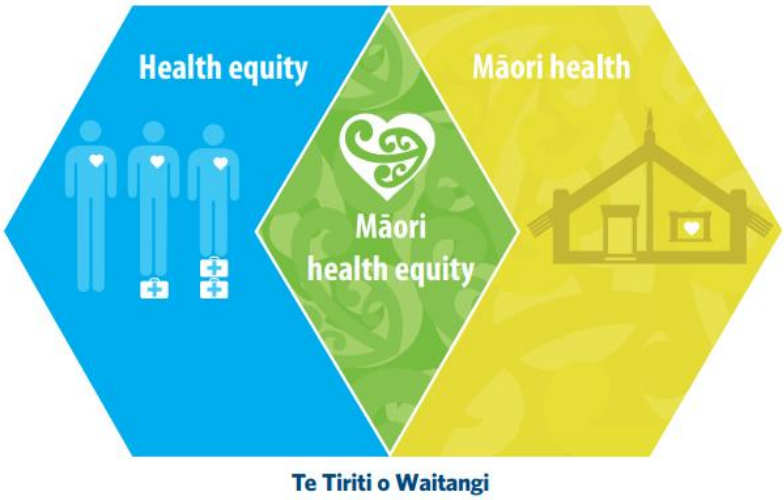
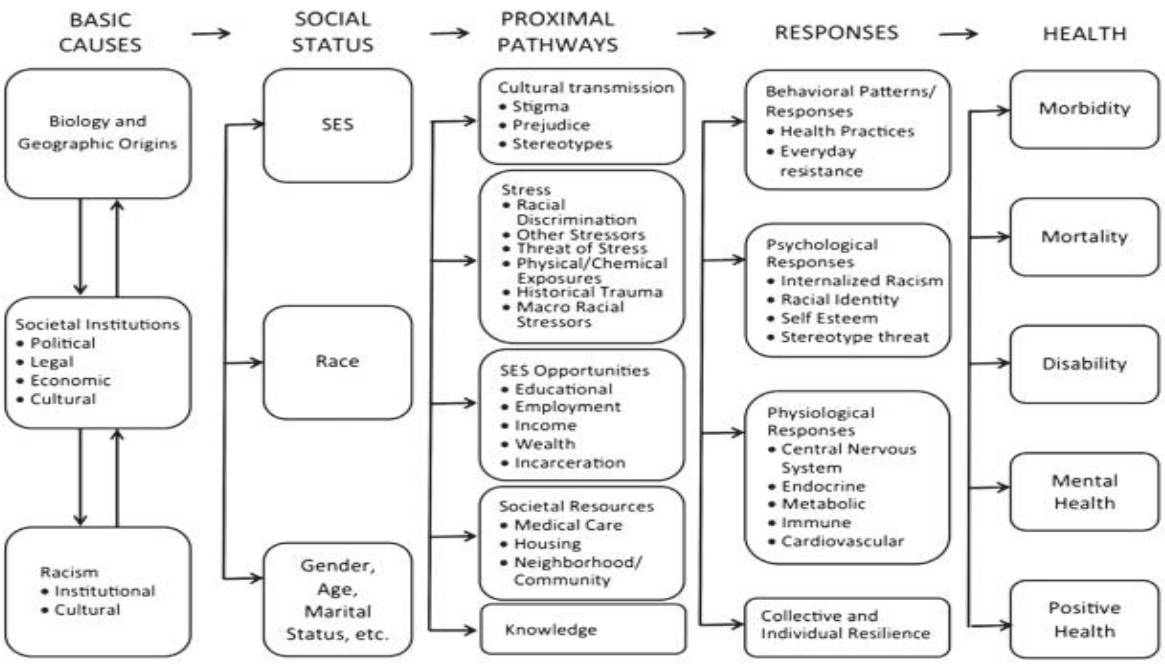


Figure 3. Williams & Mohammed's model of societal-level determinants of health inequity (HQSC, 2019)



Goals of the review

The main goals of the review were:

- Establish current health literacy capability of Children's health workforce
- Conduct a basic health literacy assessment for a sample of patients/whānau attending children's clinics (including Māori patients/whānau)
- Identify effective communication strategies for patients and whānau
- Use the review findings, in combination with previous review findings, to develop a health literacy education approach tailored for the Children's health workforce

Establishing the current state

The main driver of the re-review was to establish the current, or baseline state. This evaluation included consumer interviews/surveys, staff surveys, clinic observations and conversations with clinicians on the subject of health literacy. Information on the ethnicity of consumers was gathered to enable us to evaluate Māori participation and voice within the review. The survey questions, clinic observation guide and all the results of the February and March 2020 review can be found in Appendices 2 to 7. Summary of the key findings are below:

Children's Health workforce survey summary of key findings:

- 70% respondents agree or strongly agreed that low health literacy has a significant impact on how effectively they were able to communicate important health information
- 100% of respondents agreed or strongly agreed that health professionals play an important role in building health literacy
- Only 45% of respondents agreed that they could recognise someone with low health literacy
- Only 41% of respondents agreed that they had a range of strategies to communicate effectively with someone with low health literacy
- No respondents reported using *ask, build, check*
- Only one respondent reported using *teachback*

Consumer/whānau clinic interviews summary of key findings:

- 100% of respondents reported being either confident or very confident filling out hospital forms without help from others, suggesting good levels of health literacy.
- 88% of respondents were clear about what the appointment was for.
- 88% of respondents reported that they let health staff know when they did not understand something

Of note

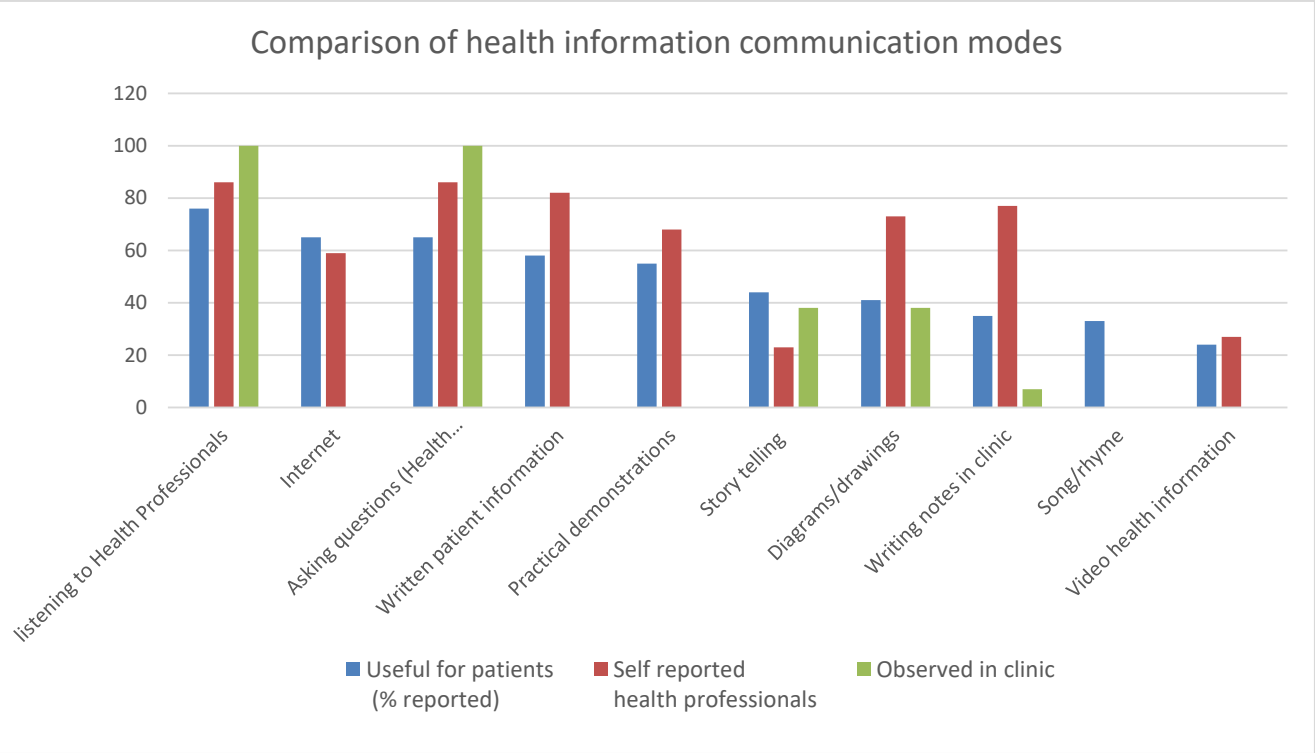
It was noted that whānau presenting in the waiting room had generally good to high levels of health literacy and may not accurately reflect the local population. It is also noted that 24% of consumers interviewed self-identified as Māori.

Comparison: what staff & consumers/whānau believe supports better health literacy and clinic observations

What patients/whānau and clinicians report as useful to support better health literacy/clinical communication showed agreement in many areas. Areas where differences were seen included whānau placing higher value on story telling and use of song/rhyme to effectively communicate health information. Clinicians tended to place a higher value on providing written notes, drawings/diagrams and written patient information (pamphlets) to whānau.

Clinic observations showed that there was a high reliance on verbal communication methods during clinics. This verbal communication was delivered in manageable chunks and in logical steps. The language used by the clinician was appropriate with all technical terms explained to whānau. Clinicians were observed using storytelling to communicate health information at higher levels than they self-reported. What was significant was that no written patient pamphlets or practical demonstrations were provided to whānau during the observed clinic appointments. No health websites were accessed or referenced and no health videos were shown to whānau.

Figure 4. Comparison of communication of health information by perceived usefulness and observed in clinic



Review recommendations

Based on the 2020 health literacy review was recommended that:

- Health professionals are provided *Ask, Build, Check/Teachback* training within the DHB & use *Ask, Build, Check/Teachback* during clinic appointments
- Children's Health Services source or develop patient information sheets suitable for those with low health literacy for common paediatric conditions and procedures and/or provide patients' access to a list of regularly updated and NZ MoH approved health websites for common childhood problems and medications (including Google search terms).
- When a patient/ whānau are given a new diagnosis or new information (i.e. change in medication) clinicians provide follow up information via approved health websites and / or patient information sheets
- All resources and training developed are evaluated by whānau, including Māori and disability representatives

Part 2. Implementation

Implementation of the review recommendations within the two health literacy workstreams (communication and workforce development) was carried out through two separate projects:

- **Review and update of the Children's Hospital website using a health literacy approach.** The focus of the website review and update was clear communication of information about the service to whānau including service approved websites to support clinical communication.
- **Development and implementation of a workforce health literacy education package**. The focus of the health literacy education was improving workforce health literacy capability and general awareness.

Due to limited resource availability within Children's Health Services, patient information sheets were not able to be developed as part of this project. However, the face to face health literacy education sessions were designed to encourage staff to critically reflect on the patient information sheets in use. It was hoped that this would lead to staff developing resources as part of professional development/career progression activities.

Each of the two projects is described below.

Review and update of the Children's Hospital website

INTRODUCTION

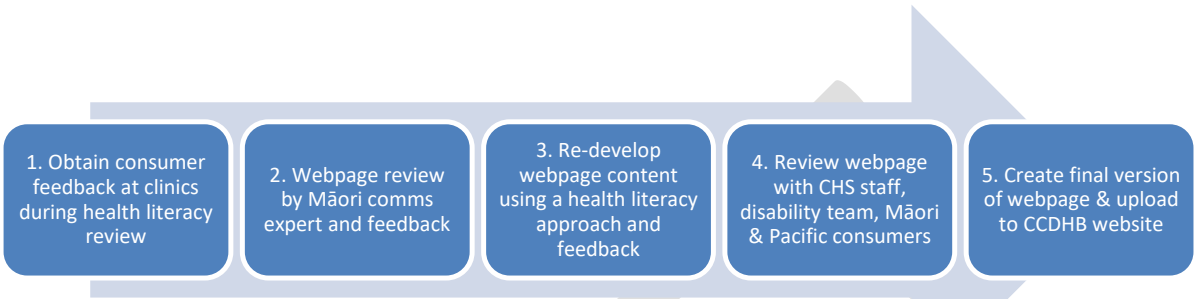
The aim of updating the Children's Hospital webpage using a health literacy approach was clear communication of information about the service to better support whānau access and use the service. The focus was communicating what whānau could expect from the service, how to find the service and information on parking. We chose to review and improve this information as whānau clinic interviews highlighted potential access barriers for those with low health literacy making it to the clinic for the first appointment. Improving the information on the website is anticipated to better support patients and whānau access the service by reducing the health literacy burden.

THE APPROACH:

A five step approach was used to develop the new webpage. The first step involved obtaining whānau feedback during the review. The second stage saw Māori communications specialist, Nicky Birch,

contracted by the Māori Health Development Group to review the webpage from a Māori perspective. Feedback from Nicky included use of te reo Māori and changing the look and feel of the webpage to make the Children's hospital appealing to Māori whānau. Appendix 8 shows the original webpage and some of the feedback from Nicky Birch.

Figure 5. Approach used for the webpage re-design



Stage 3 involved a re-write of the webpage using the Rauemi Atawhai guidelines as a reference and incorporating whānau feedback. We organised a photoshoot in the Children's hospital, supported by Louise, the hospital photographer, Sylvia in comms, ward one and two staff, patients and their whānau. The aim was to address Nicky's feedback and change the banner photos to ones with a positive wairua as the original banner showed empty rooms. The children were very enthusiastic about wanting to have their photos on the new webpage. The new draft was sent to a variety of DHB staff including Māori health and the disability team. Lots of feedback was provided, including the requirement for an email to support deaf whānau communicate with the service. The new site was also shown to Māori and Pacific consumers. Consumers were asked a number of questions including; would you use a webpage? would you want to read it? who needs this information? what are the main messages? what is clear/unclear? what is missing? The feedback informed us that not all consumers would use a webpage, but for those who would, the information was clear and covered all areas they would need to know about. Stage five involved review of all the feedback and creation of a final version of the webpage (Appendix 9). Rauemi Atawhai recommends evaluation of the resources in use and this will be incorporated into the evaluation stage of the project.

Development of health literacy education package

We used the health literacy education developed by the Health, Quality and Safety Commission (HSQC) three steps to better health literacy education and resources as the basis for the education to support consistent messaging. The resources were freely available nationally and used by other several other DHBs.

Consideration of the health workforce required a flexible approach to education. Health workers can be shift workers and different workforce groups (medical, nursing, allied health and administration) have different education preferences and access to education. The project budget did not include any resource for external education and very limited internal education resource was available due to other Child Health Service commitments. Wanting to reach as many of the workforce as possible with our limited resource we decided on a multi-modal approach outlined in figure 6 below. Communications about the education were sent via emails within the service and daily dose (organisational wide) communication. Flyers were produced and put up across Children's Health Services.

Figure 6. Child health services health literacy education package

1. FACE 2 FACE SESSIONS: a three week health literacy education course was developed by the nurse educators (Victoria Hollier and Ann Newby) in Children's Health Services (CHS). These education sessions were supplemented by a short 15 minute introduction to health literacy session delivered to CHS leadership, senior nursing, SMO and RMOs at service specific meetings with the dual aim of

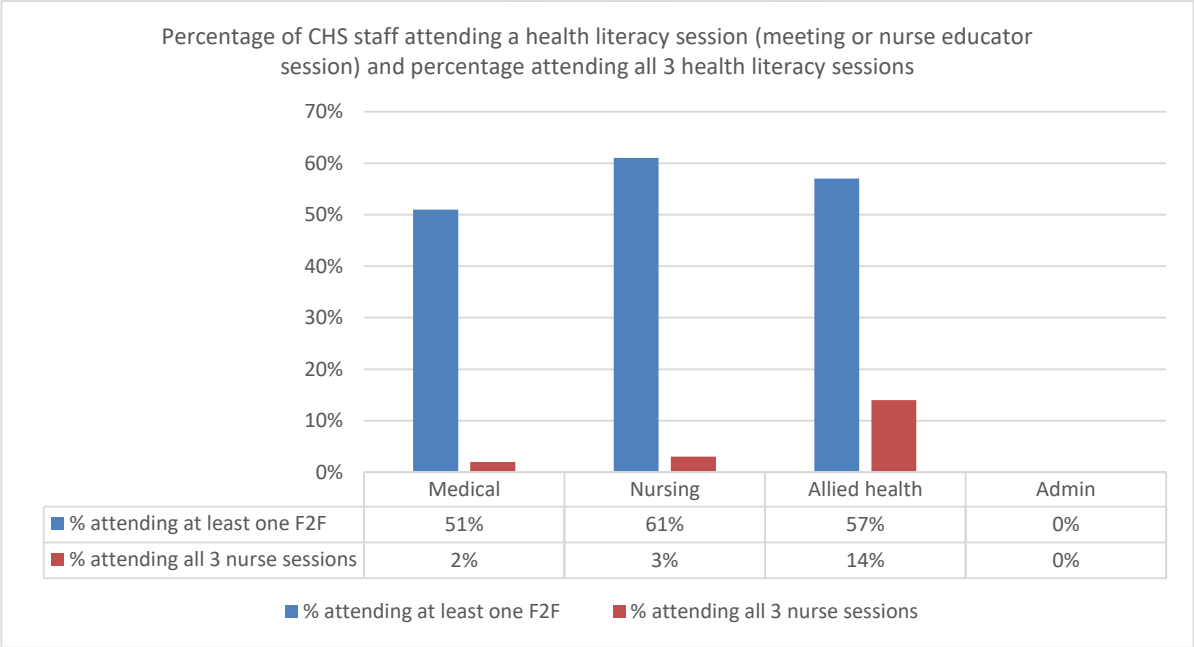
both promoting the nurse educator led sessions and providing a basic introduction to health literacy and the Ask, Build, Check tool to those unable to attend the nurse led sessions.

Nurse Educator sessions overview:

- Week one - an introduction to health literacy and the CHS project
- Week two - introduction to health literacy tools
- Week three - a practice session using scenarios to apply health literacy tools.

The health literacy education sessions ran in October and November 2020 and a Zoom option was provided for staff in Kenepuru and other locations to access the session. A QR code was provided to staff to provide feedback. An additional SMO/RMO session that combined sessions 2 and 3 was requested and is planned to be provided in December 2020.

Figure 7. Percentage of CHS workforce attending at least one health literacy session (at a meeting or nurse led education session) and attending all three health literacy sessions (as of November 2020)

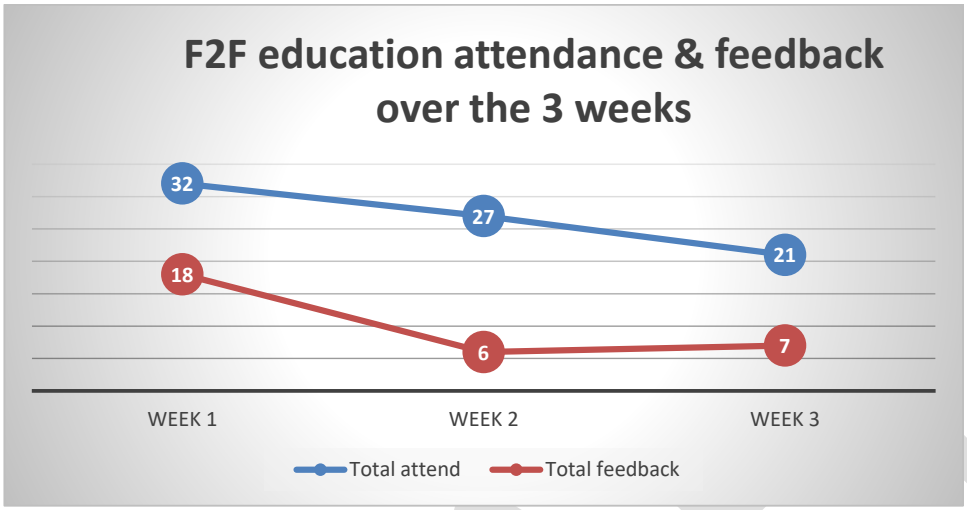


	Medical	Nursing	Allied health	Admin
% attending at least one F2F	51%	61%	57%	0%
% attending all 3 nurse sessions	2%	3%	14%	0%

Whilst numbers attending at least one health literacy session (either the short introduction or one of the nurse educator led sessions) was at least 50% for all groups (with the exception of administration), the percentage attending all three health literacy sessions was much lower. The decrease in staff

attending sessions over the three weeks was notable. Reasons for this are unclear as whilst the feedback gathered via the QR code was positive, the numbers providing feedback also dropped off.

Figure 8. Nurse led Face to face (F2F) session staff attendance and numbers providing feedback

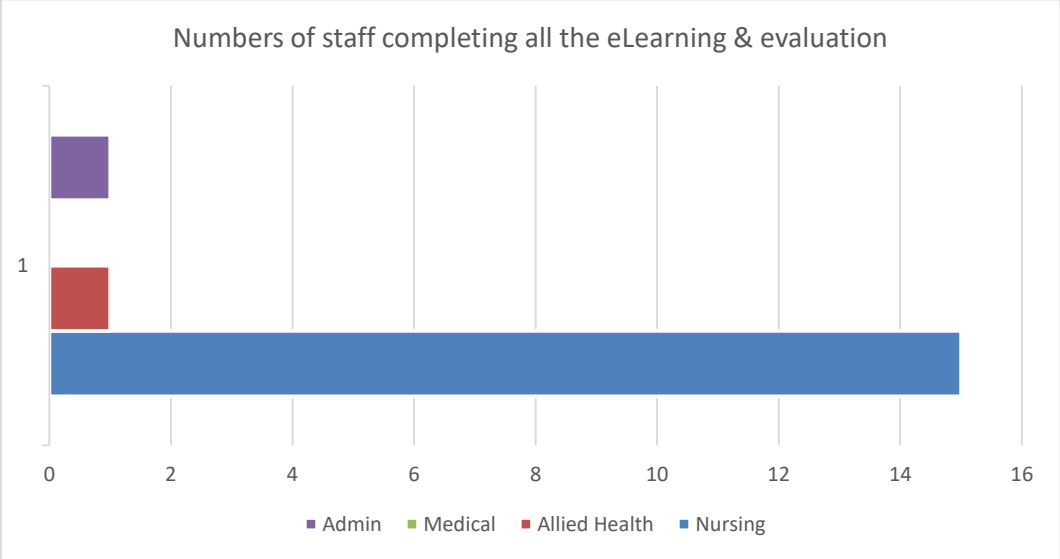


2. ELEARNING VIA CONNECT ME: health literacy eLearning developed in Hawkes Bay DHB and freely shared on KoAwatea LEARN was adapted for CCDHB by Capability development following consultation with Māori and Pacific health teams. The Health literacy learning comprised four 15 minute modules covering:

- What is Health Literacy?
- Organisational Health Literacy
- Communication
- Tools to Improve Health Literacy

The eLearning was open from October and on completion of all four modules, participants were invited to complete an eLearning evaluation. The evaluation questions asked how the eLearning impacted understanding of health literacy, organisational health literacy, how communication can influence an individual's health literacy, understanding of health literacy approaches and tools. Only a small number of staff (17) completed the four eLearning modules and evaluation. Nursing were the pre-dominant group completing eLearning, with the medical workforce acknowledging the eLearning is not traditionally a learning media they engage with. Connect Me is also a self-identified challenge for medical staff.

Figure 9. Number of staff completing the eLearning and evaluation November 2020



The results (available in Appendix 10) showed that the eLearning increased understanding of health literacy, health literacy, approaches and tools in over 80% of staff completing the evaluation.

3. HEALTH LITERACY RESOURCES - the Health Quality Safety Commission (HQSC) provides free resources to health professionals. We used the HQSC 'Three steps to better health literacy – a guide for health professionals' the HQSC 'Let's P.L.A.N. for better healthcare' as well as developing some in-house lanyard cards. Resources were available at all the face to face sessions and also at Children's health leadership, SMO, RMO and nursing meetings during October and November. These resources were made available during sessions for staff to take away. It is recommended evaluation of the resources be included in the post-implementation review by including a question in the staff survey related to the specific use of each of the resources provided.

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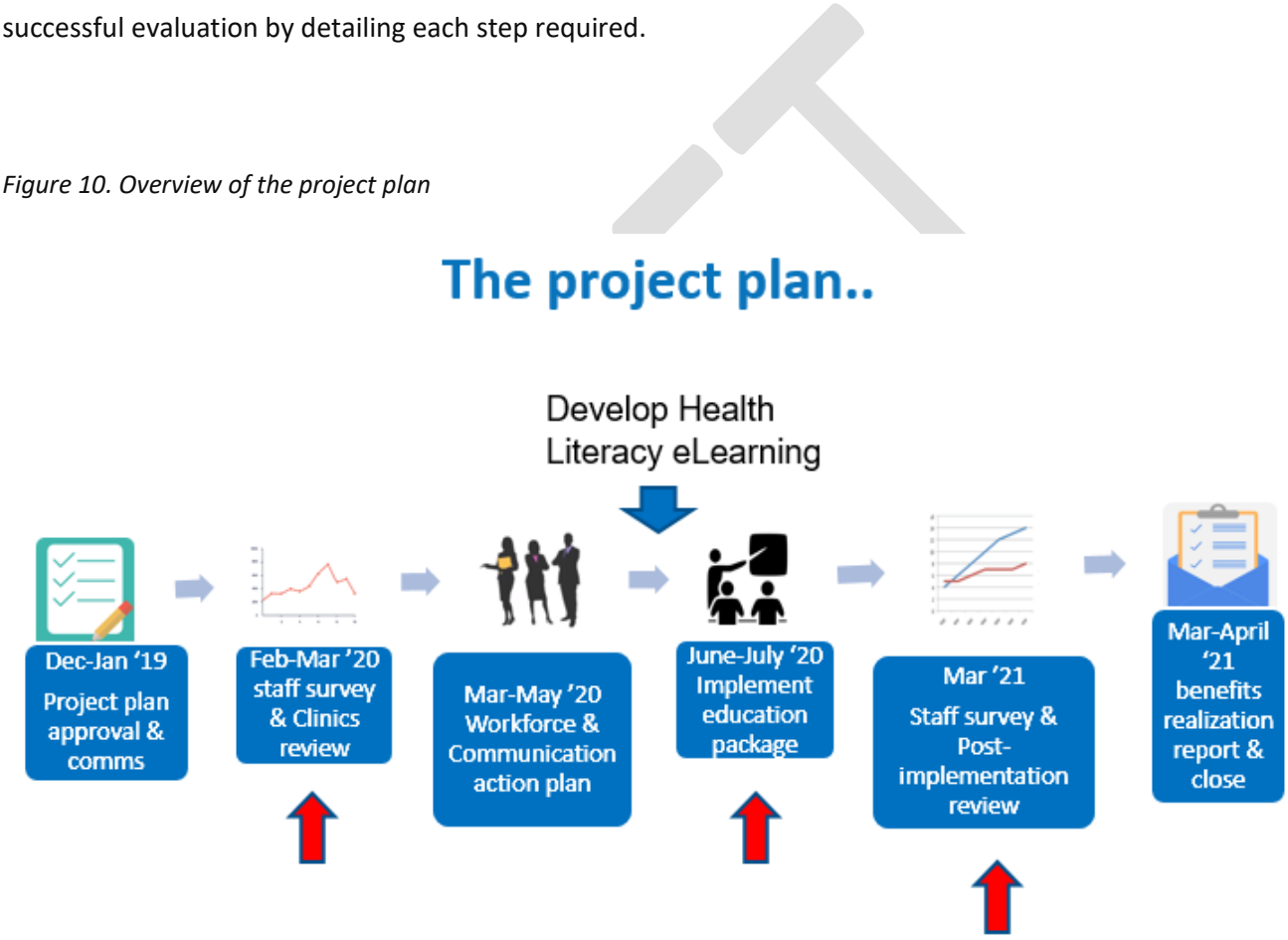
Part 3 Planning next steps – post-implementation review March 2021

The project plan is outlined below. The next step requires a post-implementation review in March 2021. The review requires a repeat of the staff survey, clinic review, consumer interviews in clinic and consumer review of the website. As Children's Health Services have limited resource and the project is part of the Taurite Ora Māori Health Strategy, it is recommended that Māori health are best placed to carry out the post-implementation review and evaluation. This report and the evaluation plan aims to support a successful evaluation by detailing each step required.

Figure 10. Overview of the project plan



A plan for the post-implementation review is outlined below:

Step 1. Repeat the staff survey

The questions used in the original staff survey, carried out using Survey Monkey are available in appendix 5. The survey was open during February and March 2020. It is recommended that the survey be repeated in February and March 2021 with question 10 changed to a question related to engagement in the Health Literacy education package and resources and extra questions added i.e. "Did you attend any of the F2F sessions? Did you access the eLearning? Did you use any of the resources provided? (name the resources), and how would you rate the effectiveness of each?"

Evaluation of effectiveness will be determined by:

- Comparison of the number of staff completing the survey to judge engagement (the 2020 survey was completed by 22 staff members). The results of the 2020 survey can be found earlier in this document and via the Survey Monkey link.
- Comparison of questions 1-9 to compare staff understanding and self-described competency pre and post implementation
- Staff rating of the effectiveness of each component of the education package

Step 2. Repeat the clinic review

The March 2020 clinic review was a week where an observer sat in on clinics across Wellington and Kenepuru as well as interviewing patient whānau in the clinic waiting rooms. It is recommended that the clinic review be repeated using the same clinic observer guidelines (appendix 6.) and same patient whānau clinic interview questions (appendix 4.) to enable comparison with the original review findings.

Step 3. Webpage evaluation

To enable evaluation of the webpage there are two main approaches:

a) Add some extra questions are added to the patient whānau interview as part of the clinic review

The advantages of this option are that no extensive planning is required and you capture whānau using the service. The disadvantage is that you potentially miss the voice of those target groups; Māori, Pacific and those with low health literacy not accessing the service.

b) Organise targeted consumer workshops to review the webpage

The advantage of this option is that you can plan to capture the views of the target groups. The disadvantage is the extra time, resource and planning required.

A combination of both these approaches is recommended. Ideas for questions to support evaluation of the re-designed children's hospital webpage are provided below:

- Have you seen the Wellington Regional Children's Hospital webpage? (show page to ensure aware of the correct page and let them scroll through)
- Would you use a webpage to look for information about a service?
- What do you like about the page?
- What don't you like about the page?
- Does the page have the information you need to prepare for a visit to the Children's clinics? (if not what is missing)
- What would improve the page?
- What could be removed?
- Any other comments?

Part 4 Lessons learnt to date

Completion of the post-implementation review should provide a good evaluation of the effectiveness of the approach taken to health literacy within this project. It is recommended that the post-implementation review and evaluation be completed prior to organisational rollout to inform the approach taken. Lessons learnt from the project to date include:

- The CHS workforce recognise low health literacy as a significant challenge to effective clinical communication and many wish to increase their capability in this area
- Consumers provide valuable insight into health literacy challenges and should be included in development and evaluation on health literacy approaches and resources
- Consumers accessing the children's clinics exhibit relatively high health literacy (compared to the general population) indicating that health literacy barriers at earlier points in the system may be impacting access to specialist hospital services
- Effective and sustainable Health literacy workforce education requires resourcing to ensure workforce education is regularly provided and evaluated
- Face to face learning is the preferred learning for the medical workforce
- Flexible learning approaches are required to address workforce diversity including offering education at Kenepuru and Hutt hospital sites in addition to eLearning

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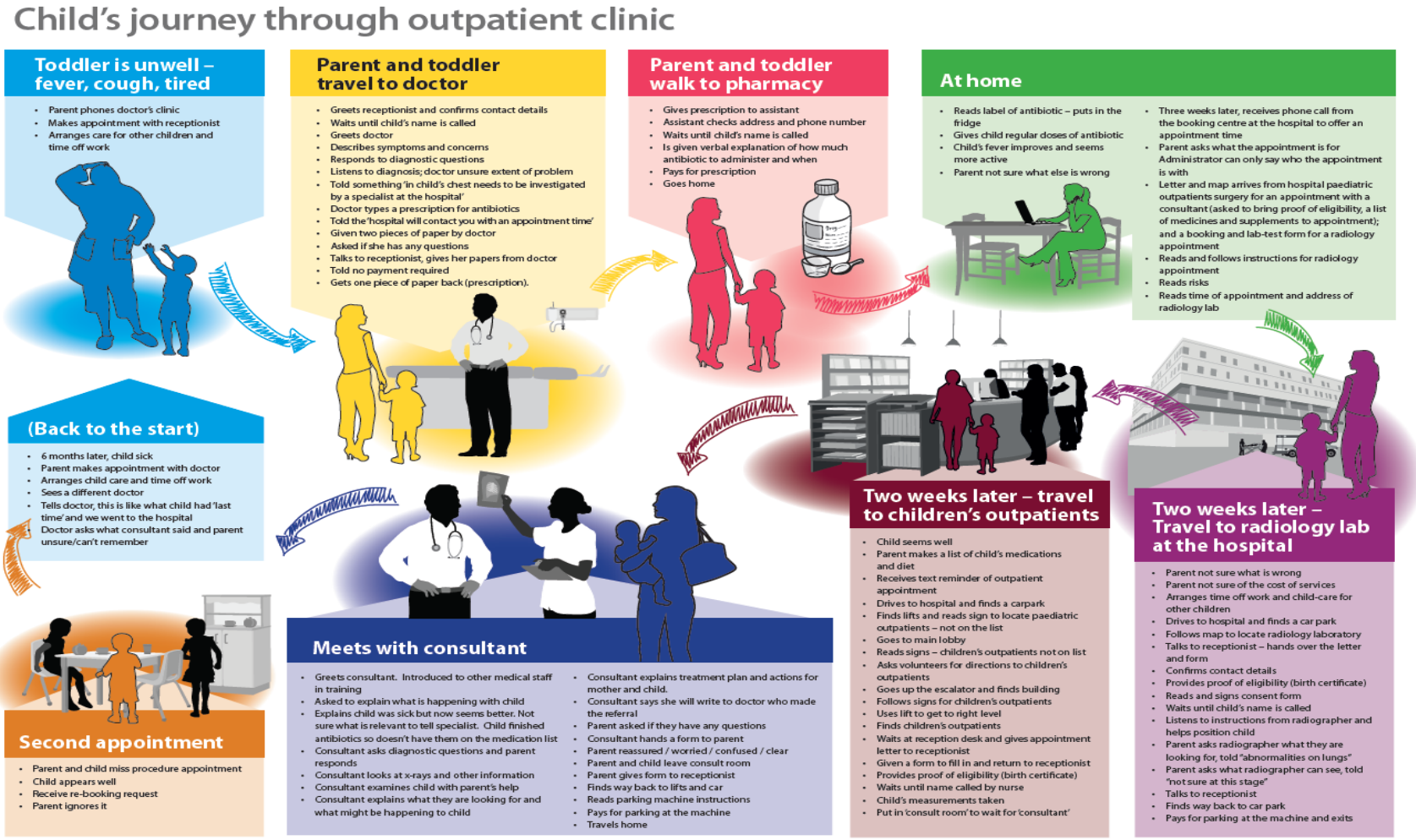
Appendix 1. Child's Journey through the outpatient clinic



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Appendix 2. Staff survey questions

CHS Health Literacy staff survey

The following is a short 3-5 min survey about staff knowledge and experience of health literacy. The aim is to find out what staff think, what supports/resources are used to help patients understand health information and what could be improved.

Top of Form

1. What part of the health workforce do you represent?

- Medical
- Allied Health
- Nursing
- Management
- Administration
- Other (please specify)

2. Low health literacy of patients/whānau has a significant impact on how effectively I am able to communicate important health information

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

3. Health practitioners play an important role in building the health literacy of New Zealanders

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

4. Every time information is given to patients or their whānau about health, it is an opportunity to check and build health literacy

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

5. If a patient/whānau doesn't follow instructions, this may be a sign of low health literacy

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

6. I can recognise when a patient/whānau member has low health literacy

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

7. I have a wide range of strategies I use with patients or whānau who have low health literacy

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

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8. Which of the following do you use in your clinic to help communication of health information to patients whānau(please tick all that apply).

- ☐ Talking to patients/whānau about their health
- ☐ Asking patients/whānau questions to determine their understanding
- ☐ Providing written notes or plans for patients/whānau to take away
- ☐ Drawing pictures/diagrams to explain health information
- ☐ Showing videos
- ☐ Providing paper based patient information sheets / health pamphlets
- ☐ Practical demonstrations of equipment/techniques etc.
- ☐ Using toys or puppets
- ☐ Using stories / story telling
- ☐ Using song / waiata or rhymes
- ☐ Accessing patient information from health websites
- ☐ Using Teach back
- ☐ Using Ask, build, check
- ☐ Other (please specify)

9. Please list any particular approaches or resources, websites, videos etc. you find very effective when working with patients/whānau with low health literacy

10. If you happy to be contacted to provide further feedback or participate in reviewing health literacy resources for clinics please provide your name

Name

Done

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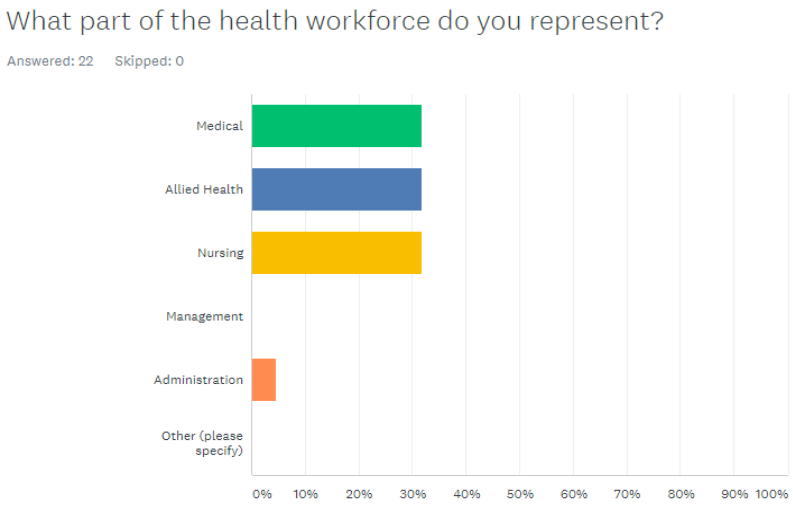
Appendix 3. Staff survey results

A staff survey was promoted within Child Health Services in March 2020. A small but representative sample of staff (equal mix of medical, allied health and nursing workforces) completed the survey.

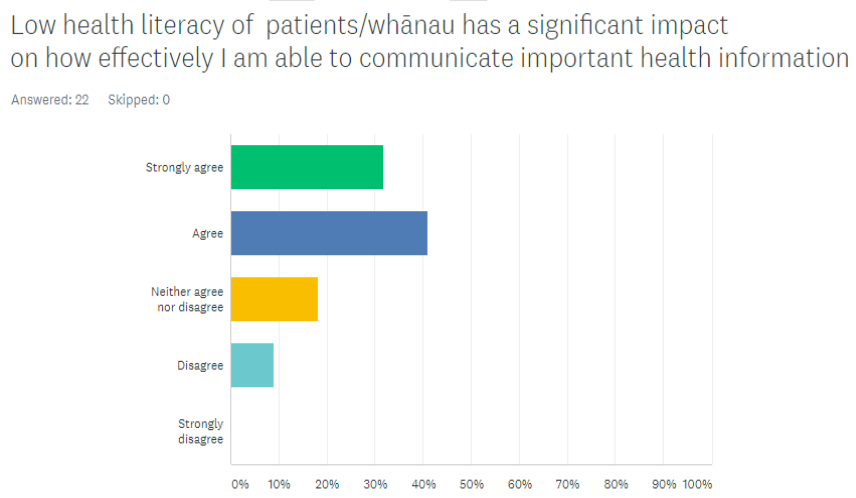
Figure 11. staff survey respondents by workforce



The impact of low health literacy on effective communication

More than 70% of respondents agreed or strongly agreed that low health literacy does have a significant impact on how effectively they were able to communicate important health information.

Figure 12. staff survey respondents view of impact of low health literacy on communication of health information



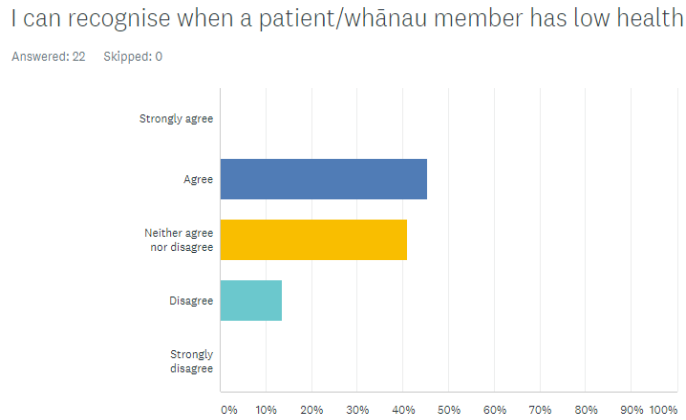
Health professionals' role in health literacy

100% of respondents agreed or strongly agreed that health professionals play an important role in building health literacy and that every time health information is given to patients of whānau it is an opportunity to check and build health literacy.

Health professional's health literacy capability

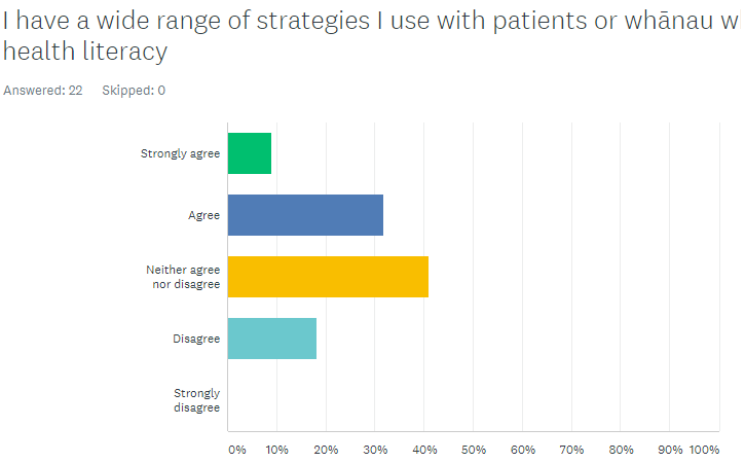
When asked about their ability to recognised a patient or whānau member with low health literacy, only 45% of respondents agreed that they could recognise someone with low health literacy

Figure 13.. staff survey respondents self-reported ability to recognise low health literacy



When asked about strategies used with patients or whānau members with low health literacy only 41% of respondents agreed or strongly agreed that they had a wide range of strategies to use to communicate effectively.

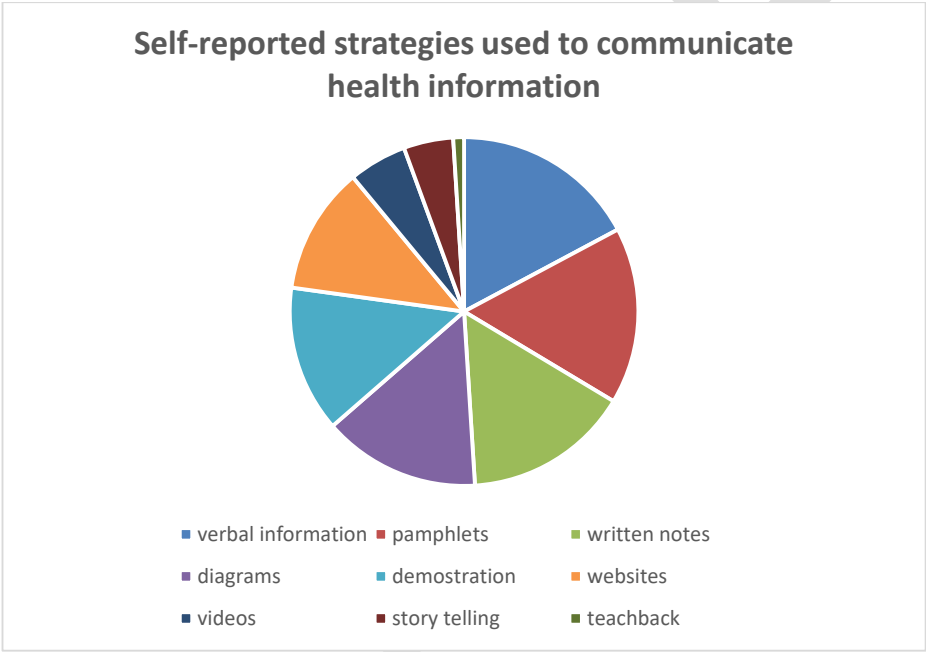
Figure 14. staff survey respondents self-reported strategies for communicating with those with low health literacy



Self-reported strategies to communicate health information

Of the self-reported strategies to communicate health information, providing verbal information in the clinic was the top reason reported (86% of respondents) followed by providing written health pamphlets (82% of respondents), written notes (77% of respondents) and diagrams (73% of respondents). These strategies are potentially less helpful for those with lower health literacy. Practical demonstrations (68% of respondents), use of health websites (59% of respondents), videos (27% of respondents) and story telling (23% of respondents) were also reported being used. These strategies may be more helpful to communicate health messages in those with lower health literacy. Of the HSQC recommended approaches to improve health literacy; *Teachback* and *Ask, Build, Check*, only one respondent reported using *Teachback* with no one reporting *using Ask, Build, Check*.

Figure 15. Staff self-reported strategies used to communication health information



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Appendix 4. Whānau interview/survey questions – health literacy review March 2020

Patient/whānau survey – Children's Clinics

The following is a short 3-5 min survey

We would really appreciate your thoughts about attending Children's Clinic appointments. The information you provide will be used as part of a project to make improvements in communication of health information at clinics. Your answers will be kept confidential, any information you provide will not be passed on outside the project or have any impact on the care you get at the hospital.

My participation in this survey/interview has been explained to me and I consent for my personal information being used for the Children's Clinics health literacy project ☐

1. Are you the patient or family/whānau member?

- ○ family/whānau member
- ○ the patient

2. What ethnic group(s) do you identify with? (please mark all that apply)

- ☐ NZ Māori
- ☐ NZ European
- ☐ Samoan
- ☐ Tokelauan
- ☐ Fijian
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Other Pacific Island
- ☐ Southeast Asian
- ☐ Chinese
- ☐ Indian
- ☐ Other Asian
- ☐ Other European
- ☐ Latin American / Hispanic

- [ ] African
- [ ] Middle Eastern
- [ ] Other ethnicity
- [ ] Don't know
- [ ] I don't want to answer

3. It was easy to get to this clinic appointment

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Comments:

4. I felt prepared for the appointment

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Comments:

5. I am clear about what the appointment is for

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Comments:

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6. I am confident filling out hospital forms without help from others

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Comments:

7. I let health staff know when I don't understand what they are telling me

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Comments:

8. What helps you understand health information? Please tick your preferred options below (tick as many or as few as you wish)

- Listening to health staff
- Listening to family members/whānau or friends
- Writing notes during the clinic
- Reading health pamphlets / patient information sheets
- Looking at drawings or diagrams
- Watching videos
- Practical demonstrations
- Stories / story telling
- Song / rhymes
- Searching health information using Google/the internet
- Asking health staff questions

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☐ Asking family members/whānau or friends questions

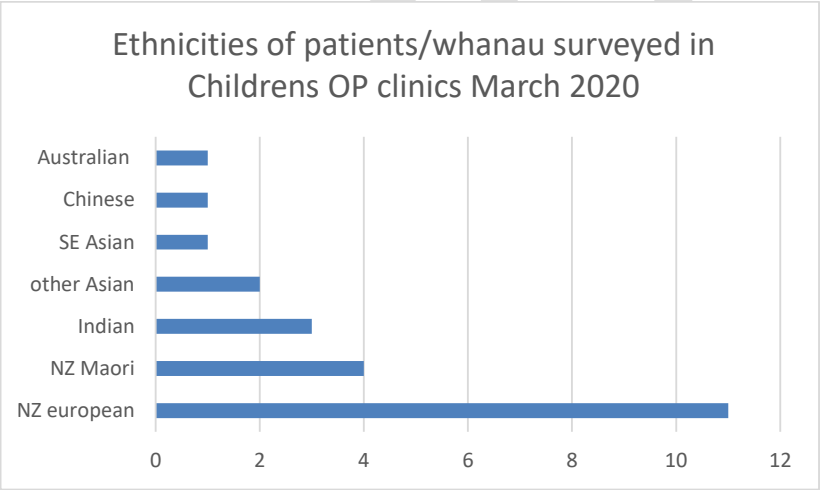
☐ Other (please specify)

9. What is one thing that would make your clinic appointment better?

Appendix 5. Whānau interview/survey results – health literacy review March 2020

Seventeen families were verbally surveyed in the waiting rooms of the children's outpatient clinics at both Wellington Hospital (GNB level 5) and Kenepuru Child Health Services. All families present in the waiting room were invited to participate in the survey, none refused to participate. Of these families, four identified as Māori, 11 as NZ European, 3 as Indian, 2 other Asian, 1 South East Asian, 1 Chinese and 1 Australian (note some families identified with more than one ethnicity).

Figure 16. Ethnicities of patients and whānau surveyed during the review



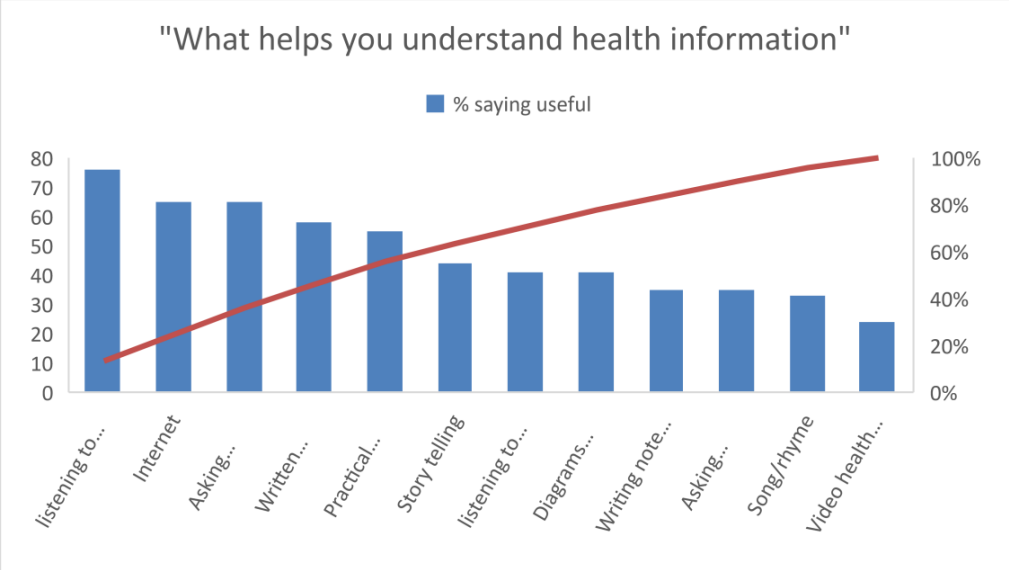
Findings

100% of respondents self-reported being either confident or very confident filling out hospital forms without help from others, suggesting good levels of health literacy. 82% of respondents reported the

appointment as easy to get to with 88% clear about what the appointment was for. 88% of respondents reported that they let health staff know when they don't understand what they are being told.

When asked what helps them understand health information 76% of whānau reported listening to health professionals was helpful, 65% found the internet helpful, 65% asking health professionals questions helpful, 58% found written patient information helpful, 55% found practical demonstration helpful, 44% found story telling helpful, 41% listening to family and friends helpful, 41% found diagrams/drawings helpful, 35% found writing notes in clinic helpful, 35% found asking family/friends questions helpful, 33% found song/rhyme helpful and 24% found health videos helpful.

Figure 17. What helps whānau understand health information survey results



Whānau comments summarised from interviews in clinic:

Comments on listening to health professionals:

- I struggle to understand some accents and if they talk fast

Comments on the internet/Google:

- I worry about how reliable information is on different websites
- I learnt about Google from watching Twilight, now I Google it all
- I Google everything – sometimes I get conflicting information and that is not helpful
- I get home and Google it

- The internet is really useful
- The internet vital - I believe my looking on the internet for information, knowing the signs and then what to ask resulted in faster investigation and finding of the cancer in my son

Comments on practical demonstrations:

- Really helpful
- A demonstration I was given on how to apply eczema cream was really helpful. It showed me how to go down the arms in one direction, not just rub it in going up and down
- Practical demonstrations are especially helpful
- Definitely helpful

Comments on story telling:

- If relevant
- Really helpful

Comments on asking family/friends:

- I have a health professional in the family
- My sister is a doctor
- Family member is a doctor
- Asking family is not helpful
- Something I avoid
- I have a family member who is a doctor
- Only (helpful) if a friend has gone through the same situation

Comments on song/rhyme:

- I always use the 'blue to the sky, orange to the thigh' rhyme a nurse taught me when giving the epi-pen.

Comments on videos:

- Depends not (helpful) if someone talking in monotone voice

Comments on one thing that could be better:

- Traffic!
- First time the lifts and link bridge confusing - once you understand it's ok.
- Blurb about the appointment purpose (rather than just clinic name)
- Texts are great reminders

- At the first appointment I learnt that I need to arrive early.
- Text reminders good
- Not so far to drive (from Upper Hutt)
- Free parking (Mother was a single parent and had no money for parking on the day I interviewed her so had left note in window asking not to be given a ticket).
- When you are given a new diagnosis or new information or a new medication they should give you a website link or brochure not just assume you know
- Coordinated appointments! Someone realising they have given me one appointment in Wellington and one in Kenepuru an hour apart or one early morning appointment and one at the end of the day so we end up spending all day at the hospital. When I ask to change appointment times this is always seems difficult for staff. Couldn't someone oversee this so appointments are more manageable for families?
- Free parking for short periods - hard to afford regular appointments on a single income
- Available and accessible parking - often I can't get a park.
- Prefer a text reminder rather than a phone call - if I miss the call there is a generic line to call back which isn't helpful as I don't get to speak to the person I need to and find out why they called
- Later appointment time for people coming from Kapiti or clinics in Kapiti

Appendix 6. Guide for clinic observations

Reviewer looks for

Consumer:

- Confident in responding to clinician
- Uses body language that matches confident response
- Asks questions
- Clarifies if not sure
- At end of consultation, patient/whānau is able to confirm what happened, what they have to do or what will happen next, consultation met expectations

Clinician:

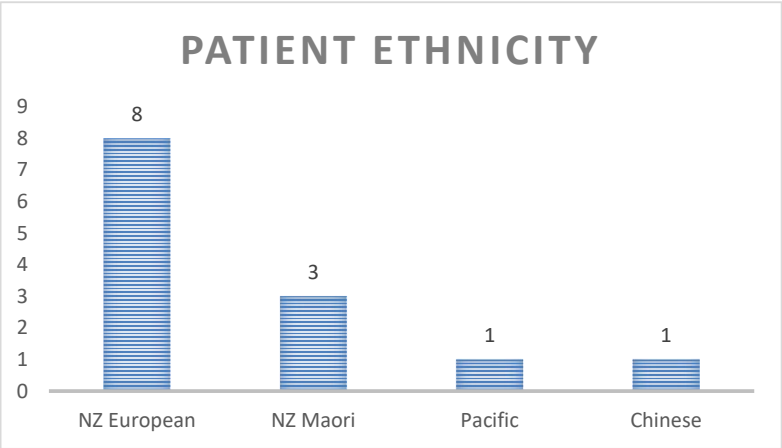
- Asks questions to find out background information (i.e. patient/whānau knowledge of their condition)
- Asks questions to find out specific information

- Gives information in logical steps
- Gives information in manageable chunks
- Uses everyday language, or if use technical words explains them (note words used that patient/whānau don't understand)
- Uses visuals to explain how the body works
- Uses written materials and explains why they are giving them to the patient/whānau, what part the patient/whānau needs to read and what they expect the patient/whānau to do
- Demonstrates procedures or correct health equipment use where relevant
- Explains what medicine is, why the patient needs to take it, how it works, how it needs to be taken, any foods to avoid, side effects and how long the patient will be taking the medicine
- Reinforces what needs to be done, emphasises key points and acknowledges what the patient/whānau are doing well
- Monitors body language, checks if patient/whānau gives any indication of uncertainty and asks questions
- At the end, checks they have been clear by getting the patient/whānau to explain what they are going to do (doesn't ask 'do you have any questions?' or 'do you understand?').

Appendix 7. Results of Clinic Observations March 2020

Several patient clinics were observed during the review week, in both Wellington and Kenepuru. The aim was to evaluate the patient clinician interaction from a health literacy perspective, noting what strategies clinicians and patients used in clinical communication and how effective this appeared to be.

Figure 18. Ethnicities of patients observed across the four clinics



Patient & whānau observations

All whānau and a couple of the older children (patients) appeared confident responding to the clinicians questions. Almost all parents asked questions and all were observed asking the clinician to clarify if they were not sure about a point. 77% of patients were observed checking information provided from the current appointment, past appointments and from other sources (internet, other health professionals). Several patients were very direct and three were observed complaining about other health professionals and/or the health system during appointments.

85% of patients observed in clinics appeared to have either a good or very high level of health literacy by the observer based on their knowledge of their child's health condition and the questions they asked. Three Māori families were observed, one appeared to have an extremely high level of health literacy, one a good level and one potentially lower level of health literacy. The family with suspected lower health literacy was observed asking less questions. The two families with good or very high health literacy asked lots of questions, explored health options and used clinic notes. One brought in previous notes and took notes in clinic, the other referenced previous clinic notes and requested written notes be sent to them after the appointment.

Only one Pasifika family was observed, they were seen to use framing to ask questions i.e. “another doctor told me …… is this true?”. The Pacific family also requested to go away and discuss the information with family before making a decision. These observations may reflect cultural norms of not directly challenging someone perceived as of higher authority and the high value placed on collective decision making.

Concerns from families and in particular children themselves (where they were old enough) were focused on being different from the norm, not being able to do what other children their age could do and not reaching the same developmental milestones. There were also lots of questions about the longer term impact (what would happen at puberty, in adulthood, life expectancy and impact on quality of life). For many families the greater the deviation from ‘normal’ the greater appeared to be the concern.

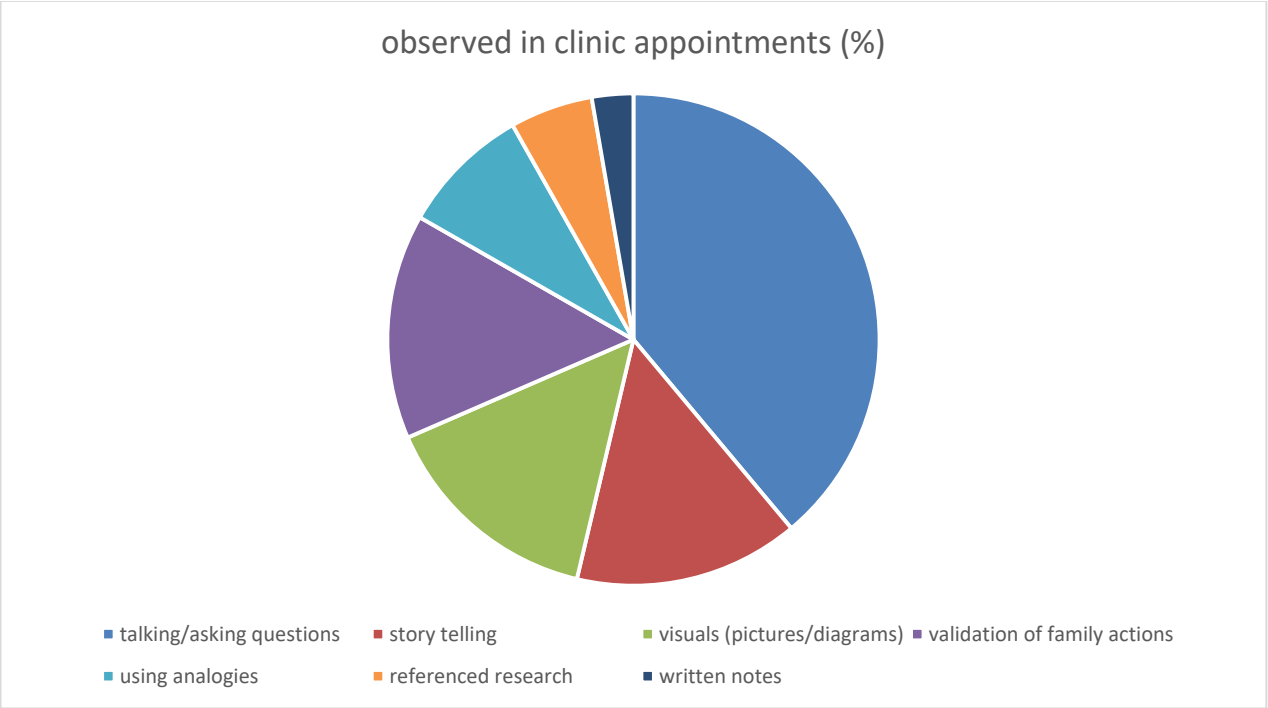
Another area of concern was medication, with several families having questions about the medication, how to effectively give to their child medication (often a struggle for families, especially with younger children), appropriate dosage and side effects of the medication.

Clinician observations

Clinicians were observed starting appointments by asking general background questions before moving on to specific health questions. More time was spent on finding out background information in new referrals compared to follow ups as would be expected. Clinicians appeared highly skilled in giving information in logical steps and manageable chunks i.e. “first we will talk about….., then we will talk about …. etc
All clinicians were observed using everyday language, child appropriate language and explaining any technical words they used.

Observations during the clinic appointments were that talking to patients and asking questions were the main way health information was communicated (100% of appointments). In 38% of clinics visuals (pictures / diagrams) were observed being used, in 38% of clinics story telling was observed, in 22% of clinics clinicians used analogies to explain health concepts, in 14% of clinics research was referenced and in 7% of clinics written notes were provided to the family. No written patient information/pamphlets were provided in the observed appointments, no health websites were referenced and no health videos shown.

Figure 19. How health information was observed being provided in clinic



Visual used –

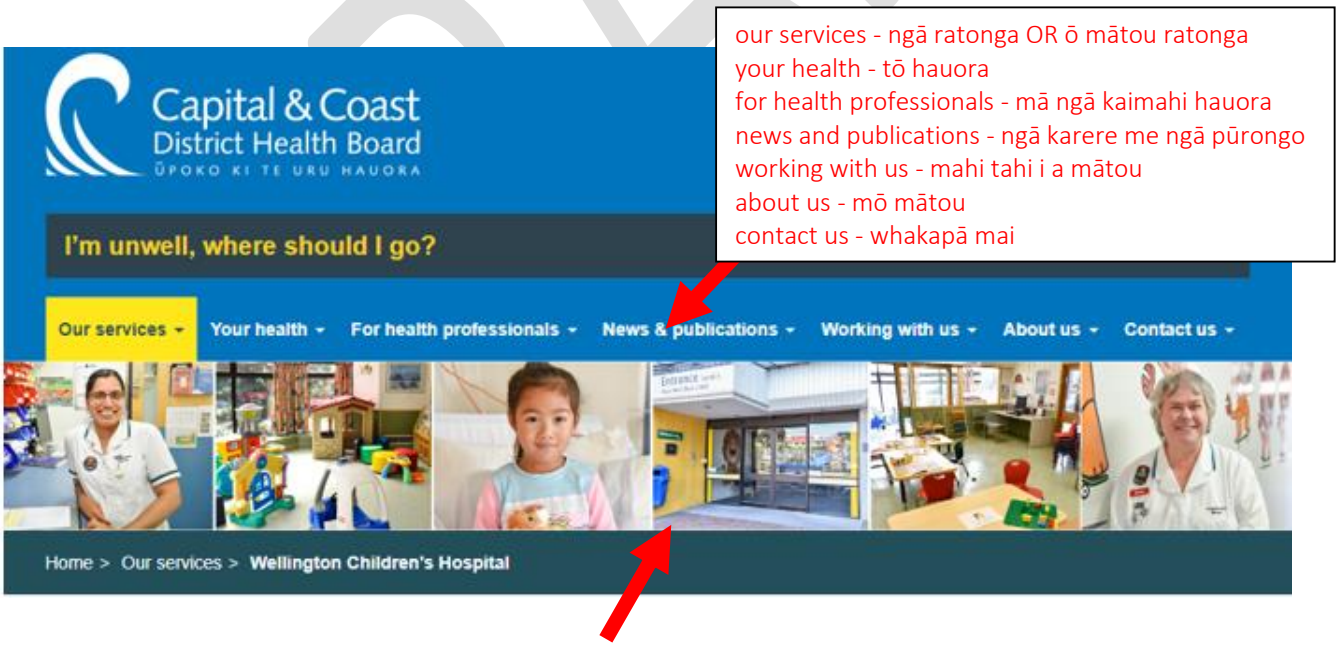
- Ultrasound images
- Photographs of surgery
- Diagrams (penis, pelvis, heart, heart vessels)
- Height/growth chart
- ASD spectrum disorders visual

Only 31% of clinicians summarised and reinforced the key information towards the end of the appointment. Examples include "we have talked about a lot today, but this is (the key information) I want you to know ……." another "these were my observations today….., this is my diagnosis…. and this is why …….". "he has got ……, this means …., our criteria for surgery is….., our recommendations are……, what will we do is…….".

No clinician used teachback or "check" (of ask, build, check) to ensure that the key information had been understood by the patient/whānau member. It was noted however that 77% of whānau initiated some form of "check" during the appointments which may have reassured clinicians that the whānau were understanding the information provided.

In 38% of observed clinics the clinician ended the appointment with a closed question such as; do you have any questions? or does that make sense? Ministry of Health and HQSC guidelines for effective health information communication advises against ending appointments with such closed questions and instead advises asking patients to 'teachback' what they have understood from the appointment. A question such as "what would you tell (a friend/family member) about what we have talked about today?" or asking about what the family plan to do next to manage the health condition (to see if it matches the clinic discussion) are a couple of examples of ways clinicians can check what they have said has been understood correctly by the whānau.

Appendix 8. Original Children's Hospital webpage (feedback in red)



Faces and images of tamariki and tamariki Māori, have a kōrero about the use of the images banner of six images, which includes three empty hospital spaces, two nurses and one tamariki on her own - perhaps more images of tamariki in their rooms with whānau and medical professionals, with a positive wairua.

Capital & Coast District Health Board
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Wellington Regional Children's Hospital

On this page:

Health information

In an emergency, call 111.
Unless it's an emergency, always call your own doctor first when you or someone in your family is sick or injured. Even after hours your call will be answered by a nurse who can give you free health advice.
You'll find information about GPs in our region here and details of after hours and emergency care here.

Health Navigator

Trustworthy, reliable and accurate healthcare information and resources are available on the Health Navigator website. Visit www.healthnavigator.org.nz.

Healthline

Call Healthline on **0800 611 116** for free advice from trained registered nurses, 24 hours a day, seven days a week.

PlunketLine

PlunketLine is a toll-free parent helpline and advice service available to all families, whānau and caregivers 24 hours a day, seven days a week.
Call **0800 933 922**. Calls are free from cell phones.

General information about the Children's Hospital

Before you come

If your child becomes unwell before they are due to be admitted to the Children's Hospital, please ring the ward (see Contact us below).

If your child is having an operation

If your child is having an operation, please read our brochure When your child needs anaesthesia (PDF).

Staying overnight at the Children's Hospital

If your child is staying overnight at the Children.

Other information about coming to Wellington or Kenepuru hospitals

General information for patients and visitors
Coming to Wellington Regional Hospital
Coming to Kenepuru Community Hospital, Porirua

Support and advocacy services

We have many support services available, including:
Whānau Care Services
Pacific support services
Chaplains, a chapel and a Muslim prayer room
Social workers
If you would like to speak to any of these teams please speak to your child's nurse.
If you're not happy with anything on the ward, let your child's nurse know or ask to speak to the Charge Nurse Manager.
You can also read about patient rights and how to give us feedback.

Interpreting services

Deaf family members have the right to request a Sign language interpreter. Find out more about booking an interpreter.
The video interpreting service is also available to help deaf people access Plunketline and Healthline.

Services provided in the Children's Hospital

Children's Day Ward

This 9-bed ward accommodates children from birth until their 16th birthday who are having a range of day case surgical procedures, including ear, nose and throat, urology, dental and general paediatric surgery.
Children also come into the Children's Day Ward for sedation for scans and infusions and a small number are seen for paediatric surgical pre-assessment.

Children's Acute Assessment Unit

This unit is situated within the Children's Day Ward and is open Monday to Friday from 7:30am to 11pm for medical and surgical referrals. It caters for children who have been referred from our emergency department.

Children's Clinic

This service is located on Level 5 of the Grace Neill Block and operates Monday to Friday. Services here include outpatient appointments with paediatricians and other specialists as well as procedures such as blood tests and allergy tests and treatments.
Our satellite service at Kenepuru Child health provides a similar service including an acute assessment service during the hours of 8:30am to 5pm.

Wellington Children's Hospital inpatient wards

There are 2 inpatient wards in the Children's Hospital at Wellington Regional Hospital.

Ward 1

Ward 1 is located on level 3 of Wellington Children's Hospital. It looks after children up to 8 years old with medical conditions and children up to 5 years old being cared for by other specialties such as Neurology, ENT and Orthopaedics. It also has an isolation unit for children who have a condition that is infectious.

Ward 2

Ward 2 is located on level 4 of Wellington Children's Hospital, it looks after children of all ages requiring general surgery and surgical care. It also takes children with medical conditions over the age of 9 and children over the age of 6 being cared for by other specialties such as neurology, ear, nose and throat (ENT) and orthopaedics. Ward 2 also has a shared care service for oncology of all age groups and an oncology day unit where patients come for blood tests, reviews and to receive day chemotherapy.

Kenepuru Child Health

Kenepuru Hospital provides acute assessment and outpatient services for children aged up to 16. These are for children and their families and whānau who live north of Johnsonville and up the Kapiti Coast.
If your child needs surgery or to be admitted to hospital, they will be referred to Wellington Regional Hospital.
There is also a children's outpatient service, which operates Monday to Friday. Services here include outpatient appointments with paediatricians and other specialists as well as procedures such as blood tests.

Paediatric Community Nurses

Paediatric nurses based at Wellington and Kenepuru hospitals visit children and their families in their homes to provide complex care and care for chronically ill children. They also run clinics for eczema and incontinence.

Location and car parking

The Children's Hospital at Wellington Regional Hospital is located behind the main hospital building. You can get there by driving down Hospital Road – there is some pay and display parking outside the Children's Hospital – or by parking in the main underground car park (also pay and display) and walking through the main hospital building.

The Children's Outpatient Clinic is located on level 5 of the Grace Neill Building. This is also accessible through the main hospital building or by driving down Hospital Road and parking outside level 5 of the Grace Neill Building.
Download a map that shows how to get to the Children's Hospital and Grace Neill Building as well as car park locations.
Find out more about car parking at Wellington Regional Hospital here.
After their first night's stay, each child is permitted to one free parking ticket per day for the main hospital car park – please ask your child's nurse for more information.

Free shuttles between CCDHB sites

Read about our free shuttles between Wellington Regional Hospital and Kenepuru Community Hospital and the door-to-door Kapiti Community and Health Transport Service.

Contact the Children's Hospital

Children's Day Ward and Acute Assessment Unit

Phone 04 385 5999 ext 5041

Children's Clinic Service

Phone 04 385 5999 ext 82476

Ward one

Phone 04 385 5999 ext 5519

Ward two

Phone 04 385 5999 ext 5518

Kenepuru Child Health

Phone 04 385 5999 ext 7003

Hospi

While visiting Wellington Children's Hospital you may see Hospi! Hospi is the official mascot of Wellington Children's Hospital and you will see Hospi and his paw prints on the walls all around Wellington and Kenepuru Hospital! If you're lucky you might also get a visit from Hospi as, thanks to Wellington Hospitals Foundation, he visits Wellington Children's Hospital wards twice weekly.

Last updated 1 October 2019.

Capital & Coast District Health Board
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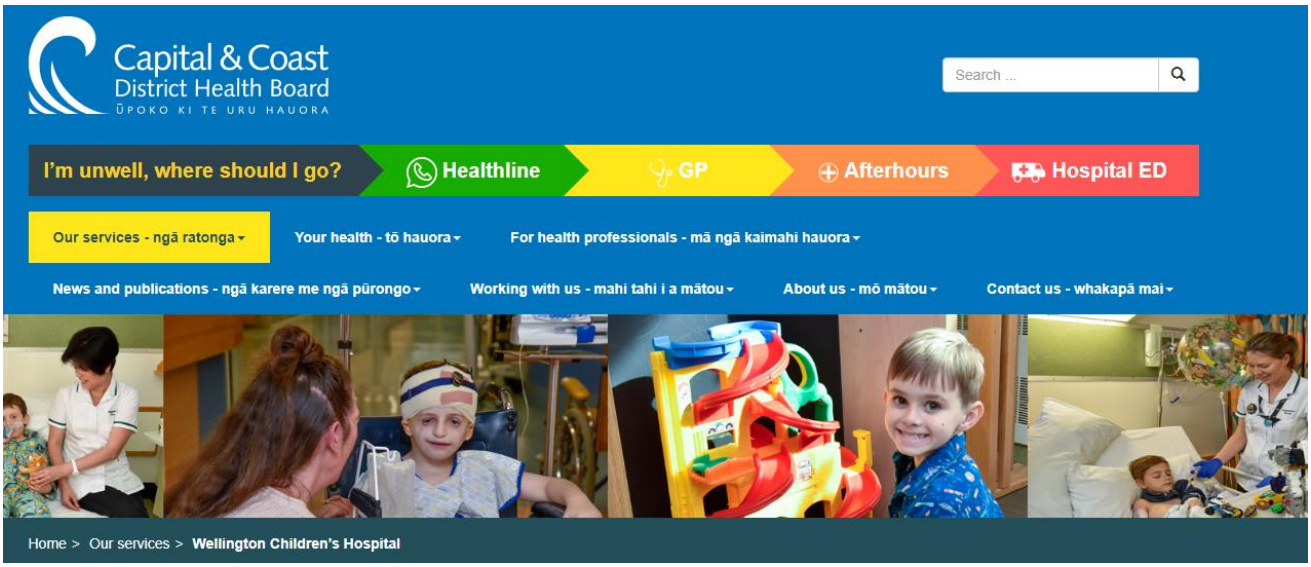
Appendix 9. Re-designed webpage



Wellington Regional Children's Hospital

On this page:

Our services for your tamariki / mokopuna (children)

Our team of doctors, nurses and allied health professionals care for tamariki / mokopuna (children) needing specialist medical and surgical care. We provide the following services

- Wellington Children's Hospital (in-patients)
- Wellington Children's Clinics (out-patients)
- Paediatric (Children's) Community Team
- Kenepuru Child Health
- We also have telephone / virtual clinics

Read more about Child Development Services on this page

It is FREE for most children who live in New Zealand to be seen at Wellington Children's Hospital services. If you are unsure if your child will get free healthcare click here .

Capital & Coast District Health Board
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Your taitamaiti / mokopuna (child's) visit

Your doctor, another health professional or our emergency department will have recommended / referred your child to us.

Even if your child seems well at the time of your appointment, it is still important they see us. Our assessment and treatment will support you to keep your child well.

If you can't make your appointment, please let us know so we can find another time for you.

Contact Children's Hospital Services

Children's Day Ward

Phone 04 385 5999 ext 5041

Children's Clinic Service

Phone 04 385 5999 ext 82476

Ward one

Phone 04 385 5999 ext 5519

Ward two

Phone 04 385 5999 ext 5518

Kenepuru Child Health

Phone 04 385 5999 ext 7003

Email us about out-patient appointments

Email us if you have a question that isn't urgent

Wellington Children's Hospital (In-patients)

Wellington hospital main building

- Finding us
- Parking
- Free shuttle service between hospital sites

- Children's Day Ward
- Ward 1
- Ward 2

Children's Day ward - Level 3 Wellington Children's Hospital

We look after children who need tests, treatments and day stay operations. We are open from 7am Monday to Friday (excluding public holidays).

If you would like information on anaesthesia for tamariki/mokupuna/children, please read our brochure when your child needs anaesthesia.

Phone 04 385 5999 ext 5041

Parent information

Children's Day Ward information sheet

When your child needs anaesthesia brochure

Capital & Coast District Health Board
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Ward 1 - Level 3 Wellington Children's Hospital

In ward 1, we look after children with medical conditions who need specialist medical care.

Phone 04 385 5999 ext 5519

Parent information

Ward 1 parent/caregiver information sheet

Ward 2 - Level 4 of Wellington Children's Hospital

In ward 2, we look after children who need surgery, surgical care and cancer services.

If you would like information on anaesthesia and sedation for tamariki/mokupuna/children, please read our brochure when your child needs anaesthesia.

Phone 04 385 5999 ext 5518

Parent information

Ward 2 parent/caregiver information sheet

When your child needs anaesthesia brochure

Finding us

The Children's Hospital is behind the main Wellington Regional Hospital building (the new Children's Hospital building is not open yet).

You can get to Wellington Regional Hospital by walking, cycle, bus, taxi and car. Read more information

You can get to Wellington Children's hospital through the Children's hospital front entrance or through the Wellington Regional hospital main building.

If you come through the main hospital building, follow the orange line, Hospi images and pawprints to the Children's Hospital level 3 entrance.

If you need any extra help to find us head to the volunteer's station or the reception desk, both are located in the main entrance way (atrium).

Parking

There is limited street parking around the hospital. If you need hospital parking, you can park in the public hospital car parks, including the underground carpark. There is a cost for parking within the hospital. Please note, to get to the Children's hospital carpark enter at hospital road. View a map showing the location of public parking (green areas) and mobility parking

Please allow extra time for car parking and bring a credit card or coins for the parking machines within the hospital.

After their first night's stay, each whānau/ family can request one free parking ticket per day for the underground hospital car park – please ask your child's nurse for more information.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Wellington Children's Clinics (Out-patients)

Grace Neill Block (GNB) Level 5 entrance

- Finding us
- Parking
- Free shuttle service between hospital sites
- Children's Clinics (out-patients)

The Children's Clinics provide outpatient appointments with paediatricians (child specialist doctors) and carry out procedures including blood tests, allergy tests and treatments.

Children's Clinics are also held at Kenepuru. See the information on Kenepuru Child Health for more details.

Phone 04 385 5999 ext 82476

Parent information

Paediatric (Children's) Community Team information sheet

Finding us

The Wellington Children's Clinics (Paediatric out-patients) are on level 5 of the Grace Neill Block (GNB) **behind the main hospital building.** You can get to us via the Wellington Regional Hospital front entrance or via the GNB level 5 entrance.

If you come via the main hospital building, take the escalator or orange lift in the atrium to level 3, then take the link bridge to the Grace Neil Block (GNB) and the yellow lift or stairs in GNB to level 5. View further instructions and a map to GNB

Paediatric (Children's) Community Team

The Paediatric (Children's) Community Team are paediatric (children's specialist) nurses based at Wellington and Kenepuru hospitals providing nursing care and support. Clinics are held in a range of locations.

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Kenepuru Child Health, Porirua

- Finding us
- Parking
- Kenepuru Child Health
- Free shuttle service between hospital sites

The Child health team at Kenepuru Community Hospital in Porirua provide **acute assessment** and **children's clinics** for children who live north of Johnsonville and up the Kāpiti Coast.

Phone 04 5999 ext 7003

Finding us

You can get to Kenepuru Community Hospital by walking, cycle, bus, taxi and car. Read more information

The Child Health team are located within the main hospital building, not far from the main entrance. View a map of Kenepuru Community Hospital Te Hōhipera O Kenepuru . Read more about Kenepuru hospital and visiting information .

If you need any extra help to find our services, hospital volunteers are available at the main entrance.

Parking

Parking is free at Kenepuru Hospital. Patient and visitor parking is at the front of the hospital

Free shuttles between Wellington and Kenepuru hospitals

There is a free shuttle between Wellington and Kenepuru hospitals for patients and their caregivers/visitors. This service needs to be booked, preferably at least one hour before you intend to travel. Read more about the shuttle service .

Children's health recommended websites

If you want more information about children's health conditions, tests, treatments, medicines and support available the following websites are recommended by our service.

KidsHealth

Kids Health NZ: provides advice and guidance on common conditions and treatments.
Access KidsHealth

Health Navigator NEW ZEALAND

Health Navigator NZ: provides advice and guidance on health conditions and medications. NZ Health Navigator is regularly updated with the latest clinical information.
Access Health Navigator

HealthEd

Health Ed NZ: a catalogue of free health resources, many in multiple languages and NZ sign language from the NZ Health Promotion Agency (HPA) and the Ministry of Health (MoH).

Access Health Ed

Capital & Coast District Health Board
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Support using our services

Wellington and Kenepuru Hospitals provide a range of support services to patients and whānau using our services including cultural and disability access services.

Read more about support services at **Wellington Regional Hospital**

Read more about support services at **Kenepuru Community Hospital**

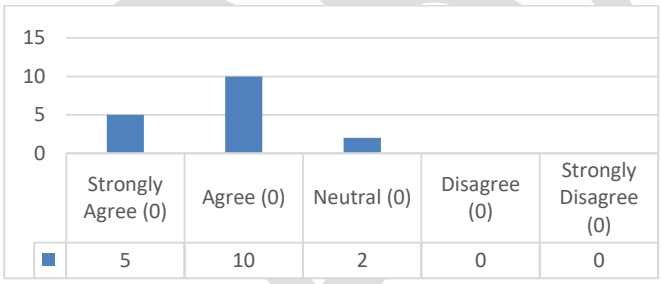
Read about what supports we provide people with disabilities

Hospi

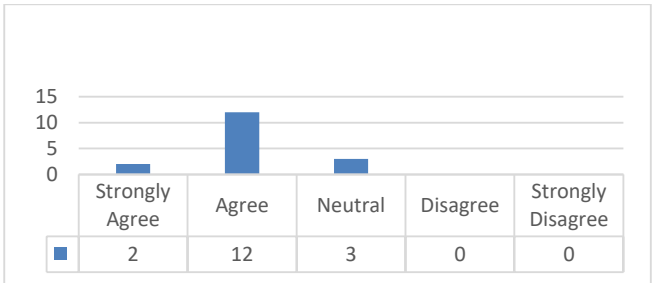
Hospi the Lion is the official mascot of Wellington Children's Hospital. You will see Hospi and his paw prints on the walls all around Wellington and Kenepuru Hospital. You might get a visit from Hospi, as thanks to Wellington Hospitals Foundation, as he visits Wellington Children's Hospital wards twice weekly.

Appendix 10. eLearning evaluation questions & results Nov 2020

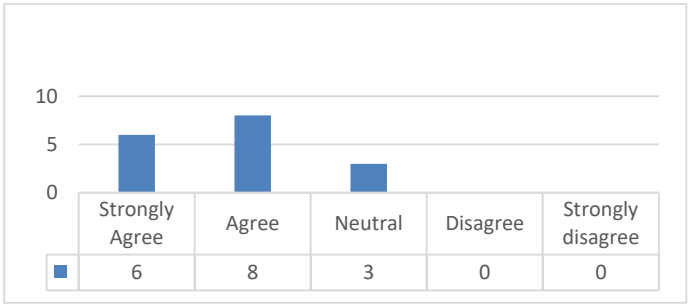
1. Completing the eLearning has increased my understanding of what Health Literacy is and who is affected by it.



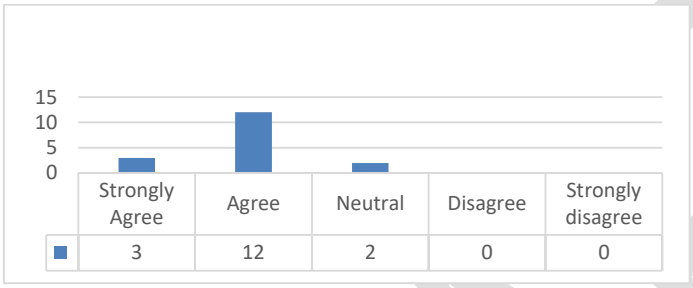
2. I have a greater understanding of how organisations influence health literacy



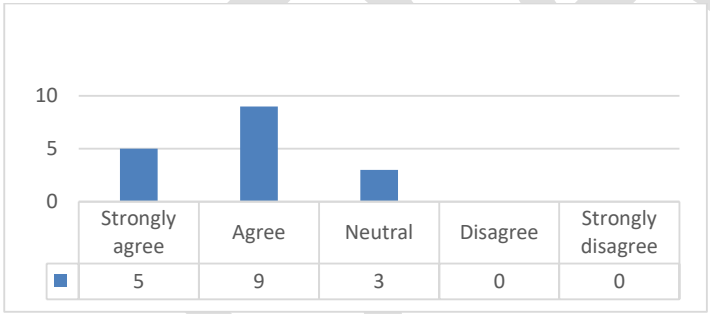
3. I have a greater understanding of how my communication can influence an individual's health literacy



4. I have a greater understanding of what approaches will reduce health literacy demands



5. I have a better understanding of the tools available to improve health literacy



Appendix 11. Face to Face education session evaluation Oct/Nov 2020

Evaluation of workshops by attendees

Workshop1.pdf Workshop 2.pdf Workshop 3.pdf

Board Information – Public

April 2021

Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025: March 2021 (Update)

Action Required

The HVDHB and CCDHB Boards note:

(a) This paper was submitted to the Health System Committee for discussion and has come to Board for any further questions.

(b) In December 2020, the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region 2020-2025 (Pacific Health Strategy) was launched.

(c) In January 2021, a 2DHB Director, Pacific Peoples Health was appointed to lead the Pacific Health Directorates across both Hutt Valley and Capital & Coast DHBs;

(d) This is the first update in relation to the Pacific Health & Wellbeing Strategic Plan for 2021.

Strategic Alignment	Ministry of Health *Ola Manuia* Pacific Health Plan 2020-2025 CCDHB Health System Plan 2030 HVDHB Vision For Change 2017-2027 WrDHB Well Wairarapa –Better Health for All Vision 2017 Faiva Ora National Pacific Disability Plan Ministry of Pacific Peoples Priorities
Author	Junior Ulu, Director Pacific People's Health, CCDHB & HVDHB
Endorsed by	Fionnagh Dougan, Chief Executive Officer, CCDHB & HVDHB
Purpose	Update the Boards in relation to the implementation of initiatives related to the Pacific Strategic Plan.
Contributors	Candice Apelu-Mariner, Integration Lead Pacific Sam McLean – Principal Analyst & Team leader - Analytics
Consultation	2DHB Strategy, Planning & Performance

Executive Summary

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

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

- A progress report regarding the implementation of the Pacific Health Strategy
- A summary of information relating to the Pacific health equity context
- A high-level dashboard and explanation of the indicators that have been developed to measure progress in relation to Pacific health equity

Strategic Considerations

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

Identified Risks

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

Attachment/s

1. 2DHB Pacific Progress and Indicators Report

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

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

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

Contents

1. Background

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region was launched in December 2020. It builds on the previous plans: "Paolo mo Tagata o le Moana 2015 – 2018" (HVDHB & WrDHB) and the "Toe Timata le Upega 2017 – 2021" (CCDHB). In January 2021, a 2DHB Director, Pacific Peoples Health was appointed to lead the Pacific Health Directorate across both the Hutt Valley and Capital and Coast DHBs.

The journey to creating a single strategy for 3DHB (Wairarapa ; Hutt Valley, and Capital & Coast DHB's) was informed by partnering with key Pacific stakeholders, and community members, to co-produce a strategy that boldly re-shapes health system design centred on the aspirations and health needs of Pacific populations.

This progress report is for the period from December 2020 – March 2021 to provide a snapshot of what is already underway to meet the goals of the plan. Progress to date therefore is limited with the view of strengthening this through the development of an 'Operational Plan'. This involves contributions from relevant stakeholders both internally and externally to ensure that expertise and resources are directed towards improving equitable health outcomes for Pacific people.

2. 2DHB Pacific Health Dashboard: Measures of Equity

The Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region highlights six priority areas that follow a life-course approach to health with a strong focus on systems change and collective impact:

1. Pacific child health and wellbeing
2. Pacific young people
3. Pacific adults and ageing well
4. Pacific health workforce and Pacific providers and non-governmental organisations
5. Social determinants of health
6. A culturally responsive and integrated health system.

In addition, the key strategic directions of the plan include:

1) **Equity** – advancing decisions, solutions and innovations that help eliminate health inequities 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.
3) **Strengthening accountability and performance monitoring across the health system** - to hold the system 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 at the centre of service design and decision making and 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) **Cultural responsive services** - Developing and sustaining a culturally safe and competent health service and work settings. This includes addressing racism and developing strategies to mitigate negative attitudes and behaviours.

3. 2DHB Pacific Strategy Work Programme and Status

Activities and actions outlined in the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region include both systemic changes as enablers of equity, and service focus areas that will improve the five key measures of equity.

We have chosen to provide updates on only a few 'actions' for each of the six priority areas to provide a basis for discussion. Therefore not all 'actions' from the plan will appear below. Moving forward we will showcase a more comprehensive picture of all actions with the development of an 'Operational Plan. Appendix 1 provides a more detailed dashboard for three priority areas: Pacific child health and wellbeing; Pacific Young People; Pacific adults and ageing well. To show the progress status of the broad activities, the following colour coding has been used:

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

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

Priority One: Pacific Child Health To give Pacific children and their families the best possible start in life and ensure they meet key childhood developmental milestones through culturally responsive and safe services and support.		
Action	***Progress Status***	***Comments/ Details***
Support family-centred initiatives to reach pregnant mothers, parents, babies, and families.		2DHBs continue to fund and support the only Pacific led Well-Child service in the Greater Wellington region "Thriving Cores" delivered by Pacific Health Services Hutt Valley. 2DHB's continue to fund and support the 'Anofale Antenatal Programme' specifically for Pacific mothers run by Naku Enei Tamariki (NET) Pacific. The 2DHB maternal health system plan, which will deliver models of care that improve access and engagement in early antenatal care and education, will also have a strong equity focus.
Collaborate with appropriate stakeholders to promote safe environments for bringing up Pacific children including warm homes,		Ongoing partnerships and joint initiatives between the 2DHB and Smoking Cessation service. We are hosting the Senior Pacific Advisor for 'Takiri Mai Regional Smoking Cessation

Priority One: Pacific Child Health To give Pacific children and their families the best possible start in life and ensure they meet key childhood developmental milestones through culturally responsive and safe services and support.		
smoke free homes, good nutrition, safe sleeping, reducing smoking and alcohol consumption		Service' a partnership with Kokiri Marae; Well Homes; Sport Wellington; and Healthy Families Hutt Valley.
Work collaboratively with Bee Healthy Regional Screening Services and key stakeholders on projects and initiatives to improve coverage of screening and preventative oral health interventions		Ongoing partnership and support provided for the Bee Healthy Oral health Regional Service. A joint Pacific health promotion event day was held at Hutt Park in partnership with Pacific providers, 2DHBs, Regional Public Health, Bee Healthy and Total touch on February 18th 2021. At this community sporting event, the Bee Healthy team were able to undertake first exams, fluoride varnish applications, routine examinations, and found Pacific children who were not enrolled.

Priority Two: Pacific Young People		
Action	***Progress Status***	***Comments / Details***
Support and strengthen initiatives that encourage young Pacific people to adopt healthy lifestyles, make informed choices about sexual health, smoking, and risk-taking behaviours		Pacific Providers supported by PHOs and funded by DHBs are running healthy lifestyle programmes with churches and ethnic specific groups targeting young people. For example Faith Led Wellness Programme in the Hutt Valley, Walking Samoans in Porirua.
Leverage Technology to promote health messages and campaigns that reach and resonate with Pacific young people		A Positively Pacific Facebook page and website specifically for the Greater Wellington Region has been developed and funded by the 2DHB. These social media platforms are focussed on reaching young people and ensuring content is local and relevant to services and programmes available for young Pacific people in The Greater Wellington region.

Priority Three: Pacific Adults and Aging Well		
Action	***Progress Status***	***Comments / Details***
Work in partnership with key stakeholders to increase and encourage participation in screening programs (cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).		The 2DHB Pacific Director continues to support the work of the Pacific National Bowel Screening Network and sits on Regional Screening Services Governance Group.
Continue identifying change levers in programme and service design that will make the greatest impact on health conditions including cultural competency training for non-Pacific workforce that support Pacific people.		Pacific Cultural Competency Trainings rolled out in Hutt Valley DHB for 2021. Planning for development of a Regional Cultural Competency Training Package to include Wellington and Keneperu Hospitals.

Priority Four: Pacific Health & Disability Workforce and Providers		
Action	***Progress Status***	***Comments / Details***
Influence HR recruitment policies and processes across the 3DHBs to improve Pacific employment		This will be addressed in the Pacific Health & Disability Workforce Strategy to be developed.

Priority Four: Pacific Health & Disability Workforce and Providers		
opportunities including increasing number of Pacific on shortlisting, interview panels, Steering groups and governance		
Strengthen and support Pacific health providers and align their work with general practices and hospital services, with a focus on health care homes and integrated family health centres in primary care and the community.		2DHB funded mobile clinics under the Covid-19 Tranche 2 funding for the Pacific Health Service Hutt Valley. Enabled Pacific Health Plus to establish an after hour service, one day per week for Porirua patients.
Increasing and attracting our Pacific workforce by targeting students via formal education settings, such as secondary schools and tertiary institutions. This pipeline needs to be socialised as well with the education sector.		Work will be undertaken Quarter 3 of this financial year to develop a Pacific health & Disability Strategy that will future proof the Pacific workforce.

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

Priority Six: Culturally Responsive and Integrated Health System		
Action	***Progress Status***	***Comments / Details***
Develop and Implement a Sub-regional Cultural Competency Framework, Checklist and Training Package that nurtures a culturally responsive work environment and improve capacity of the health workforce to deliver culturally sensitive services.		Pacific Cultural E-Learning in place that is part of mandatory training for all staff. Face to face two hour Pacific cultural training for the health workforce for HVDHB. This will be explored for CCDHB and WrDHB.

4. Next Steps

The Pacific team across 2DHB will:

- Develop an 'Operational Plan' to implement the Pacific Health & Wellbeing Strategic Plan for the Greater Wellington Region
- Development of the COVID-19 vaccination plan utilising Pacific health providers and Pacific groups
- Identify intersections with Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025
- Work with Wairarapa DHB Planning & Performance and 2DHB Strategy, Planning & Performance to manage identified risks for 2021/22 and beyond.

5. Appendix One: 2DHB Pacific Health Dashboard

Pacific child health and wellbeing

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

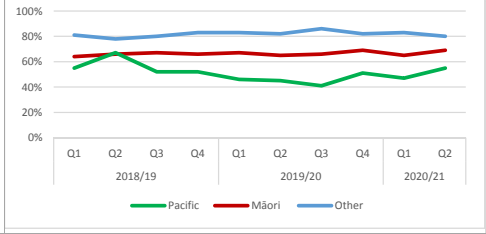
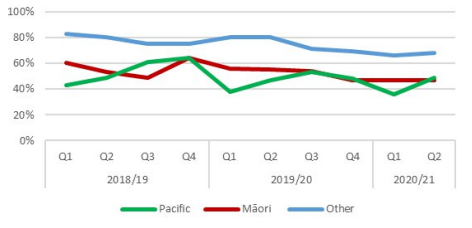
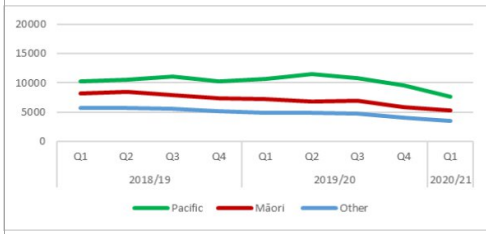
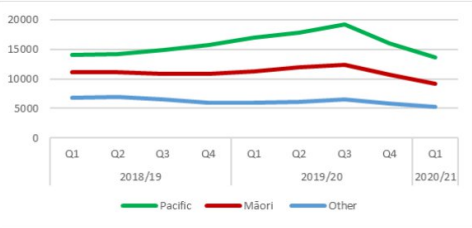
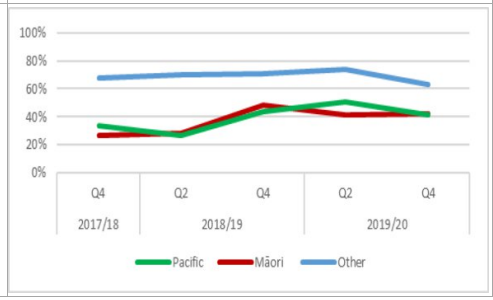
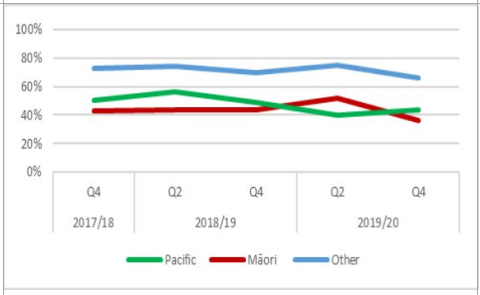
Ensure Pacific Children meet key childhood developmental milestones through culturally responsive and quality services and support

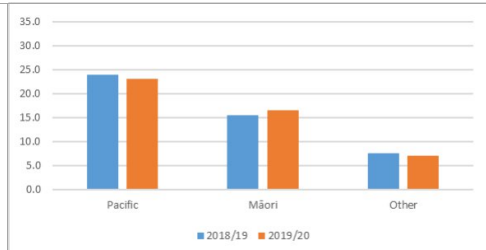
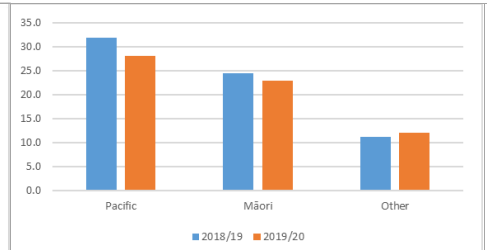
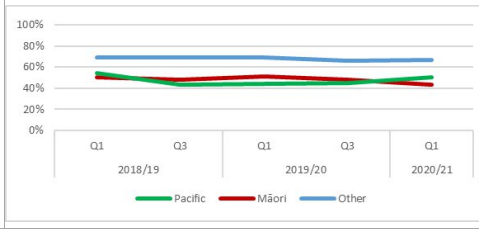
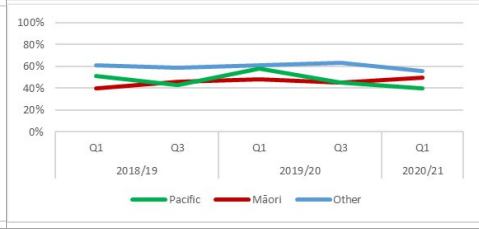
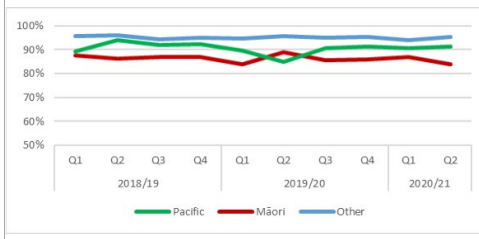
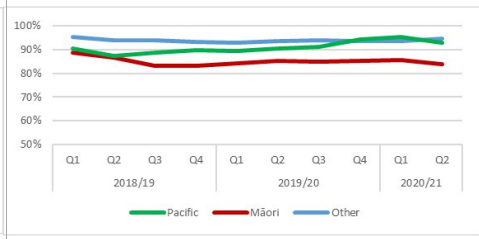
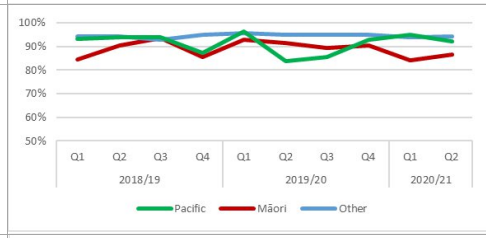
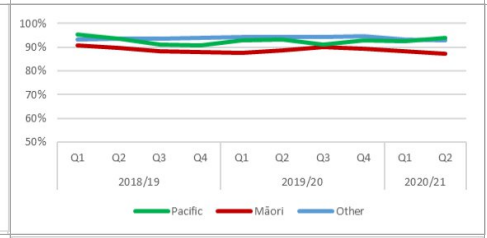
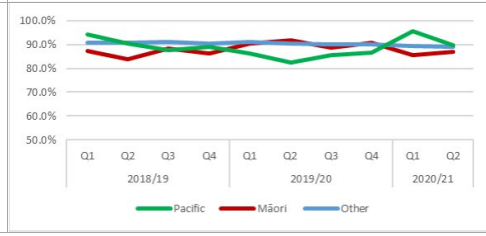
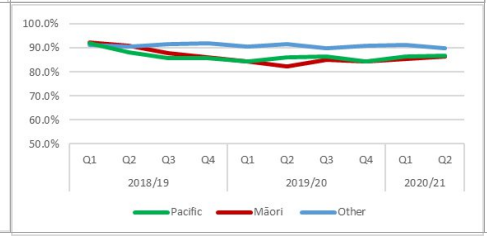
Areas of focus for next 12 months

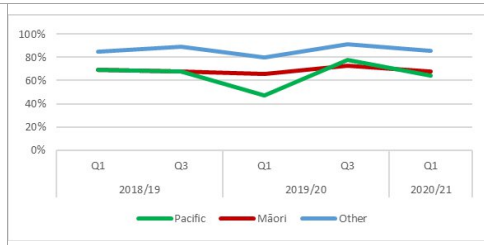
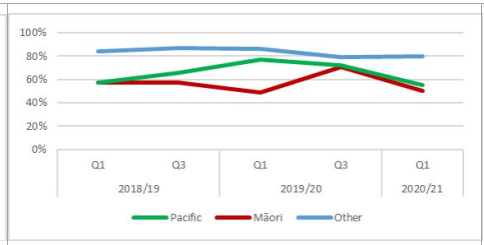
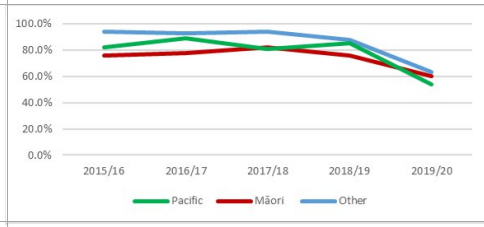
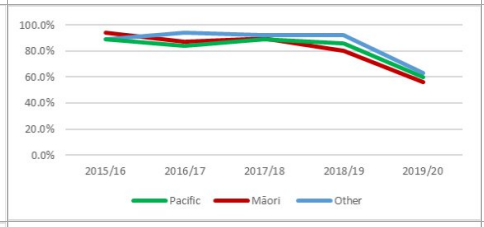
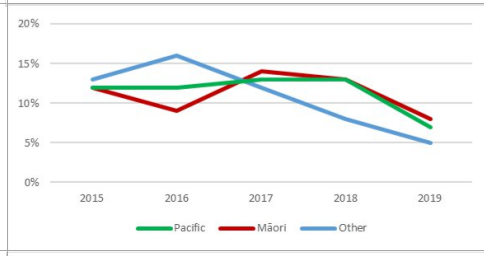
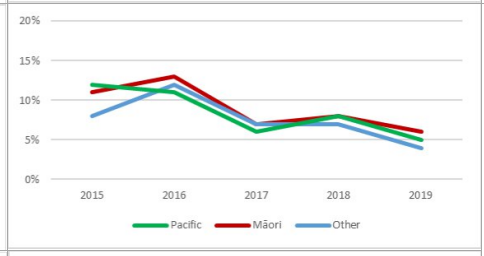
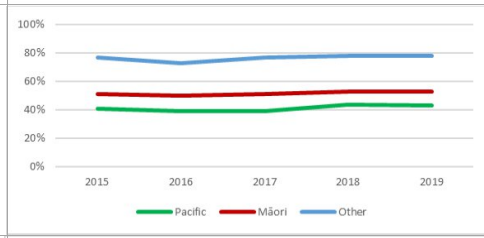
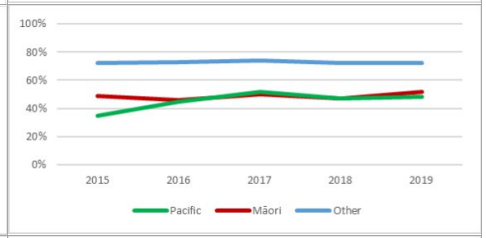
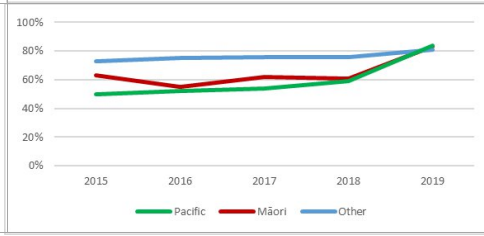
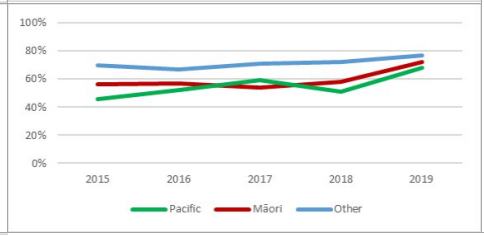
- More accessible and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.
- Increase the number of Pacific children living in healthy homes that are warm and smokefree

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
% of Pacific pregnant women registered with a Lead Maternity Carer within the first trimester of pregnancy	Early engagement with an LMC enables opportunity for screening, education and referral, and begins the primary maternity continuity of care relationship between a woman and her LMC.	≥75%			In 2020/21 CCDHB has invested in a new Māori and Pacific midwifery collective in Porirua, which is expected to improve access to antenatal care in Porirua and across the DHB catchment. In 2020/21 we will commence our 2DHB maternal health system plan, which will deliver models of care that improve access and engagement in early antenatal care and education.
Rate of Ambulatory Sensitive Hospitalisations for children aged 0-4 years (per 100,000 people)	Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through primary care interventions. This indicator also highlights variation between different population groups. ASH rates can be reduced by shifting care closer to home, providing coordinated primary and secondary care services, and improving timely access to high-quality and culturally safe primary care services.	CCDHB: ↓6% (≤10,865) HVDHB: ↓2% (≤17,459)			Actions to improve ASH rates, particularly for Māori and Pacific children, are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. We continue to actively monitor performance in this area and identify actions to improve performance. The declining rates are driven by decreased respiratory illness in 2020.
% of Pacific babies living in smoke-free households at 6 weeks	This measure is important because it aims to reduce the rate of infant exposure to tobacco smoke by focusing attention beyond maternal smoking to the home and family environment and will encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to - from pregnancy, to birth, to the home environment within which they will initially be raised.	CCDHB: 54% HVDHB: 54%			From April 2021 the CCDHB Hapū Ora service will be able to offer nicotine replacement therapy directly to their clients as an additional support tool. HVDHB continues to progress work promoting the relationship between the Hapū Māmā smoking cessation service and maternal and child services provided in secondary care.

Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15	Housing related hospitalisations are related to the quality of housing. This indicator highlights variation between different population groups. Rates can be reduced by ensuring that homes are safe, warm and dry.	CCDHB: ≤16 HVDHB: ≤11			Actions to improve performance are related to ASH rates, particularly for Pacific children. These are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. We continue to actively monitor performance in this area and identify actions to improve performance. The declining rates are driven by decreased respiratory illness in 2020.
% of Pacific infants fully or exclusively breastfed at 3 months	The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of life long physical and psychological benefits for babies.	≥80%			CCDHB is supporting the training of five Māori and Pacific lactation consultants (LC). It is expected that the first LC will complete the qualification in April 2022 so it will take time to see the benefits of this investment. In HVDHB a three-stage breastfeeding improvement project is currently being scoped to strengthen the level of breastfeeding support services available to mothers.
% of Pacific children fully vaccinated at eight months old	Immunisation rates at age eight months are a measure of timely protection against whooping cough, among other vaccine-preventable diseases. Timely protection is important because whooping cough is particularly dangerous to babies aged under 1 year; around half of babies who catch whooping cough when they are aged under one year will need hospital treatment.	≥95%			Work is underway to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register and how both primary care and the OIS provider can be supported to reach families with children still needing vaccinations. 12 month immunisation coverage for all ethnicities was at 95% or above which shows that some children are delayed in completing the full schedule of vaccines but do 'catch up'.
% of Pacific children fully vaccinated at two years old		≥95%			Work is underway to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register and how both primary care and the OIS provider can be supported to reach families with children still needing vaccinations.
% of Pacific children fully vaccinated at five years old		≥95%			

% of Pacific children accessing Well Child Tamariki Ora (WCTO) services and completing Core Checks (all checks by 1yrs)	The early years of life set the foundation for lifelong health and wellbeing. The WCTO programme is a package of universal health services offered free to all New Zealand families for children from birth to 5 years. The programme includes 12 Core Contacts.	≥90%			COVID restrictions had a significant impact on the ability to deliver the core checks and services. We have worked hard to catch up on core checks that were missed. HVDHB has recently reviewed its investment in its WCTO provider (Tamariki Ora, Pacific Health Services Hutt Valley), with a view to validate or correct the level of WCTO activity the DHB purchases from our providers.
% of eligible Pacific children receiving and completing a B4 School Checks	The purpose of the B4 School Checks is to promote health and wellbeing in four year olds, and to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school. This measure particularly monitors and promotes quality improvement across WCTO providers	≥90%			The B4SC programme was interrupted in 2019/20 due to COVID restrictions and the service has been working hard to catch up. We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Pacific.
% of Pacific children (0-12) enrolled in Community and DHB oral health services overdue for their scheduled examinations	By providing effective publicly funded child oral health programmes (health promotion, prevention and treatment) that reduce the prevalence of oral disease in children of primary school age, the DHB will contribute to the outcome of protecting and promoting good health and independence through decreasing the prevalence and severity of dental decay experienced by children in school Year 8 (12/13-year olds).	≤5%			We continue to work closely with the Bee Healthy Service to improve health outcomes and achieve equity for Pacific children. We are working to ensure that our pathway for follow-up is integrated with other services including WCTO, Public Health Nurses, Pacific Providers and other relevant stakeholders.
% of Pacific children caries free at 5 years		CCDHB: ≥69% HVDHB: ≥85%			
% of Pacific children caries free at 12 years old		TBC			

Pacific Young People

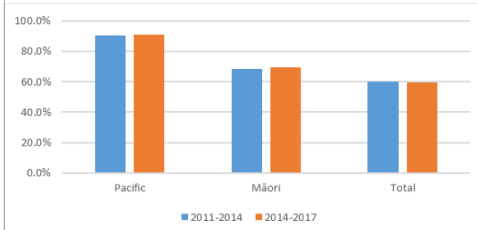
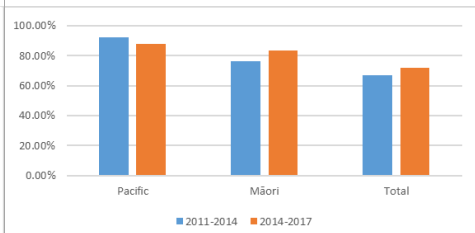
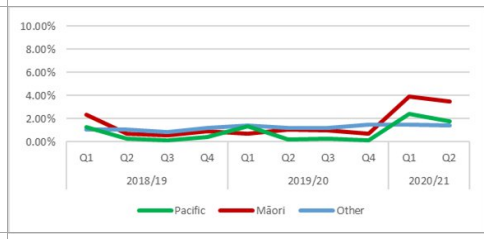
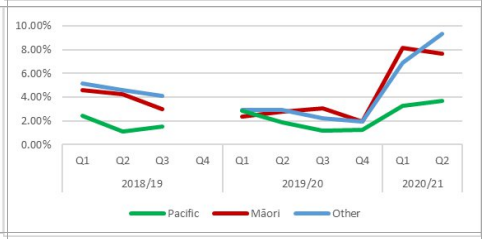
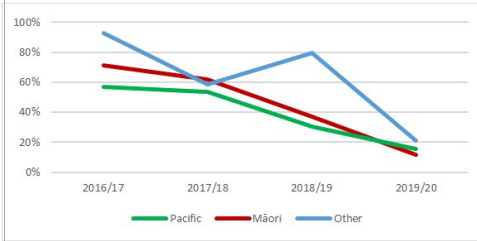
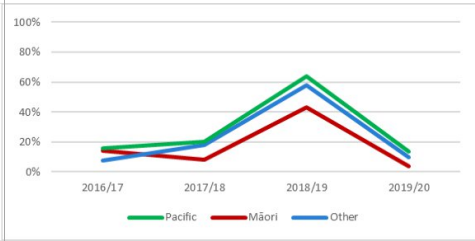
Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives

Areas of focus

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

Sub-regional initiatives (2DHB)

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

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

Pacific adults and ageing well

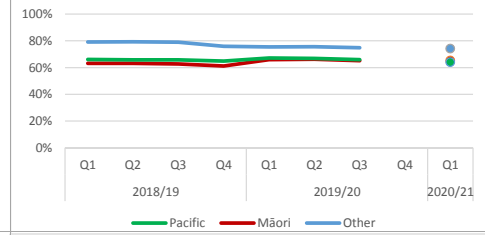
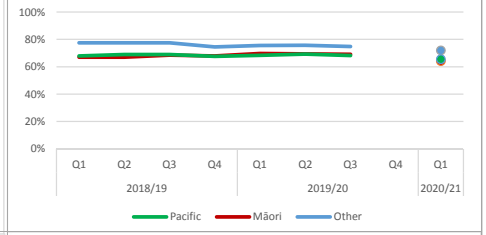
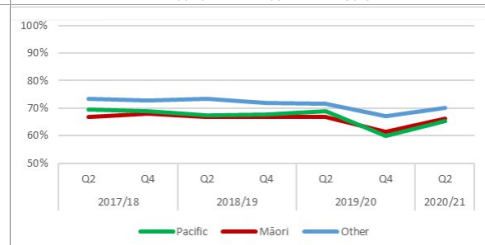
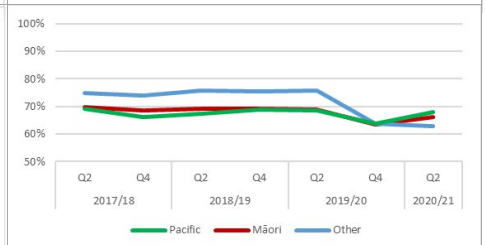
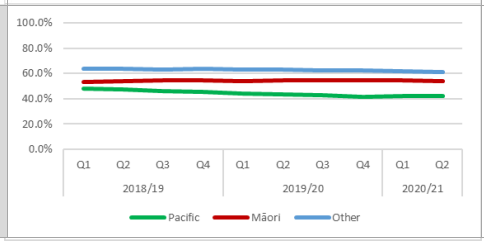
Pacific adults and elderly are actively engaged in their health care, live productive, active, culturally secure and quality long lives.

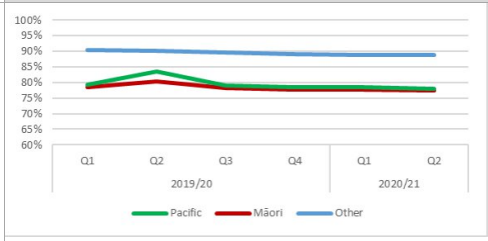
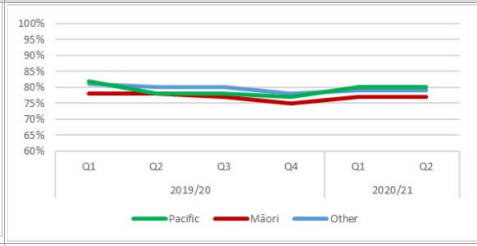
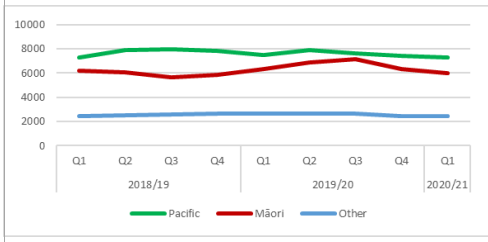
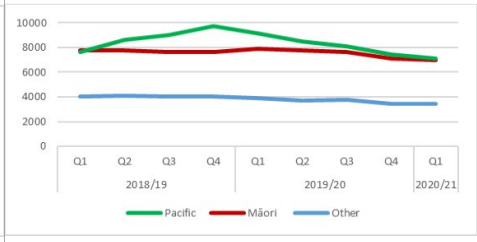
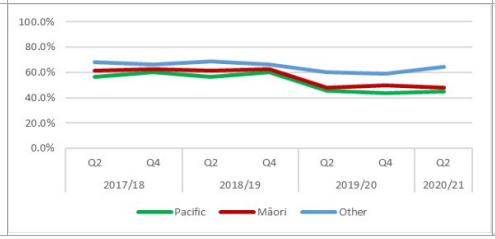
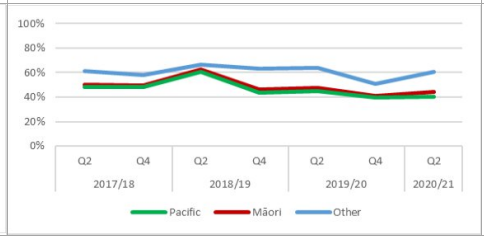
Areas of focus

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

Sub-regional initiatives (2DHB)

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

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
% of eligible Pacific women (25-69 years old) completing cervical screening	By improving cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health. Cervical, Breast and Bowel screening reduce Pacific morbidity and mortality via improved access to early identification.	≥80%			Regional Screening Services continue to provide additional supports for Pacific women who are overdue or unscreened to attend a breast screening clinic. Same day biopsies and first specialist appointments are now more common in our symptomatic imaging clinic which runs concurrently alongside the breast clinic. We continue to work with Pacific Navigation Services to improve our referral pathways, booking and rescheduling appointments.
% of eligible Pacific women (50-69 years old) completing breast screening		≥70%			
% of eligible Pacific population (60+) completing bowel screening testing			CCDHB does not provide bowel screening services		HVDHB continues to support the Bowel Screening Regional Team by assisting with the Secretariat support to the Pacific National Bowel Screening Network (PNN). PNN members assist in ensuring pathways, development of kits, translations and collateral developed are culturally appropriate and relevant for Pacific people.

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

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 7 April 2021

Resolution to exclude the Public

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

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

TABLE

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

and Operational Performance Report		
Patient Story	As above	As above
Service Spotlight	As above	As above
Hospital Network development framework	As above	As above
Strategic priorities – Communication and Engagement framework	As above	As above
Bowtie Analysis: Provider workforce does not have capacity or competency to deliver safe care	As above	As above
FRAC Update and Items for Approval Chiller Replacement Wellington Regional Hospital Update to Delegation Schedules in the Delegated Authority Policy – Capital & Coast DHB Update to Delegation Schedules in the Delegated Authority Policy - Hutt Valley DHB	As above	As above
3DHB Data and Digital Quarterly Board Report Q2	As above	As above
2DHB Māori Health Change Proposal	As above	As above
2DHB Māori Health Services Update	As above	As above

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

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