PUBLIC

HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**AGENDA** Held on Wednesday 16 February 2022 Time: 9:00am Location: Zoom Zoom Meeting ID: 835 0269 8434

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Pg
1.	**PROCEDURAL BUSINESS**			
1.1.	Karakia		All members	2
1.2.	Apologies	**NOTE**	Chair	
1.3.	Public Participation – Nil	**NOTE**	Chair	
1.4.	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair	3 7
1.5.	Minutes of Previous Concurrent Meeting – 1 December 2021	**APPROVE**	Chair	9
1.6.	Matters Arising	**NOTE**	Chair	18
1.7.	Chair's Report and Correspondence	**NOTE**	Chair	
1.8.	Chief Executive's Report	**NOTE**	Chief Executive	19
1.9.	Board Work Plan 2022	**NOTE**	Chair	30
2.	**STRATEGIC PRIORITIES**			
2.1.	Strategic Priorities update and presentation 2.1.1. Mental Health and Addictions Commissioning presentation	**NOTE**	Chief Executive Acting Director Strategy, Planning and Performance Executive Director MHAIDS Executive Clinical Director MHAIDS	33
3.	**DHB PERFORMANCE AND ACCOUNTABILITY**			
3.1.	HVDHB Financial and Operational Performance Report – December 2021 3.1.1. Report	**NOTE**	Director Provider Services Acting Chief Financial Officer Acting Director Strategy, Planning and Performance	38 41
3.2.	CCDHB Financial and Operational Performance Report – December 2021 3.2.1. Report	**NOTE**	Director Provider Services Acting Chief Financial Officer Acting Director Strategy, Planning and Performance	89 92
4.	**UPDATES**			
4.1.	2DHB COVID Update	**NOTE**	Chief Executive	137
4.2.	3DHB Data and Digital update – Q2 Report	**NOTE**	Chief Digital Officer	146
4.3.	Māori Health Update – Q2 Report	**NOTE**	Director Māori Health	155
4.4.	Pacific Health and Wellbeing Strategic Plan Update	**NOTE**	Director Pacific People's Health	174
4.5.	2DHB Quality & Safety – Clinical Governance	**NOTE**	Director of Clinical Excellence	190
5.	**OTHER**			
5.1.	General Business	**NOTE**	Chair	
5.2.	Resolution to Exclude the Public	**APROVE**	Chair	

Next concurrent Board meeting:
Date: Wednesday 30 March 2022, **Location:** Zoom **Time:** 9.00am

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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

16/02/2022

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

	• Brother-in-law is a medical doctor (anaesthetist), and niece and nephew are medical doctors,all working in the health sector in Auckland • Son is Deputy Chief Executive (Insights and Investment) of Ministry of Social Development, Wellington
Hamiora Bowkett	• Deputy Chief Executive, Te Puni Kōkiri • Chair, Eastern bay of plenty primary health alliance • Chair, Māori Communities COVID-19 Fund • Former Partner, PricewaterhouseCoopers • Former Social Sector Leadership position, Ernst & Young • Staff seconded to Health and Disability System Review • Contact with Associate Minister for Health, Hon. Peeni Henare
Brendan Boyle	• Director, Brendan Boyle Limited • Director, Fairway Resolution Limited • Director, Fairway Holdings Limited • Member, NZ Treasury Budget Governance Group • Member, Future for Local Government Review. • Daughter is a Pharmacist at Unichem Petone
Josh Briggs	• Councillor, Hutt City Council • Wife is an employee of Hutt Valley District Health Board / Capital & Coast District Health Board
Keri Brown	• Councillor, Hutt City Council • Council-appointed Representative, Wainuiomata Community Board • Director, Urban Plus Ltd • Member, Arakura School Board of Trustees • Partner is associated with Fulton Hogan John Holland
'Ana Coffey	• Father, Director of Office for Disabilities • Brother, employee at Pathways, NGO Project Lead Greater Wellington Collaborative • Shareholder, Rolleston Land Developments Ltd

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

Yvette Grace	• Member, Hutt Valley District Health Board • Member, Wairarapa District Health Board • Husband is a Family Violence Intervention Coordinator at Wairarapa District Health Board • Member - Te Hauora Runanga o Wairarapa • Member - Wairarapa Child and Youth Mortally Review Committee Member - He Kahui Wairarapa

	• Sister-in-law is a Nurse at Hutt Hospital • Sister-in-law is a Private Physiotherapist in Upper Hutt
Dr Tristram Ingham	• Associate Professor, University of Otago (2001 – present) • Review Panel Member, PHARMAC Review (2021) • Board Member, Capital & Coast District Health Board (2019 – present) • Board Member, Health Quality & Safety Commission (2020 – present) • Chair- Muscular Dystrophy Assoc. (Tuaatara | Central Region) (2018 – present) • Director , Calls 4 Charity Limited (2021 – present) • Director, Miramar Enterprises Limited (2014 – present) • Chairperson, Foundation for Equity & Research New Zealand (2018 – present) • Co-Chair, My Life My Voice Charitable Trust (2019 – present) • Governance Representative, Disabled Persons Organisation Coalition (2018 – present) • Representative, Independent Monitoring Mechanism to the United Nations Convention on the Rights of Persons with a Disability (UNCRPD) (2018 – present) • Chair, Te Ao Mārama: Māori Disability Advisory Group, Ministry of Health (2018-2021) • Chair, Te Ao Mārama Aotearoa Trust: Māori Disability Advisory Group (2021) • Deputy Chairperson, Te Āparangi: Māori Advisory Group to HealthCERT, Ministry of Health (2019 – present) • Member, COVID-19 Immunisation Implementation Advisory Group, Ministry of Health (2021 – present) & Tātou Whakaha Disability Advisory Sub Committee • Member, Enabling Good Lives Governance Group, Ministry of Health (2020 – present) • Member, Machinery of Government Working Group, Ministry of Social Development (2020 – present) • Member, Māori Workforce Development Group, Ministry of Health (2021-present) • Member, Māori Monitoring Group, Ministry of Health (2021-present) • Professional Member, Royal Society of New Zealand • Member, Institute of Directors • Member,– Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Wife, Member 3DHB Disability Advisory Group & Tāngata Whaikaha Roopu
Dr Chris Kalderimis	• National Clinical Lead Contractor, Advance Care Planning programme for Health Quality & Safety Commission

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

HUTT VALLEY AND CAPITAL & COAST DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

16 FEBRUARY 2022

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

Wednesday, 9 February 2022

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

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	MINUTES Held on Wednesday 1 December 2021 Location: Zoom Zoom: 876 5068 1844 Time: 9:00am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

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

PRESENT

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

APOLOGIES

Yvette Grace

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

*Fionnagh Dougan	Chief Executive
*Rosalie Percival	Chief Financial Officer
*Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Services
*Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
*Joy Farley	Director Provider Services
*John Tait	Chief Medical Officer
*Peter Guthrie	Acting Director Strategy Planning and Performance
*Rachel Gully	Director People and Culture
*Sue Gordon	Director Transformation
*Helen Mexted	Director of Communication and Engagement
*Sally Dossor	Director, Office of the Chief Executive and Board Secretary
*Meila Wilkins	Board Liaison Officer
Anne Pedersen	2DHB Group Manager Clinical Excellence
*Jamie Duncan	General Manager Hospital & Specialty Services
*Lisa Smith	Hospital Network Commissioning Team Leader
*Dr Sean Galvin	Clinical Leader 2DHB Transformation

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1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

1.2 APOLOGIES

As noted above.

1.3 PUBLIC PARTICIPATION

1.4 INTEREST REGISTER

1.4.1 COMBINED BOARD INTEREST REGISTER

The Boards **noted** the update to the interest register for Tristram Ingham.

- Associate Professor, University of Otago

Any further changes were to be sent to the Board Liaison Officer via email.

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

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

1.5 MINUTES OF PREVIOUS CONCURRENT MEETING

The Boards **approved** the minutes of the concurrent Board Meeting held on 3 November 2021 with minor errors corrected for clarity.

	Moved	**Seconded**	
HVDHB	Ria Earp	John Ryall	**CARRIED**
CCDHB	Brendan Boyle	Roger Blakeley	**CARRIED**

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

There were no updates or comments.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

- Recorded appreciation for CE, staff and teams involved in vaccination programme.
- Noted the confirmation from the Wellington Hospital's Foundation that it has approved funding of Tiltaway Beds, Equipment for Child Development Service & Rehabilitation Service, whiteware, appliances and TVs with a combined value of $360k for Te Wao Nui. The Chair also thanked Noel Leeming for its support. Noted that staff have acknowledged the notification and thanked WHF.

1.8 CHIEF EXECUTIVE'S REPORT

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

Notes:

- The CE updated the vaccination statistics reported as follows:

	Capital and Coast	**Hutt Valley**	**Total**
Māori Full Vax	77%	71%	74%
Pacific Full Vax	79%	78%	78%

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Other Full Vax	93%	90%	92%
Total Full Vax	**91%**	**86%**	**89%**

- Noted the issues with unvaccinated staff and that significant effort has been put into encouraging staff to be vaccinated. The number of unvaccinated staff has reduced further (now below 100 – which is approximately 1%).
- Noted the vaccination strategies for mental health patients, however noted that there is insufficient data held to establish what proportion of unvaccinated people had opted out of vaccination vs had not yet been reached (note 65% vaccinated / 35% unvaccinated).

1.9 BOARD WORK PLAN 2022

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

2 DHB PERFORMANCE AND ACCOUNTABILITY

2.1 HVDHB FINANCIAL AND OPERATIONAL PERFORMANCE REPORT – SEPTEMBER 2021

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

The HVDHB Board noted:

(a) the DHB had a ($0.99m) deficit for the month of September 2021, being $1.3m favourable to budget;

(b) the DHB year to date deficit excluding $0.2m net COVID-19 costs was ($4.8m);

(c) the Funder result for September was $2.2m favourable, Governance $0.2m favourable and Provider $1.0m favourable to budget;

(d) total Case Weighted Discharge (CWD) Activity was on plan year to date.

	Moved	**Seconded**	
HVDHB	John Ryall	Wayne Guppy	**CARRIED**

Notes:

- A Board member raised a question about the discrepancy in the data presented to the Board in item 3.1 of the Board agenda for 3 November 2021 regarding C-section rates at HVDHB for 2019. It was noted that there was an error in the report as the reported rate (52%) had captured the c-section rate for all HVDHB residents, regardless of whether they had birthed at Hutt Hospital or Wellington Regional Hospital. The data has been corrected and is shown by the underlined text below:

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

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

2016	33%	33%

2.2 CCDHB FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS – SEPTEMBER 2021

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

The CCDHB Board noted:

(a) The DHB had a ($6.4m) deficit for the month of September 2021, being ($2.3m) unfavourable to budget before excluding COVID-19;

(b) In the one month we have incurred ($5.1m) additional net expenditure for COVID-19;

(c) The DHB has an overall YTD deficit of ($6.5m) from normal operations (excluding COVID-19) being $4.6m favourable to the underlying budget

	Moved	**Seconded**	
CCDHB	Chris Kalderimis	Kathryn Adams	**CARRIED**

3.0 STRATEGIC PRIORITIES

3.1 STRATEGIC PRIORITIES UPDATE

The Boards noted:

(a) Progress against implementation of the strategic priorities agreed for delivery in 2021/22 as we transition to the new health and disability system;

(b) the 2DHB Maternal and Neonatal System Plan is provided for Board approval following endorsement by HSC (item 4.1 of the agenda);

(c) the update and recommendations on the 2DHB Hospital Network are provided in a separate paper at this meeting.

	Moved	**Seconded**	
HVDHB	John Ryall	Naomi Shaw	**CARRIED**
CCDHB	Stacey Shortall	Kathryn Adams	**CARRIED**

4.0 DECISIONS

4.1 HSC UPDATE AND ITEMS FOR APPROVAL FROM MEETING DATED 24/11/21

The Chair of HSC spoke to each of the items considered at the HSC meeting.

Item 2.1: 2DHB Maternal and Neonatal Health System Plan

Health System Committee recommends the Boards:

(a) **approve** the 2DHB Maternal and Neonatal System Plan (Appendix 1).

(b) **note** the description of the proposed evidence-based maternity system to be developed and funded across both DHBs going forward.

(c) **note** a whole of system approach, defining care and experience across the maternal care service continuum has been adopted to develop the above. This has created specific

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interdependent actions that need to be implemented in order to realise the shifts outlined in the strategy.

(d) **note** we have taken a pro-equity approach to creating the Plan. This means the actions defined as "culturally responsive care" and "enabling maternal and neonatal care" have been prioritised for implementation.

(e) **note** the Plan outlines over 50 actions that have been developed in partnership with the community and clinicians and reflects what they believe will make a meaningful change for all women and families having babies across the 2DHB region.

(f) **note** DHB leads are of the view that it is possible to drive many of the initiatives within existing resources (refer to Section 10 of this paper) by December 2022.

(g) **note** that to fully realise the changes outlined in the strategy, additional investment in new services will be required.

(h) **note** that to achieve a significant increase in access to primary birthing (refer to Appendix 1, slide 31), additional capital investment is required. This would need to be considered by Health New Zealand.

(i) **note** that a detailed implementation plan to support the 2DHB Maternal and Neonatal System Plan will be provided to the Health System Committee and the 2DHB Boards in March 2022. This will include funding considerations and recommendations to Health New Zealand and the Māori Health Authority.

(j) **note** that the Health System Committee requested the following amendments to the 2DHB Maternal and Neonatal System Plan (which have been made and are in Appendix 1 (attached)):

i. ensure that the reference on page 27 of the Plan (page 52 on Diligent Book) to the 2014 study is accurate;

ii. ensure that the language in the Plan does not conflate home birth and primary birthing; and

iii. amend page 33 of the Plan (page 58 on Diligent) to refer to creating a pathway that better integrates maternal and neonatal pathways for babies with impairments with pathways to children's services.

Item 2.2 Commissioning in Localities

The Board notes:

(a) The presentation on Commissioning in Localities given at the Health System Committee meeting on 24 November 2021.

(b) the alignment to our early understanding of the systems being implemented by Health NZ and the Māori Health Authority and the draft Pae Ora (Health Futures) Bill currently open for submissions.

	Moved	**Seconded**	
HVDHB	Keri Brown	Ken Laban	**CARRIED**
CCDHB	Kathryn Adams	Sue Gordon	**CARRIED**

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Notes:

- The Chair of HSC gave a comprehensive overview of item 2.1 – 2DHB Maternal and Neonatal Health System Plan which the Health System Committee recommended to the Board for its approval.
- The Boards thanked staff for a thorough and progressive system plan and commended the work. The Boards noted that immediate implementation action points that can be funded within the existing budget will be progressed this financial year.
- Noted an investment plan to support the System plan will be provided to the Board at the meeting on 30 March 2021 and this will include recommendations to Health New Zealand on recommended actions beyond 1 July 2022.
- A member expressed concern that the Plan did not provide a timeline for the establishment of a new primary birthing facility in Hutt or Wellington, however it was noted that a new primary birthing facility in the Hutt Valley or Wellington would require significant capital investment and that given the health reforms and transition to Health New Zealand, this is not a matter the Boards can address – other than through inclusion in the implementation plan as noted above.

4.2 DELEGATIONS FOR THE 2021/22 SUMMER BREAK IN BOARD SCHEDULE

The Chair of the Boards introduced the paper.

Capital & Coast District Health Board agreed to:

(a) delegate authority to the Chair and Chair of CCDHB FRAC to make any decisions that require Board approval from 2 December 2021 to 15 February 2022 provided that:

i. on advice from the Chief Executive, the Chair is satisfied that it is not appropriate to delay the decision until 16 February 2022

ii. all decisions made under this delegation are reported to the concurrent Board meeting on 16 February 2022 for ratification

Hutt Valley District Health Board agreed to:

(a) delegate authority to the Chair and Chair of HVDHB FRAC to make any decisions that require Board approval from 2 December 2021 to 15 February 2022 provided that:

i. on advice from the Chief Executive, the Chair is satisfied that it is not appropriate to delay the decision until 16 February 2022

ii. all decisions made under this delegation are reported to the concurrent Board meeting on 16 February 2022for ratification

	Moved	**Seconded**	
HVDHB	Josh Briggs	Ria Earp	**CARRIED**
CCDHB	Chris Kalderimis	Sue Kedgley	**CARRIED**

5.0 UPDATES

5.1 DSAC UPDATE FROM MEETING DATED 24/11/21

Naomi Shaw introduced and spoke to the paper.

The Boards note:

(a) The papers are in the Diligent Board book for the HSC meeting dated 24 November 2021

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

Item 2.1 3DHB Sub Regional Disability Strategy 2017 – 2022 Update

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

Item 2.2 - Review of Sub-Regional Disability Strategy 2017-2022

(a) Grant Cleland, Director of Creative Solutions, will present the preliminary findings of his review on progress with the Disability Strategy.

(b) The review was based on the recommendations made at the 3DHB Disability Forum in Silverstream 2019.

Item 2.3 – MHAIDS Service Performance Update

(a) The MHAIDS Service Performance update – November 2021, included as Attachment 1.

(b) MHAIDS is currently implementing a range of improvement strategies to mitigate immediate demand and access pressures.

Item 2.4 – 3DHB Mental Health and Wellbeing Strategy update

(a) Hutt Valley and Capital & Coast DHBs have formally established the Mental Health and Addiction Change Programme to redesign and implement a pro-equity, whole of population system of care to support the mental health and wellbeing of the people across the subregion.

(b) the continued expansion of the Access and Choice programme across the 3DHB region, with investment increasing monthly to fund a total of 82.4 FTE by June 2023.

(c) the growth of the Primary Care Liaison Service, with the recent establishment of a full-time consultant psychiatrist role in Wellington, two nurse practitioner roles in Hutt Valley DHB, and upgrading of the two liaison roles in Wellington to nurse practitioner level.

(d) a new Acute Alternative service in Lower Hutt will be operational from mid-November 2021, serving as an alternative to inpatient care for those experiencing acute mental illness.

(e) that four Kaupapa Māori and Pacific providers across the Capital & Coast and Hutt Valley regions have been contracted to provide Primary and Community AOD Kaupapa Māori and Pacific Counselling.

(f) an updated 3DHB Suicide Prevention and Postvention Action Plan has been developed. This updated Action Plan incorporates *Every Life Matters* focus areas. It is also responsive to the 2020/2021 annual provisional suicide statistics, the Ministry of Health suicide web tool, and recent 3DHB data.

	Moved	**Seconded**	
HVDHB	Ria Earp	Ken Laban	**CARRIED**
CCDHB	Sue Kedgley	Kathryn Adams	**CARRIED**

Richard Stein left the meeting at 9.55am.

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6.0 OTHER

6.1 2DHB COVID PLANNING

The Boards noted:

(a) progress with implementing the next phase of 2DHB COVID planning

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Ria Earp	**CARRIED**
CCDHB	Roger Blakeley	Brendan Boyle	**CARRIED**

COVID Response and Resilience.pptx

Notes

- Presentation on Covid response and resilience, particularly care in the community.
- The Covid governance group oversees the modelling and the assumptions that the planning is based on.
- We have learned from the international experience in addition to Auckland. International networks are drawn on by all teams.
- 2000 seeded cases was questioned as seeming high. That number includes undetected, asymptomatic and symptomatic cases. Scenario planning takes into account a worst-case scenario when capacity (beds and staff) is exceeded and there is a clinical response to that.
- Discussed the clinical model and the care in the community. Highlighted focus on triage system with high risk groups having clinicians visiting. Clinical assessments will be by health professionals.
- Discussion on risks to vaccination staff and ensuring that all people working in the vaccination programme are supported. Security staff are in place and have trained in de-escalation and are liaising with police.
- The Boards commended the pro-equity approach and the co-ordinated approach across agencies and providers.
- Wider welfare response is being joined up across agencies taking an intersectorial approach. Our DHBs are working with many other agencies (e.g. MSD, Kainga Ora, and Te Puni Kōkori) and this is an opportunity to connect with agencies.
- Liaising with Wellington Free Ambulance on transfer of Covid patients and protocols and approach.
- ICU co-ordination and capacity is being managed across the New Zealand and at a local level there is significant planned surge capacity, and as previously noted to the Boards, 2 extra ICU beds will be commissioned early next year.

6.2 GENERAL BUSINESS

Nil.

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6.3 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Josh Briggs	**CARRIED**
CCDHB	Brendan Boyle	Kathryn Adams	**CARRIED**

3 NEXT MEETING

Date: 16 February 2021 **Location:** Hutt Hospital **Time:** 9am

The public meeting concluded at 10.40am.

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

DATED this day of 2022

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 16 February 2022

Action Number	Date of meeting	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status

Nil - no actions carried forward from 2021

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 17th November 2021 to 28th January 2022.

2 Communications and Engagement

2.1 External engagement with partners and stakeholders

The main focus has been on ongoing engagement with iwi, Māori providers, Pacific providers, primary health, community partners, councils, WREMO, and government agencies on the COVID-19 Care in the Community programme, and the ongoing vaccination campaign, particularly as we start boosters and vaccinations for tamariki aged 5-11 years.

2.2 External communications and engagement – news and media

We have had a large number of news and media updates over the period to mark a number of vaccination milestones and celebrate achievements amongst our people:

DHB	Subject	Outlet / Channel
CCDHB	New investment in Wellington's health infrastructure	Ministerial PR
CCDHB	CCDHB reaches 90 percent fully vaccinated	PR
RPH	Community-minded youth play vital role to achieve smokefree law change	PR
2DHB	2DHB Maternal and Neonatal System Plan Approved	Website article
2DHB	Wellington's Pacific communities to pass 90 percent vaccination rate with festival event	PR
2DHB	Celebrating Success weeks highlight innovation and camaraderie throughout 2DHB	Website article
HVDHB	Paul Sayers: Youth champion	Website article

HVDHB	Reconnecting Pacific communities with the health sector	Website article
CCDHB	Cultural care supports Māori mental health	Website article
CCDHB	Siaosi Anamani – A people's hero	Website article
CCDHB	A passion for improving care of the older person	Website article
2DHB	Supporting our Tongan community	Website article
2DHB	New Zealand to move to COVID-19 traffic light Red	Website article
CCDHB	Link Building – Wellington Regional Hospital	Website article
CCDHB	Pilot scheme findings conclude mental health response partnership model a success	Joint PR – CCDHB, NZ Police, Wellington Free Ambulance
2DHB	Delay to opening of Te Wao Nui	Website article

2.3 Health promotion campaigns

COVID-19 vaccination programme highlights

On Around 14 January, Capital & Coast District Health Board (CCDHB) became the first DHB in the country to report 90 per cent of eligible Māori having had their second dose. Hutt Valley DHB has fewer than 250 people to go to reach that same milestone.For the 2DHB region, 97 per cent of eligible people have received their second dose, including 90 per cent of Māori, and 93 per cent of Pacific people.

This milestone achieved media coverage in Stuff here and here and and RNZ here.

These achievements are the result of collaborative equity drive efforts, led by five experienced Māori health providers in partnership with the 2DHB team and supported by primary health care, pharmacists, and GPs.

Arawhetu Gray, Director Māori Health - Hutt Valley and Capital & Coast DHBs says we unapologetically focused on Māori. Providers built their workforces from their own people, creating jobs and ensuring that the people on the front lines were people that their communities trusted.

"The accolades go to all the people that are on the front line, to those who do it hard every day. It's our job to get out of the way and make their lives easier," Ms Gray says.

In addition to continuing to reach the pockets of people who are still to receive their first and/or second dose, vaccination centres have seen strong demand from people wanting their booster doses and to vaccination their 5-11-year-olds.
There are over 60 clinics operating in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites.

We are working with Māori and Pacific providers, PHOs, pharmacies and partners to create opportunities and events, including school pop-up clinics, while increasing engagement with local leaders who have the ability to reach into groups within their communities.

Booster Programme and Tamariki 5-11 year-old vaccinations

From 5 January, the eligibility period for booster vaccinations was shortened to four months, and from 17 January children aged 5-11 became eligible for their first dose. Both of these factors have driven strong demand at vaccination sites and clinics across the region.

As at 31 January, 71 per cent of eligible people in the 2DHB region have received their booster doses, and all eligible people in Aged Residential Care and covered by Disability Support Services have had the chance to receive their booster shot. Approximately 66 per cent of eligible Māori have received their booster, 63 per cent of Pacific and 56 per cent of Asian.

A national reminder campaign started on 17 January, ensuring people receive an email and text when they become eligible for their booster, with a follow-up two weeks later if they have not booked or received their booster. Māori health partners and providers are also actively communicating with kaumātua regarding booster vaccinations and the response has been strong.

The Pacific Health team working alongside Pacific providers and PHOs are focusing on reaching families for boosters and 5-11 year old vaccinations. A special event held on Saturday 29 January in Cannons Creek Porirua, administered over 300 vaccinations including 135 booster doses for Pacific people and 44 first doses.

At 31 January, 48 per cent of tamariki 5-11 year olds in the 2DHB region have had their first dose of the vaccine, with bookings and walk-in appointments steady at participating vaccination sites, especially community vaccination centres that have set up child-friendly spaces.

A series of accessible, low-sensory events are being held in February and March. These events offer more space, with fewer people and longer appointment times. In line with our whanau approach, the events are open to everyone and both children and adults can be vaccinated. We have also organised some dedicated quiet, relaxed times at Community Vaccination Centres for those who need more time or space, and a lower stress environment.

We are working with targeted schools to provide information and to run school pop-up clinics for their families and communities. These clinics will offer all doses including boosters and tamariki 5-11 year old vaccinations. As a priority, we are initially working with schools in the Porirua area with a higher percentage of Māori and Pacific students, and with less access to community vaccination options. Our 2DHB Disability Team is working with schools with a disability focus, or disability units to see what will work best for them.

Prime Minister Visits Tamaiti Whāngai COVID-19 Vaccination Centre

It was our pleasure to welcome Prime Minister Jacinda Ardern to the Tamaiti Whāngai COVID-19 Vaccination Centre in Waiwhetū, Lower Hutt on Thursday 27 January 2022.

After a *pōwhiri* at Waiwhetū Marae, Tim Bignall, Operations Manager, Te Atiawa, led Prime Minister Jacinda Ardern, Hon Chris Hipkins, MP Ginny Anderson and MP Rino Tirikatene, to the vaccination centre nearby.

The Tamaiti Whāngai COVID-19 Vaccination Centre opened in June 2021, and is one of the five Maori Providers under Te Rūnanganui o Te Āti Awa. As Te Āti Awa manawhenua, the team have completed over 25,000 Vaccinations over this period, and were the first to open drive-through vaccinations during COVID-19 lockdown in 2021.

Working in partnership with Māori Health Providers is key to our vaccination programme approach of 'trusted faces in trusted places.' The team are doing a fantastic job of creating a warm and welcoming environment for vaccination.

Care in the Community programme

The majority of people who contract COVID-19 will experience a mild to moderate illness and will be able to recover safely in their own homes.

A new 3DHB COVID-19 social media hub was launched on 26 January and by 31 January had more than 2,500 followers. Full page checklist ads appeared in four community newspapers and a new 3DHB COVID-19 web hub is under development.

We are collaborating with primary care and our iwi, Pacific and disability providers, welfare providers, and councils to ensure we have a clear, shared view of how we will be managing and supporting patients and their whānau. The 'trusted faces in trusted places' approach that has proven so critical to the success of our vaccination programme remains central to our Care in the Community model. It is key in ensuring people across our region feel comfortable and confident accessing the support they need to isolate and recover safely in the community.

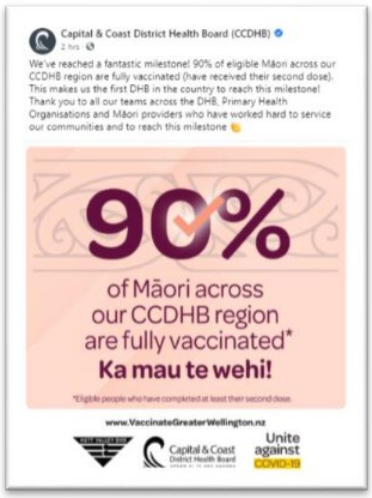
We are working closely with the different organisations involved in the COVID-19 response at local, regional and national levels including councils, WREMO and the Regional Leadership Group, to plan and implement our communications and public information strategy. This includes sharing information to ensure that information for both public and stakeholder audiences is easy to access, and putting in place shared communications, channels, and resources for the public.

Building individual and household resilience is crucial to managing COVID-19 in the community and a regional public information campaign kicked off in late January. Practical preparedness tools and tips have been developed locally and shared with stakeholders, partners, providers and partners to support national messaging on the need to prepare and provide people with specific steps they can take to get prepared.

2.4 Social media views and stories

2.4.1 Top social media posts

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 1,012,100 Twitter: 22,456 LinkedIn: 17,234	Facebook: 292,479 Hutt Maternity Facebook: 6,520 Twitter: 4,859 Instagram: 95 LinkedIn: 5,355	Facebook: 553,651



2.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
314,628 page views	81,187 page views	114,498 page views	25,737 page views

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

Top five webpages CCDHB

1. Exemption for face coverings
2. COVID-19 Community based assessment centres
3. Careers with CCDHB
4. COVID-19: changes to our services
5. After hours and emergency care

Top five webpages HVDHB

1. COVID-19 Community based assessment centres
2. Hutt Hospital campus map
3. Careers with HVDHB
4. COVID-19: Information for visitors
5. 2DHB Maternal and Neonatal System Plan Approved

Top five webpages RPH

1. Vaccination Centres
2. Getting Vaccinated
3. COVID-19 FAQ's
4. Wairarapa District Health Board Vaccination Information
5. COVID-19 Resources

Top five webpages MHAIDS

1. Do you, or does someone you know, need help now?
2. Community Mental Health Teams
3. Child and Adolescent Mental Health Services
4. Central Region Eating Disorder Services
5. Te Whare o Matairangi Inpatient Service

2.6 Website stories and releases

Our People

Celebrating Success weeks highlight innovation and camaraderie

Teams at both DHBs were encouraged to nominate staff who have gone above and beyond for both patients and their peers.

This month, CCDHB and HVDHB hosted "Celebrating Success Weeks, a celebration that includes Ngā Tohu Angitu: Celebrating Success Awards. All teams at both DHBs were encouraged to nominate staff who have gone above and beyond for both patients and their peers.

Due to COVID-19, this year the awards ceremony could not be held in the same way as in previous years. As a result, the awards were changed to a virtual ceremony, and smaller-scale 'celebrations in a box' were delivered to the winners with their awards so smaller team-based celebrations could be held, allowing winners to honour winners safely in their bubbles.

Along with the Celebrating Success Awards, the week was celebrated by circulating goodwill with signs highlighting what staff are proud of and downloadable 'shining star certificates'. After a difficult year, these signs of hope were circulated to spread a bit of cheer and acknowledge the mahi of all 2DHB staff.

Cultural care supports Māori mental health

Mental health leader Maire Ransfield has been recognised for promoting best practice in her service, which works to improve mental health care for Māori.

Maire is team leader of Te Whare Marie, a Porirua-based Māori mental health service that is part of the Mental Health, Addiction & Intellectual Disability Service (MHAIDS). The outpatient service offers a range of supports, with a crucial cultural perspective, to its clients or whaiora motuhake.

“The idea was that we were able to practice things that we hold dear as Māori – that lift not only our mental health, but our wairua, and help build cultural connections,” says Maire.

The service works with those referred to make a plan for ongoing treatment, with as much whānau involvement as possible. Depending on the needs of whaiora, this could involve a combination of psychology, art-based therapy, CBT, group gatherings, or connecting to nature, all with a Te Ao Māori lens.

“For example, the pūrākau/story of Tāne ascending to the heavens to retrieve baskets of knowledge is used to help whaiora identify their own goals, and the steps needed to reach them,” explains Maire.

The Māori holiday of Matariki offered another opportunity to explore Te Ao Māori, with Maire leading celebrations that included kai hākari, whakairo Māori (carving) and kapa haka, and discovering the genealogy of Matariki.

It’s vital that all staff have insight and knowledge to run the service in a culturally safe way, so Maire encourages attendance at weekly tikanga sessions at which staff not only gain knowledge, but are invited to engage in self-reflection.

2.7 Internal Engagement and Communication

2.7.1 Intranet page views and stories

CCDHB	HVDHB
600,000 page views	407,741 page views

2.7.2 Staff posters

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

2.7.3 Top intranet stories

Celebrations are in order

Our teams have achieved a major milestone in New Zealand's vaccination push. Capital & Coast District Health Board (CCDHB) have reached the target of having 90 per cent of Māori receiving their second dose of the COVID-19 vaccine, which makes us the first DHB in the country to reach this milestone.

Hutt Valley is also closing in on the 90 per cent target. These achievements are the result of concerted and collaborative equity drive efforts, led by five experienced Māori health providers in partnership with the 2DHB team and supported by public health organisations, pharmacists, and GPs.

Fionnagh Dougan, Chief Executive Officer - Hutt Valley and Capital & Coast DHBs, said "while there is still work to do to provide even higher levels of protection for whānau, it is important to acknowledge this significant achievement. It is a reflection of the hard work and creativity that has been employed by a huge number of people".

Arawhetu Gray, Director Māori Health - Hutt Valley and Capital & Coast DHBs said "the dedication and perseverance seen within this programme has been beyond impressive. Each week our providers are poring over detailed information showing which suburbs need more attention and devising the best way to reach them, shifting their approach based on experience and evolving knowledge of our communities."

Ringing in Christmas with the 2DHB Orchestra and Choir 'Manawa Ora'

Our 2DHB Orchestra and Choir 'Manawa Ora' brought Christmas cheer to audiences at Hutt Valley and Wellington Hospitals last weekend.

The sun came out for the performances, where patients, whānau, and of course Manawa Ora family and friends showed great appreciation and support. The repertoire included both orchestral pieces and traditional Christmas carols.

"Being part of a group of such talented and supportive musicians of all levels has become the highlight of my week. Having a safe environment with which to play music is a fantastic way to spend an afternoon and I feel so proud to be a part of it" Victoria – Flautist

The Manawa Ora 2DHB Orchestra and Choir is proudly supported by the Wellington Hospitals Foundation

16 Days of action campaign brings awareness to family violence

This month, the Violence Intervention Programme teams across both DHBs ran a family violence awareness campaign entitled 16 Days of Action – from 25th November (International Elimination of Violence against Women Day / White Ribbon Day) to 10th December (International Human Rights Day) – based on the UN's annual campaign to end gender-based violence. This year marks the 30th anniversary of the international campaign and the theme is 'Orange the World: End Violence Against Women NOW!'

A series of workshops and events were held over the '16 Days of Action' to highlight family violence and violence against women and girls as health issues. There were over 200 people registered for the workshops, and over 200 responses to the family violence survey. You can find recordings of these workshops here.

The family violence team would just like to extend a thank you to who participated in the workshops, the seminars, or just supporting with wearing orange or the white ribbon to raise awareness.

2DHB BOARD WORK PLAN 2022 – 16 February 2022

	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Location	**All meetings on zoom until further notice**		
Service Spotlight	**TBC**	**Community Dental Service**	**TBC**
2DHB Quality and Safety	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report
Financial and Operational Performance Reporting			
Financial and Operational Performance HVDHB	Report for January 2022	Report for April 2022	Report for May 2022
Financial and Operational Performance CCDHB	Report for January 2022	Report for April 2022	Report for May 2022
Scheduled reporting			
People and Culture Report	People and Culture Report		People and Culture Report
3DHB Digital Report		Q3 Report	

	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Māori Strategy (Te Pae Amorangi and Taurite Ora)		Q3 Report	
Pacific Health and Wellbeing Strategic Plan		Q3 Report and selected focus area (To be advised)	
Strategic Priorities			
	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC or DSAC work plasn – and will be reported to the Boards via HSC or DSAC - both of which are meeting on 16 March 2022.*		
Strategic Priorities Overview	*Strategic priorities update*	*Strategic priorities update*	*Strategic priorities update*
Our Hospitals	2DHB Hospital Network Update	TBC	Our Hospitals and the 2DHB Hospital Network (incl. Master Site Plan)
Commissioning and Community	*Commissioning and Community – including Localities and review of Accident & Medical and Community Radiology		
Mental Health and Addiction Services			
Maternity & Women's Health	*Implementation Plan for the 2DHB Maternal and Neonatal Health System Plan		
Enablers			
Committees			
FRAC items for Board Approval	FRAC items for Board Approval from meeting dated 03/03/22	FRAC items for Board Approval from meeting dated 27/04/22	FRAC items for Board Approval from meeting dated 01/06/22
MCPAC update	MCPAC update and items for approval from meeting dated 3/03/2022	MCPAC update and items for approval from meeting dated 27/04/2022	MCPAC items for Board Approval from meeting dated 01/06/22

	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
HSC update and items for Board Approval	HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval	DSAC items for Board Approval from meeting dated 16/03/22		
Engagement			
Te Upoko o te Ika Māori Council (TUI MC)	TUI MC/Engagement with MHA		Boards meet with TUI MC
Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group
Annual Planning and Reporting			
Budgets for 2022/23	**Advice to each DHB**: The 22/23 budget process will be run by interim Health New Zealand and the budgets for each entity amalgamating into HNZ will be agreed by the HNZ Board. These budgets do not get agreed by the outgoing DHB Boards.		
Annual Report	N/A		
Other items			
Environmental Sustainability Strategy	Sustainability Strategy update		
Procedural and Board process issues			
Action log items			
Other			
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)			
Site Visit			

Board Information – Public

16 February 2022

2DHB Strategic Priorities Update

Action Required

The Boards note:

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

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

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

Executive Summary

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

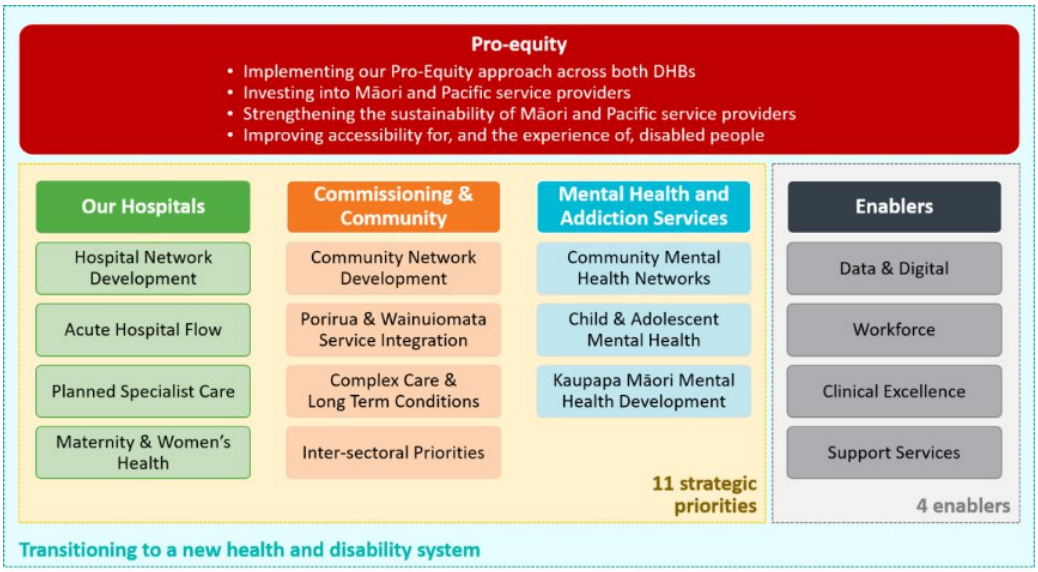
Our focus remains on delivering equitable health outcomes and intensifying support for Māori, Pacific people and those living with disability, mental illness and addiction.

We will:

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

This paper focusses on the first bullet point.

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



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

Strategic Considerations

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

Engagement/Consultation

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

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A	There is a risk of diluting our focus and resources across areas of work that are not critical to the needs of our populations during this time of change and transition to the new system.	Fionnagh Dougan	Communicating an agreed set of strategic priorities and enablers ensures that we are focussed on meeting the needs of our populations during this period of transition. The Director Transformation role is designed to ensure there is executive level focus and alignment across the programme.	Low Risk	Low Risk
N/A	There is a risk that the omicron variant of COVID-19 will spread into the community before the transition to Health NZ. Although we are well prepared for this, it may at times disrupt the focus on our strategic priorities work programme.	Fionnagh Dougan	We continue to focus on getting our staff and community vaccinated to mitigate the risks of an omicron outbreak.	Medium Risk	Medium Risk

Implementing our Strategic Priorities

Governance

There are three ELT-led Forums overseeing the Strategic Priorities work programme.

Programme and Project Development – Key Deliverables

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

Rolling Programme of Reporting

There is a rolling programme of 'deep dive' reports and commissioning decisions to the concurrent Board and committees. At this Board meeting there will be presentation covering:

- an update on the overall programme and focus until 30 June 2022.
- the Mental Health and Addictions Commissioning focus area and associated workstreams.

Focus area updates

Mental Health and Addictions Commissioning

This workstream is co-creating and commissioning community mental health networks to improve local service integration and achieve equity, particularly improving Māori mental health and addiction

outcomes. Concept design working groups were held late last year to test the piloting of community mental health and addiction hubs, and initial workshops were held in January with lived experience representation and a range of providers. This work will integrate, where required, with the Porirua locality prototype project, which is part of the Community & Commissioning workstream.

The Māori Expert Advisory Group has been established to provide advice and support to the design of Kaupapa Māori mental health services and the broader change programme.

The project team have held three co-design workshops for the Community Mental Health and Addiction Project (integrated locality-based mental health and addiction services). These workshops were the first in the series for this project, with additional workshops being planned for February. Initial discussions have been held with leaders in the younger persons sector to co-design and inform the Community Child and Adolescent Project.

Community & Commissioning

The Transition Unit has invited the DHBs in partnership with Ngāti Toa to submit a proposal for Porirua to be a prototype locality. The locality approach is intended to drive a focus on equity and priority populations, taking a place-based approach using population-health analytics and community engagement to plan and deliver in a way that meets local needs and preferences. The Transition Unit has allocated additional funding ($20,000) to support the development of the prototype proposal. A consultancy, Te Amokura, has been engaged to work with the Iwi, the DHB and the PHOs to write the submission to the Transition Unit by 18 February 2022.

The proposal sets out a high-level plan for developing the Porirua Locality Prototype. We are using the collective impact approach to structure how we work together, in partnership with Ngāti Toa, to develop the Porirua locality.[1] Key focus areas for the early stages of Porirua Locality development include establishing governance and oversight; relationship building between the Iwi Māori Partnership Board, providers and other stakeholders; developing an operations team; community engagement and planning; and reviewing current services to create a Porirua Locality Plan. Locality planning and priority setting for Porirua will be closely worked up with the Iwi Māori Partnership Board and Health NZ.

The existing Ngāti Toa hauora-wellbeing plan (Whiti Te Rā Mauri Ora Plan 2021-2024) will set out the strategic direction for the locality plan. The Mauri Ora plan identifies four key focus areas for Porirua: best start to life, empowered patients and whānau, living well with long term conditions, and outstanding systems and services.

A working group has also been established to progress a locality approach with Wainuiomata. This group includes the DHB, Te Awakairangi Health Network (the PHO), and Healthy Families Hutt Valley. They have undertaken initial stakeholder analysis, collected data to support a mapping exercise and a specification for a community asset mapping exercise. An initial data analytics pack has been developed to support community engagement.

In partnership with Te Ātiawa Ki Whakarongotai and Tū Ora Compass Health, the Kāpiti Community Health Network has continued to develop and strengthen relationships. The Kāpiti Network has a well-developed work programme and this is progressing to plan. Plans for Community Network Development in Wellington and Hutt Valley are being refreshed by the Community & Commissioning Forum.

We have also been consolidating relationships with our community and agency partners to address housing issues and prevent people reaching homelessness. We have a clear and well communicated

[1]Collective Impact is a collaborative approach that brings different groups together around a common agenda and principles.

process to identify and support the unique needs of homeless during pandemics. Regional Public Health is actively engaged in a number of cross-agency collaborations to address issues along the housing continuum.

Synergia Consulting has been commissioned to provide advice on priorities for investment and implementation in relation to Accident and Medical/After Hours services and Community Radiology. Synergia is working to finalise a report that will inform recommendations to ELT. Phase 2 is more detailed analysis and the development of proposals to inform business cases for investment.

2DHB Maternity and Neonatal Health

The 2DHB Maternity and Neonatal Health Strategy was endorsed by 2DHB Board at the 1 December 2021 meeting. Work has begun with the Maternity & Neonatal Health Planning Advisory Group and other lived experience, cultural and clinical experts to implement the new system.

A Communications and Engagement Lead has been appointed and is drafting a 2DHB Communications and Engagement Plan for the 'Strengthened Health Response to Family Violence' work programme. A scoping session with ThinkPlace (consultant) has been completed. Thinkplace will lead work to design better support for health professionals and people with lived experience of family violence, post-disclosure.

Our Hospitals

Front of Whare detailed design work is underway. Clinical and operational teams are workshopping the future state of patient flows and required facility design. Business case elements are being developed in parallel to support a May 2022 submission. Master site planning is progressing with a current focus on the implementation of the clinical configuration and demand modelling approaches endorsed by the Boards in December. The project leads met with Te Upoko o te Ika Māori Council (TUI MC) on 3 February 2022 and are meeting with the Sub-Regional Disability Advisory Group on 17 February 2022.

Planned care delivery is at risk as discussed at FRAC and Board, primarily driven by the COVID-19 environment. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. In addition, acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. Both DHBs are actively working to maximise utilisation of theatre and bed capacity internally, and private hospital capacity as available.

Next Steps

We will provide a high-level progress update on the 2DHB Strategic Priorities at the 2DHB Board meetings in March, May and June 2022.

Separate and more detailed 'deep dive' presentations/papers are also scheduled, as follows:

- Commissioning & Communities (Localities and review of Accident & Medical and Community Radiology) – to the Health System Committee on 16 March 2022
- Implementation Plan for 2DHB Maternity and Neonatal Health System Plan – to the Health System Committee on 16 March 2022
- The 2DHB Hospital Network – to the 2DHB Board 30 March 2022 and 22 June 2022

Board Information – Public

16 February 2022

HVDHB Financial and Operational Performance Report – December 2021

Action Required

The HVDHB Board notes:

(a) the DHB had a ($3.1m) deficit for the month of December2021, being ($0.6m) unfavourable to budget;

(b) the Funder result for December was $0.5m favourable, Governance $0.1m favourable and Provider ($1.2m) unfavourable to budget;

(c) total Case Weighted Discharge (CWD) Activity was 4% ahead of plan year to date;

(d) the DHB year to date deficit, excluding COVID-19 costs, was ($7.4m). This is against the budgeted position of ($9.2M), which is $1.8M favourable to the underlying budget.

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

Executive Summary

The COVID-19 response costs for the 21/22 financial year are expected to be fully funded by the Ministry of Health, and revenue has been accrued to cover the costs reported to the Ministry. The net impact to December is additional costs of $1m in relation to Regional Public health and Provider costs.

- Excluding the net COVID-19 costs the DHB's result for the six months to 31 December 2021 is a ($7.4m) deficit, versus a budget deficit of ($9.2m).
- For the six months to 31 December 2021 the overall DHB result, including COVID-19 and Holidays Act costs is a ($8.4m) deficit compared to a budget deficit of ($9.2m).
- Key underspends in the provider include; Medical and Allied Health personnel. In the funder underspends in demand driven costs including; Laboratory, Mental health contracts, other external provider payments and IDF outflow.
- The December month included the additional unbudgeted costs of the nursing MECA however this was offset by additional unbudgeted MoH revenue of $5.4m.

- Agreed budget changes of $14m were actioned in the October results. The budget changes impacted the funder by $13m reducing community pharmaceuticals and IDF outflow. The provider arm was reduced by $1m for anticipated reduction in depreciation for the current year.
- Capital Expenditure to 31 December was $4.5m with $34.8m remaining including projects that were delayed and funding which has been transferred into this financial year.
- The DHB has a positive cash balance at month-end of $75.9 million which is better than budget due to delayed capital spend and MoH funding relating to January received in December. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (Maternity upgrade projects and the procedure suit). The equity injections are expected in 2021/22 and 2022/23 to line up with forecast expenditure.

Hospital:
The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority.

- In response to the increasing wait times though the ED services the Operations Centre has commenced a major project to find issues and solutions. This is urgent as we approach the likelihood of increasing ED presentations.
- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with the same staff shortages. Worrying ethnicity differences in waiting times are not consistent across all specialties - over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.

Funder:
In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. The four main work streams are:

Complex Care and Long Term Conditions
- Improve access and reduce inequities for Maori and Pacific

Locality Services Integration
- Formalise locality function and networks in Porirua and Wainuiomata (Porirua being a bid for iHNZ locality Prototypes)

2DHB Community Health Networks
- Strengthen Kapiti Community Health Network
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- Community Radiology redesign

Inter-sectoral Priorities
- Disability – World of Difference
- Strengthen our response to family violence

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Hutt Valley populations.
People	Staff numbers for HVDHB are 76 below plan year to date.
Financial	Planned deficit for HVDHB is $16.8 million with no COVID-19 impacts included.
Governance	This monthly report enables the Board to scrutinise the financial and operational performance.

Engagement/Consultation

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

Identified Risks

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

Attachments

3.3.1 Hutt Valley DHB Financial and Operational Performance Report – December 2021

Monthly Financial and Operational Performance Report

For period ending
31 December 2021

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

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Executive Summary (continued)

- **Hospital:** The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority .
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- Strengthen Kapiti Community Health Network / Develop Community Health Networks in Wellington and the Hutt Valley / Allied Health Integration / Community Accident and Medical redesign/ Community Radiology redesign

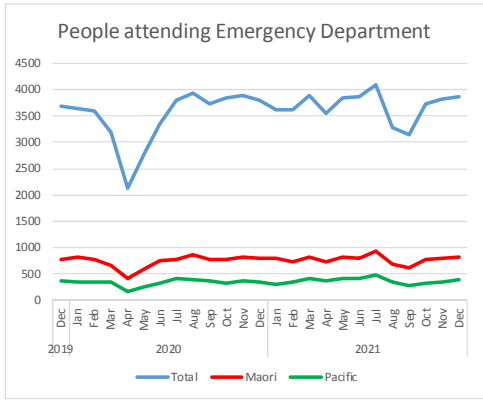
Inter-sectoral Priorities

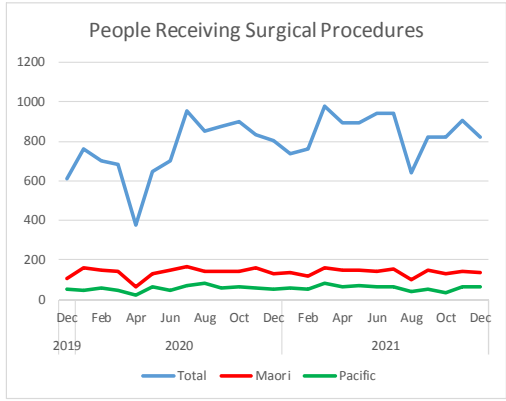
- Disability – World of Difference / Strengthen our response to family violence

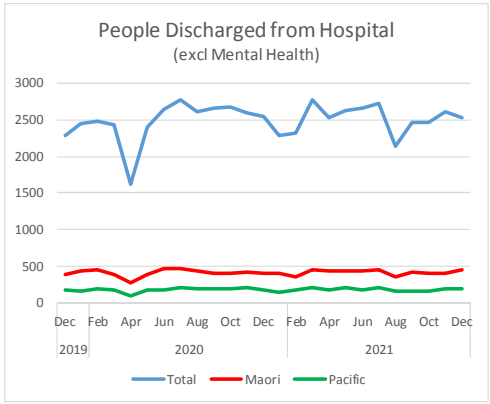
Performance Overview: Activity Context (People Served)

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

People attending ED	**3,869**	831 Maori, 385 Pacific
People receiving Surgical Procedures	**819**	134 Maori, 63 Pacific
People discharged from Hospital (excl Mental Health)	**2,520**	447 Maori, 195 Pacific







Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community

8,401

1,354 Maori, 611 Pacific

Primary Care Contacts

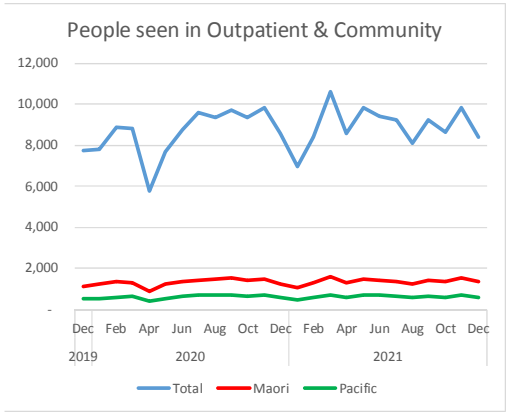
31,791

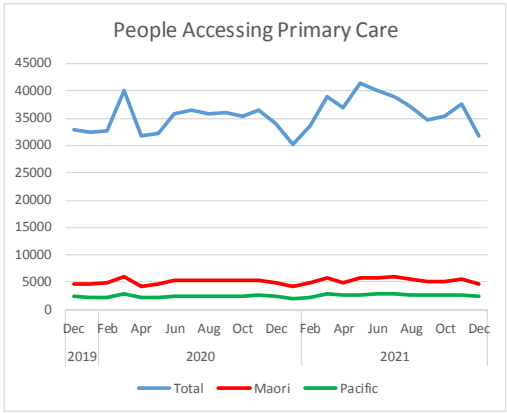
4,550 Maori, 2,330 Pacific

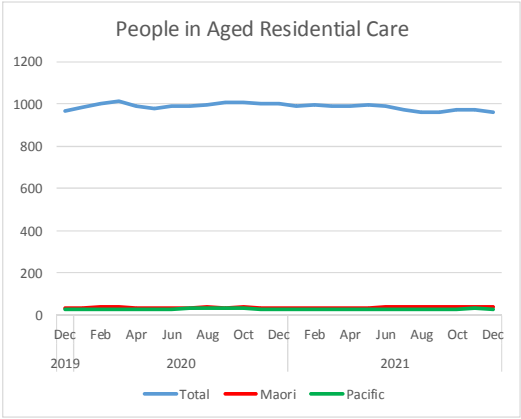
People in Aged Residential Care

962

38 Maori, 30 Pacific







Financial Overview – December 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$8.4m deficit	$1.7m Deficit	$7.1m deficit	$4.5m
Against the budgeted deficit of $9.2m.	Against the budget deficit of $1.5m.	Against the budget deficit of $7.6m.	Compared to a maximum budgeted spend of $39.3m

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
4% ahead	1,850	$24.3m
605 CWDs over PVS plan at end of Nov. IDFs were 66 CWD below budget at the end of the month	YTD 76 FTE below annual budget of 1,928 FTE.	This is an increase of $0.5m on prior period.

Hospital Performance Overview – December 2021

YTD Shorter stays in ED	People waiting >120 days for treatment (ESPI5)	People waiting >120 days for 1st Specialist Assmt (ESPI2)	Faster Cancer Treatment
82%	1,169	830	100%
13% below the ED target of 95%, and below December 20 87%.	Against a target of zero long waits a monthly increase of 29.	Against a target of zero long waits a monthly decrease of 6	We were below the 62 day target this month. The 31 day target was not achieved at 68%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
4% ahead	1,842	2
605 CWDs over PVS plan at end of Nov. IDFs were 66 CWD below budget at the end of the month	74 below YTD budget of 1,916 FTE. Month FTE was 77 under budget an upwards movement from November of 7 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has an favourable variance of $0.5m for the month.
- Funding of $5.4m has been received to support the additional nursing MECA costs and this has been passed to the hospital provider arm.
- Community pharmaceuticals have increased for the month by $352k which reflects the increased dispensing fees and timing of pharmacies claims being requested and processed.
- Mental Health costs are under budget for the month and under year to date reflecting timing of contracts which will be rectified with the acute care continuum investments come on stream.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:

  Complex Care and Long Term Conditions
  - Improve access and reduce inequities for Maori and Pacific

  Locality Services Integration
  - Formalise locality function and networks in Porirua and Wainuiomata (Porirua being a bid for iHNZ locality Prototypes)

  2DHB Community Health Networks
  - Strengthen Kapiti Community Health Network
  - Develop Community Health Networks in Wellington and the Hutt Valley
  - Allied Health Integration
  - Community Accident and Medical redesign/ Community Radiology redesign

  Inter-sectoral Priorities
  - Disability – World of Difference
  - Strengthen our response to family violence

Funder Financial Statement – December 2021

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of December 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										
39,641	39,837	(196)	37,924	1,717	Base Funding	237,845	239,019	(1,174)	227,045	10,800	475,689	478,038	(2,349)	455,083	20,607
8,815	2,411	6,404	2,546	6,268	Other MOH Revenue	23,181	14,466	8,715	16,502	6,679	40,363	28,932	11,432	34,030	6,333
74	26	48	40	34	Other Revenue	191	153	38	473	(281)	332	307	26	733	(400)
9,783	9,557	227	9,115	669	IDF Inflows	57,405	57,339	66	57,718	(312)	114,834	114,678	156	111,945	2,889
58,313	**51,830**	**6,483**	**49,625**	**8,688**	**Total Revenue**	**318,622**	**310,977**	**7,645**	**301,738**	**16,885**	**631,219**	**621,955**	**9,264**	**601,791**	**29,429**
					Expenditure										
349	349	0	443	94	DHB Governance & Administration	2,091	2,091	0	2,401	309	4,183	4,183	0	4,652	469
26,846	21,391	(5,455)	20,814	(6,032)	DHB Provider Arm	133,857	128,344	(5,513)	126,855	(7,003)	262,308	256,689	(5,619)	252,732	(9,576)
					External Provider Payments										
3,907	3,555	(352)	3,488	(419)	Pharmaceuticals	20,766	20,035	(731)	21,347	580	39,519	38,057	(1,462)	37,162	(2,357)
4,387	4,413	26	4,392	5	Laboratory	26,297	26,620	323	26,546	249	52,906	53,169	263	52,577	(330)
2,659	2,684	26	2,585	(74)	Capitation	16,080	16,107	27	15,697	(383)	32,187	32,214	27	31,021	(1,166)
1,315	1,264	(51)	1,402	87	ARC-Rest Home Level	7,648	7,497	(151)	7,120	(528)	15,161	14,858	(302)	13,871	(1,290)
1,866	2,009	142	2,025	159	ARC-Hospital Level	11,630	11,908	278	10,829	(801)	23,322	23,599	278	21,724	(1,597)
2,749	2,803	54	2,391	(358)	Other HoP	16,945	16,818	(127)	15,357	(1,587)	33,889	33,635	(254)	30,333	(3,556)
842	1,022	180	932	90	Mental Health	5,875	6,133	257	5,315	(561)	12,558	12,265	(293)	11,898	(660)
2,267	1,797	(470)	2,143	(125)	Other External Provider Payments	12,940	11,164	(1,776)	12,626	(314)	28,454	23,403	(5,051)	25,067	(3,387)
12,043	11,991	(52)	10,154	(1,889)	IDF Outflows	71,570	71,947	377	56,368	(15,203)	142,707	143,894	1,187	108,813	(33,894)
59,229	**53,278**	**(5,951)**	**50,767**	**(8,462)**	**Total Expenditure**	**325,699**	**318,663**	**(7,036)**	**300,462**	**(25,238)**	**647,194**	**635,967**	**(11,227)**	**589,851**	**(57,342)**
(917)	**(1,449)**	**532**	**(1,143)**	**226**	**Net Result**	**(7,077)**	**(7,686)**	**609**	**1,276**	**(8,353)**	**(15,975)**	**(14,012)**	**(1,963)**	**11,939**	**(27,914)**

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($196k) to budget for the month.
- Other MoH revenue is favourable $6,404k for December.
- IDF inflows $227k favourable based on information available.

Other MOH Revenue Variance	MTH $000's	YTD $000's
Capitation Funding	17	166
COVID-19 Funding	514	2,585
COVID-19 Comm. Pharmacy from balance sheet	351	731
2020/21 Planned Care	-	(111)
Additional Immunisation funding	-	31
Nurses' MECA Funding	5,421	5,421
Crown funding agreements		
B4 School Check Funding	0	(32)
Additional Immunisation funding	-	31
More Heart and diabetes checks	(11)	(33)
Additional School Based MH Services	(10)	(58)
Maternity Quality and Safety Programme	0	100
Rheumatic Fever / Healthy Homes	(45)	(280)
Midwifery Clinical Coaches and Return to Practice Pro	8	50
Pilot Alert Programme	(7)	(45)
B4SC Active Families	(25)	(37)
VIP Programme Coordination in DHB's	0	(0)
Tobacco Control	(23)	(87)
Well Child/Tamariki Ora Services	15	89
Other CFA contracts	6	12
Year to date Variance $000's	**6,404**	**8,715**

Expenditure:

Governance and Administration is on target for October. Provider Arm payments variance includes IDF Inflows passed through to the Provider and the additional funding for the Nurses MECA Settlement.

External Provider Payments:

Pharmaceutical costs are unfavourable ($352k) for December.

Capitation expenses are $26k favourable for the month, partially offset by changes to revenue.

Aged residential care costs are $91k) favourable for the month.

Other Health of Older People costs are favourable by $54k for the month and ($127k) YTD.

Mental Health costs are favourable $180k for the month.

Other External Provider Payments are ($470k) unfavourable for the month including the IDF budget reduction.

IDF Outflows are unfavourable ($52k) for the month based on available information.

Inter District Flows (IDF)

IDF Wash-ups and Service Changes December 2021			
IDF Inflows ($000s)	Variance to budget		
	Month	YTD	Forecast
WAI - Child Epidemiology	0	3	5
CAP-LTS CHC residential care	57	57	115
Wash-ups			
2021/22 Inpatient estimate	20	(386)	(357)
2021/22 PHO	-	18	18
2020/21 Inflow Wash-ups	-	226	226
CAP-LTS CHC residential care	149	149	149
Timing differences/changes outstanding	-	-	-
IDF Inflow variance	**227**	**66**	**156**

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 $227k favourable for the month.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are unfavourable for the month ($52k), favourable YTD $377k due to COVID lock down.

Commissioning: Families & Wellbeing

What is this measure?

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

Why is this important?

- Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through preventative care and coordinated care in the community and primary care setting.
- Children who receive the complete set of age-appropriate vaccinations are less likely to become ill from certain diseases.
- The Before School Check (B4SC) aims to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school.

How are we performing?

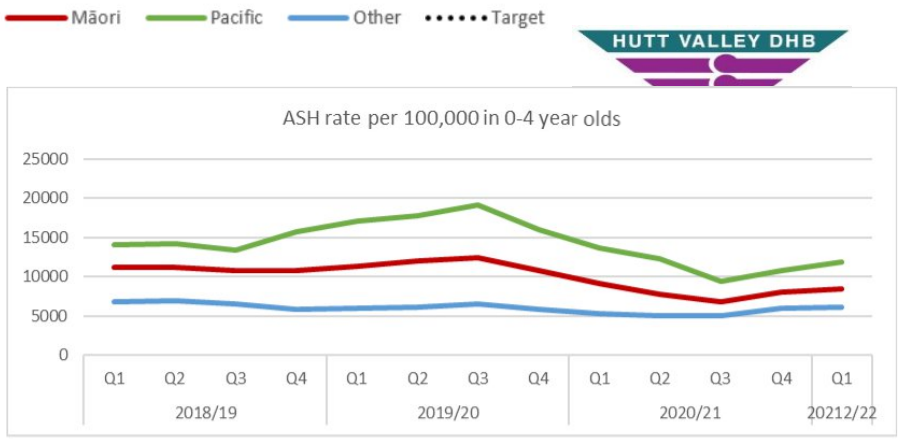
- ASH 0-4 Performance is 8,448 for Māori, 11,818 for Pacific and 6,175 for non-Māori, non-Pacific
- Performance is below the 95% target for 5 year old immunisation coverage for Māori (77%), Pacific (90%), and non-Māori, non-Pacific (86%).
- B4SC performance is below the 45% year to date target for Māori (17%), Pacific (17%) and non-Māori, non-Pacific (29%).

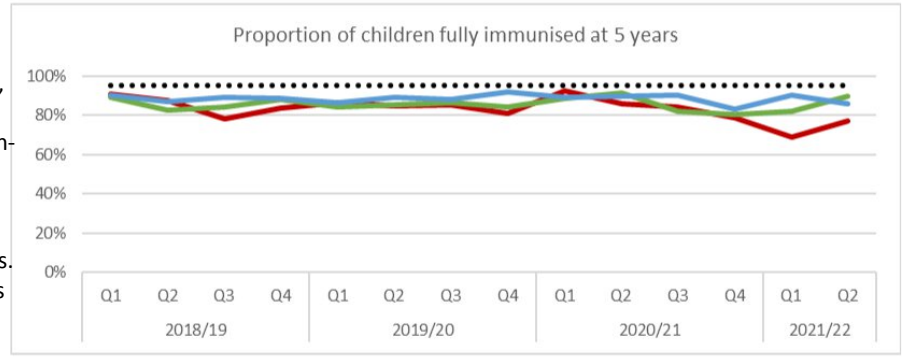
What is driving performance?

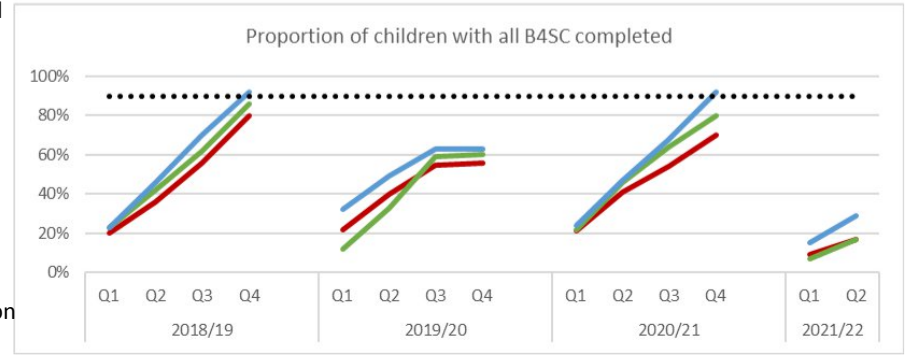
- Increases in hand hygiene and border closures have had the most significant impact on reducing ASH rates.
- The 1 October change to the immunisation schedule (which changed the two MMR doses from 12 months and 4 years to 12 months and 15 months) may be impacting immunisation coverage. A 2DHB Immunisation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

Management comment

- We are raising the profile of, and linkages to, respiratory support services (such as those provided by the Tū Kotahi Asthma Trust) across primary and secondary care.
- We are working to identify the factors contributing to the high number of children on the Outreach Immunisations Service (OIS) register. HVDHB is working with Te Awakairangi Health Network PHO, Regional Public Health and Kōkiri OIS to improve how childhood immunisations are delivered in the Hutt Valley and how Kōkiri OIS is supported to reach families with children still needing vaccinations.
- We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for tamariki Māori.







Commissioning: Primary & Complex Care

What is this measure?

Older People and Frailty

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

Why is this important?

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

How are we performing?

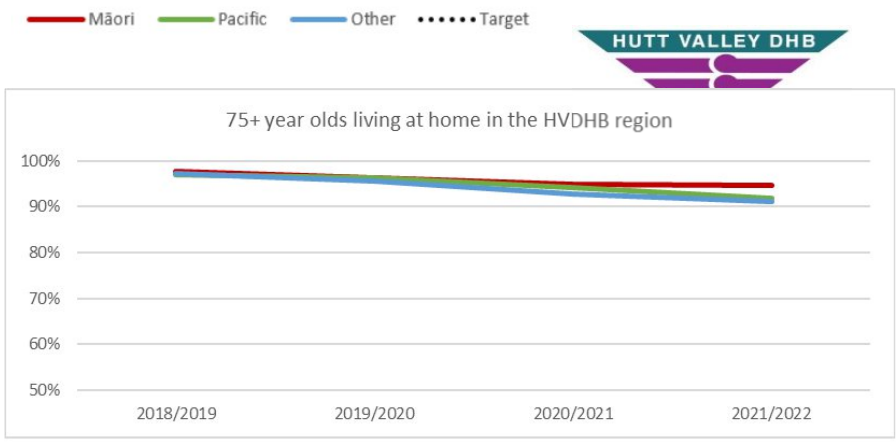
- The proportion of 75+ year olds living at home is 95% for Māori, 92% for Pacific, and 91% for non-Māori, non-Pacific.
- The acute bed day rate for 75+ year olds is 1,943 for Māori, 1,971 for Pacific, and 1,790 for non-Māori, non-Pacific.
- The 0-28 day acute readmission rate for 75+ year olds is 14% for Māori, 10% for Pacific, 13% for non-Māori, non-Pacific.

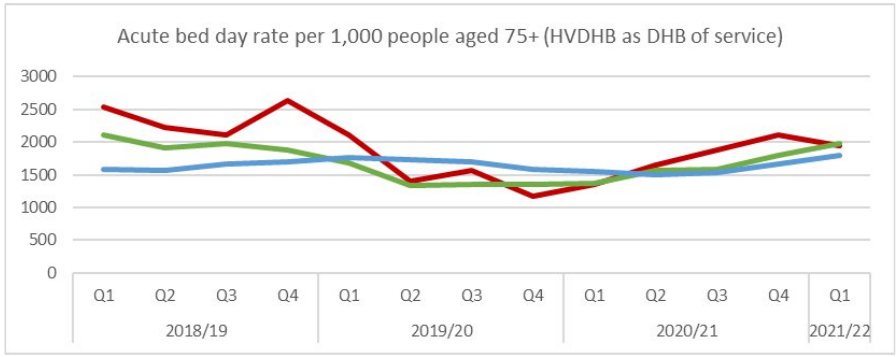
What is driving performance?

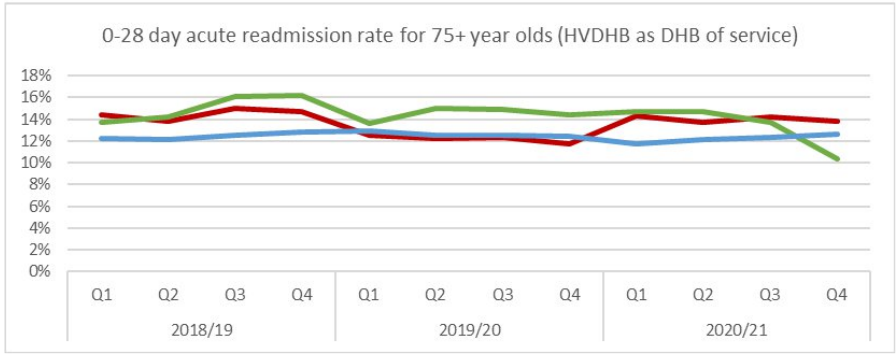
- Frail older people contribute to a significant volume of hospital bed occupancy due to their complex health and social circumstances. We have invested to support frailty across our health system to reduce their length of stay in hospital and decrease risk of further functional decline.

Management Comment

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







Commissioning: Hospital & Speciality Services

What is this measure?
Planned Care
Elective Service Performance Indicator (ESPI) 5 100% of patients given a commitment to treatment are treated within the required timeframe (120 days).

Why is this important?
Capacity constraints are driving increases in waiting lists and waiting times for surgical treatment and the DHB is not meeting the ESPI5 target. It is important to continually analyse who is waiting and ensure that this impact is not disproportionally affecting any of our communities and we are achieving the principles of ***Equity:*** patients receive care that safely meets their needs, regardless of where they live and who they are.
Timeliness: patients receive care at the most appropriate time to support improved health.
Access: patients can access the care they need in the right place, with the right health provider.

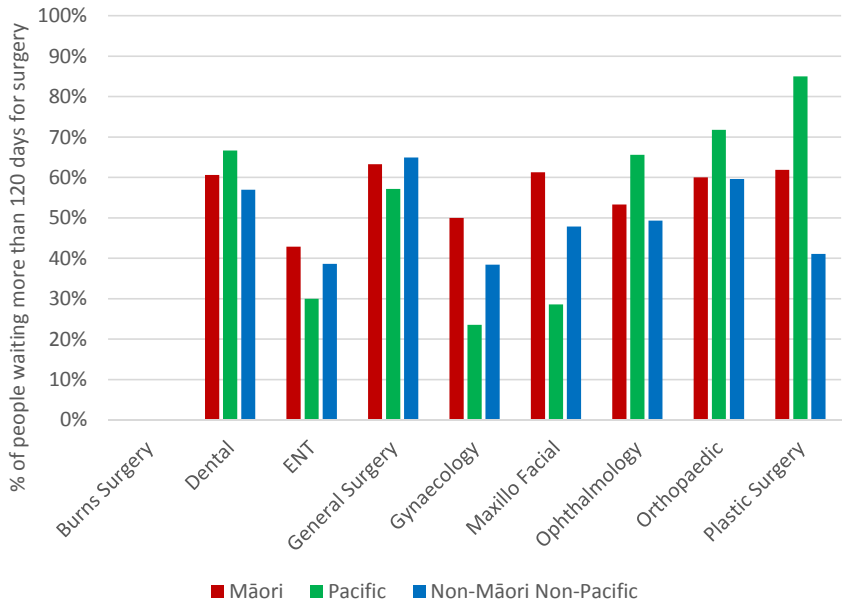
How are we performing?
We are not meeting the target and Māori and Pacific are over-represented in the people waiting longer.
- More than half of the people on the waiting list have been waiting more than 120 days for treatment however this is not equal across ethnic groups.
- 58% of Māori and 59% of Pacific peoples have waited longer compared with 51% of Non- Māori Non-Pacific people.
- On average Māori wait 16 days longer for surgery and Pacific people 11 days longer than Non- Māori Non-Pacific people.

Ethnicity differences in waiting times are not consistent across all specialties.
- Māori are waiting longer for access to Dental, ENT, Gynaecology, Maxillo Facial surgery, Ophthalmology, and Plastic Surgery.
- Pacific peoples are waiting longer for Dental, Ophthalmology, Orthopaedic and Plastic Surgery.

What is driving performance?
Waiting times are increasing across specialties and ethnicities due to capacity constraints limiting delivery of planned care.
- COVID-19 continue to challenge our expected delivery of planned care due to additional precautions.
- We continue to manage workforce issues such as recruiting to key vacancies.
- HVDHB continues to prioritise ESPI-5 waitlist by clinical urgency and time on waitlist.

Management comment:
Over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.

Surgical waiting list statistics	Māori	Pacific	Non-Māori Non-Pacific	Total
Number of people on waiting list	485	200	2,155	2,840
Average number of days waiting	192	187	176	179
Median number of days waiting	161	161	122	127
% of people waiting more than 120 days (ESPI5)	58%	59%	51%	53%
Number of people waiting more than 120 days	280	118	1,103	1,501
Average wait time if waiting more than 120 days	284	273	284	283
Median waiting time if waiting more than 120 days	223	238	225	226



Commissioning: Mental Health & Addictions

What is this measure?

- Rate of access to primary care mental health and addictions services per 100,000
- Rate of access to specialist mental health and addiction services per 100,000 (DHB and NGO)
- Rate of Māori under the Mental Health Act: section 29 community treatment orders

Why is this important?

- Enrolment in a PHO and engagement with primary care supports access to specialist services. It also generates opportunities for early intervention; and integration across primary, community and specialist services.
- Better access to a broad range of services improves people's mental health and wellbeing. This includes access to specialist mental health services for people with severe mental illness.
- Reducing the rate of Māori under s29 aims to support independent/high-quality of life for Māori under compulsory community treatment, and improve equity.

How are we performing?

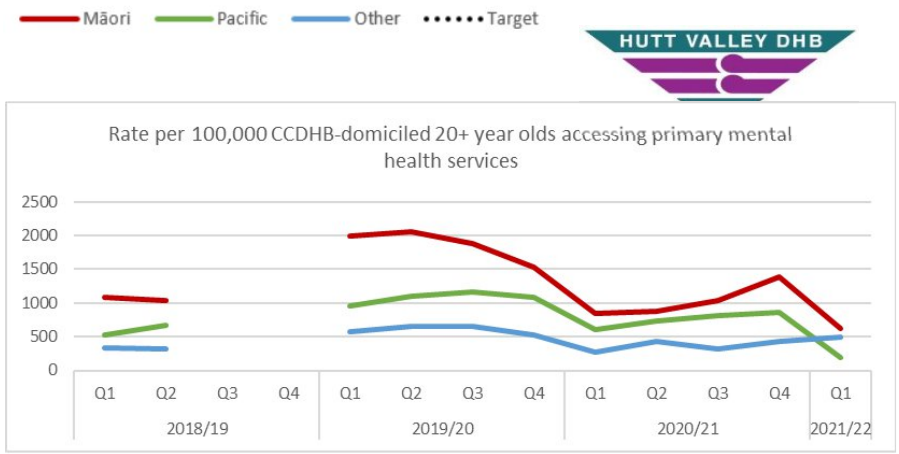
- Performance for access to primary mental health care is 618 for Māori, 184 for Pacific, and 493 for non-Māori, non-Pacific.
- Performance for access to specialist mental health services is 9,362 for Māori, 4,620 for Pacific, and 4,570 for non-Māori.
- The rate of Māori under s29 per 100,000 is 321; the rate of non-Māori is 111.

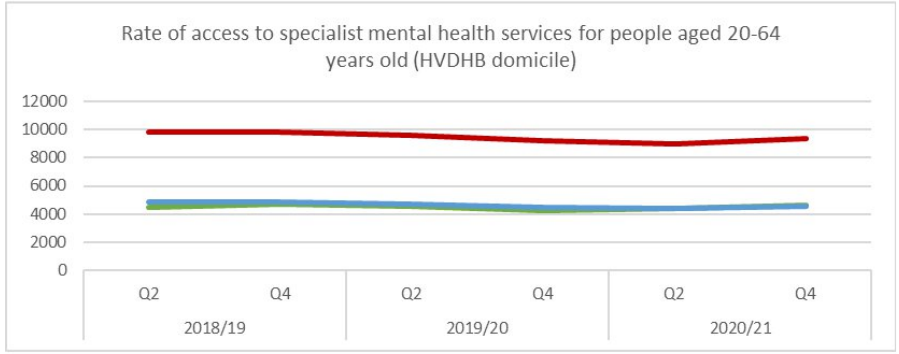
What is driving performance?

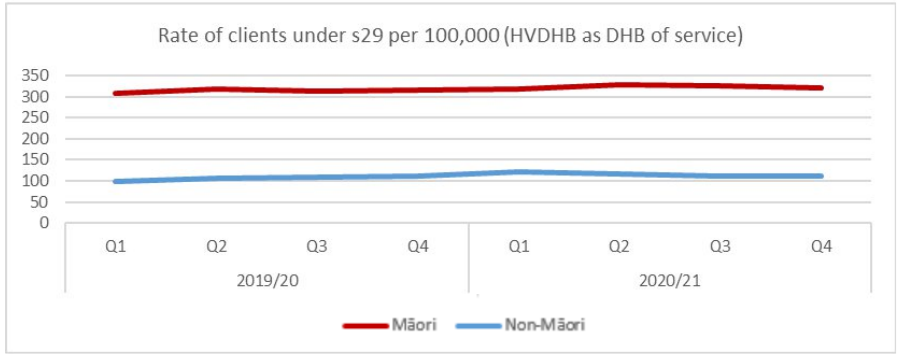
- All ethnicities, particularly Māori, have higher access rates to specialist mental health services provided by NGOs and DHBs. This is driven by how our mental health system has evolved over time and has resulted in a concentration of services in specialist care. Under-investment in primary mental health services means populations, and in particular Māori are unable to access and engage in prevention, early detection and management services. This is resulting in an acceleration of Māori through our system and reflected in higher rates of compulsory treatment.

Management comment

- We are partnering with community leaders and providers to co-develop community mental health and addiction services in localities with high levels of unmet need (the Hutt Valley and Wainuiomata) that are inclusive, accessible and well-connected to better meet population needs. This includes support for whānau ora and culturally appropriate models of care. Our key partner is Tākiri Mai Te Ata.
- In line with Te Rau Matatini best practice framework, we are implanting Kaupapa Māori mental health and addiction services in Te Awaikarangi, that support whānau Māori in a manner that preserves their unique cultural heritage, spirituality and wellbeing.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination roll-out

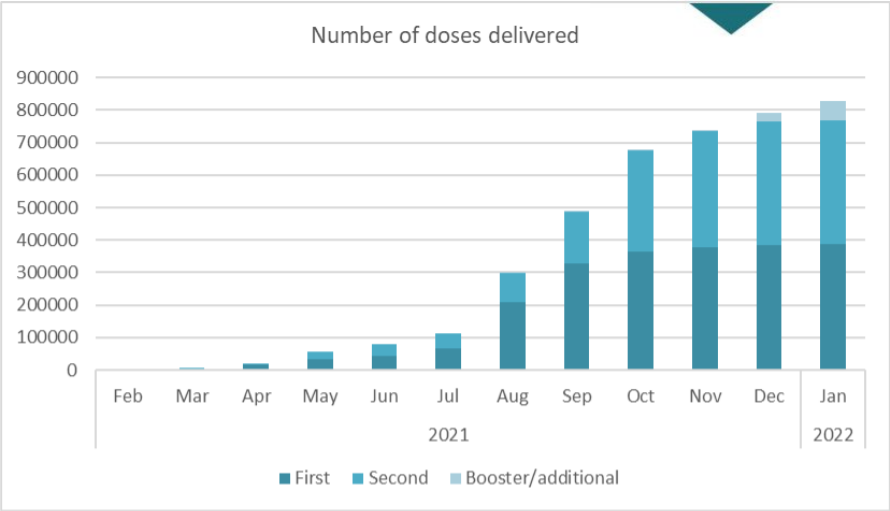
Why is this important?

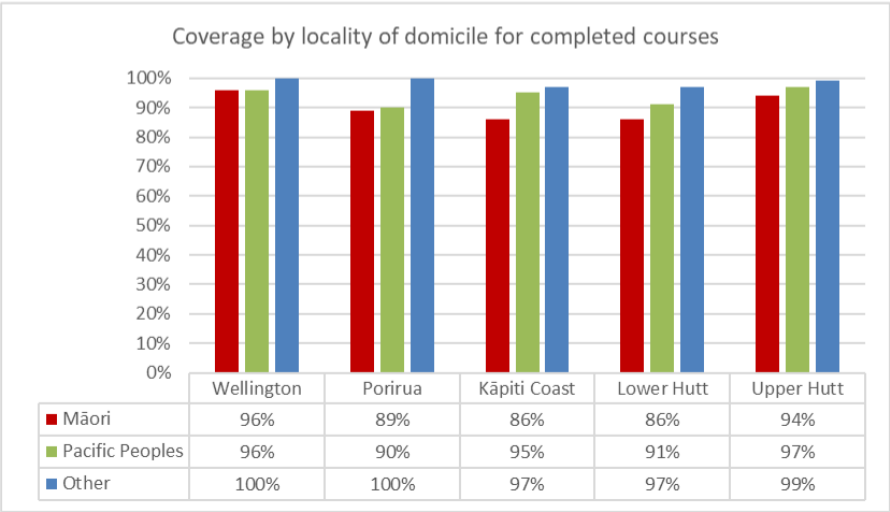
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 5 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- We are now implementing our vaccination programme for:
  - Boosters to the eligible population
  - Children aged 5-11 years of age
- First we are protecting those most at risk of COVID-19.

How are we performing?

- 385,231 people in the 2DHB region are fully vaccinated (96%)
  - 262,416 people in CCDHB (97%)
  - 122,815 people in HVDHB (94%)
- 41,093 Māori in the 2DHB region are fully vaccinated (89%)
  - 24,443 Māori in CCDHB (91%)
  - 16,650 Māori in HVDHB (87%)
- 26,663 Pacific Peoples in the 2DHB region are fully vaccinated (92%)
  - 17,589 Pacific Peoples in CCDHB (92%)
  - 9,074 Pacific peoples in HVHDB (92%)

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





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	96%	89%	86%	86%	94%
Pacific Peoples	96%	90%	95%	91%	97%
Other	100%	100%	97%	97%	99%

Data Sources: MOH Covid-19 Vaccine Data
Date Range: 22/02/2021 to 18/01/2022
Data current at: 19/01/2022 @4:00pm

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority .
- In response to the increasing wait times though the ED services the Operations Centre has commenced a major project to find issues and solutions . This is urgent as we approach the likelihood of increasing ED presentations.
- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with the same staff shortages. Worrying ethnicity differences in waiting times are not consistent across all specialties - over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- We remain at budget.

Hospital Throughput

Completed for period					Hutt Valley DHB Hospital Throughput YTD Dec-21	Year to Date					Annual	
Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year		Actual	Budget	Variance Actual vs Budget	Last year	Variance Actual vs Last year	Annual Budget	Last year
					Discharges							
1,105	1,138	33	1,096	(9)	Surgical	6,478	7,231	753	7,008	530	14,143	13,880
1,917	1,684	(233)	1,874	(43)	Medical	11,469	10,542	(927)	11,614	145	20,853	22,570
398	386	(12)	433	35	Other	2,342	2,257	(85)	2,630	288	4,464	5,221
3,420	**3,209**	**(211)**	**3,403**	**(17)**	**Total**	**20,289**	**20,030**	**(259)**	**21,252**	**963**	**39,461**	**41,671**
					CWD							
1,258	1,229	(28)	1,231	(27)	Surgical	7,344	7,618	273	7,406	61	14,879	13,880
1,020	936	(83)	997	(23)	Medical	6,250	5,769	(481)	6,076	(174)	11,317	22,570
449	449	0	433	(16)	Other	2,590	2,611	21	2,509	(81)	5,146	5,087
2,726	**2,615**	**(112)**	**2,660**	**(66)**	**Total**	**16,184**	**15,997**	**(187)**	**15,991**	**(193)**	**31,342**	**41,537**
					Other							
4,362	4,179	(183)	4,259	(103)	Total ED Attendances	24,584	24,701	117	25,178	594	49,261	50,206
1,053	944	(109)	1,031	(22)	ED Admissions	5,859	5,816	(43)	6,197	338	11,294	12,086
761	824	63	744	(17)	Theatre Visits	4,544	5,213	669	4,808	264	10,232	9,587
107	134	27	133	26	Non- theatre Proc	764	839	75	840	76	1,638	1,631
6,189	6,870	680	6,818	629	Bed Days	39,283	42,793	3,510	40,258	974	84,357	80,941
3.90	4.55	0.65	4.75	0.85	ALOS Inpatient	4.29	4.55	0.26	4.52	0.23	4.55	4.55
1.84	2.08	0.24	2.24	0.40	ALOS Total	1.95	2.08	0.13	2.06	0.11	2.08	2.08
7.40%	8.02%	0.62%	8.26%	0.86%	Acute Readmission	7.71%	8.02%	0.31%	8.00%	0.29%	7.31%	7.80%

Reduced planned care services since the national COVID level 3-4 restrictions during 18 Aug – 7 Sept has affected volumes year to date. Surgical discharges and caseweights are under budget year to date but close to budget for December. Medical discharges were over budget for the month but similar to December last year. Year to date, Medical caseweights are higher than budget mainly due to higher Emergency (treated over 3 hours and discharged) especially during the RSV outbreak in July. Discharges Other services were close to budget for the month and last year. Year to date, caseweights for other services are close to budget.

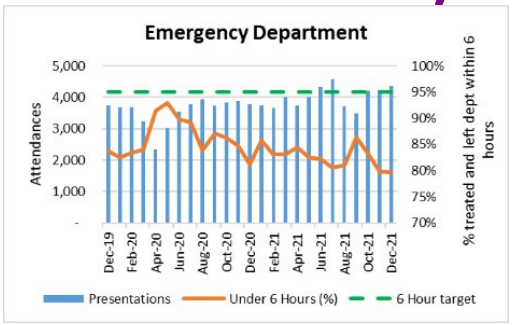
Total ED visits were over budget for the month and the same time last year. Theatre visits are 13% lower than budget year to date. Bed days are lower than budget for the month and year to date. Inpatient ALOS in December was lower than budget and the same time last year. The acute readmission rate for the month was lower than budget and the same time last year.

Operational Performance Scorecard – 13 mths

Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend												
			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Safe	Serious Safety Events[1] confirmed	Zero	0	1	3	3	3	0	2	0	3	1	3	2	2
	SABSI Cases [2]	Zero	1	1	0	1	0	0	1	3	2	0	3	2	2
	C. difficile infected diarrhoea cases	Zero	0	1	0	1	2	1	1	2	5	1	2	3	4
	Hand Hygiene compliance (quarterly)	≥ 80%	79%		79%			80%			79%				
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		43.6	7.6	22.4	39.8	13.6	21.0	21.4	16.9	22.4	14.7	14.1	12.3	7.9
Timely	Emergency Presentations	49,056	4,259	4,059	4,026	4,315	3,982	4,315	4,331	4,593	3,711	3,482	4,199	4,235	4,362
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.5%	79.0%	80.0%	86.1%	82.1%	78.6%	78.2%
	SSiED % within 6hrs - non admitted	≥95%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	89.2%	86.5%	87.0%	91.6%	88.0%	84.1%	84.0%
	SSiED % within 6hrs - admitted	≥95%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	56.8%	55.5%	60.2%	71.2%	65.2%	62.8%	62.4%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	1,115	1,251	1,328	1,238	1,177	1,020	904	930	1,021	1,118	1,135	1,140	1,169
	No. Theater surgeries cancelled (OP 1-8)		138	87	139	198	124	127	186	153	206	150	144	127	110
	Total (Elective, Acute & Arranged) Operations in MainTheatres 1-8[6]		744	664	712	898	816	843	856	867	600	743	760	812	761
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	758	1,016	1,124	1,093	1,015	808	625	624	717	812	1,003	836	830
	Outpatient Failure to Attend %	≤6.3%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.6%	6.5%	6.5%	7.8%	6.4%	7.2%	7.6%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($14.64)	($14.29)	($16.06)	($19.72)	($20.40)	($25.09)	($25.43)	($3.94)	($3.94)	($3.24)	($1.85)	TBC	TBC
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($14.54)	($14.33)	($14.24)	($14.25)	($14.01)	($16.93)	($12.23)	($30.84)	($30.84)	($16.84)	($17.71)	TBC	TBC
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.2%	86.4%	87.2%	87.8%	88.4%	87.8%	87.3%	87.1%	86.0%	85.9%	86.2%	87.7%	83.8%
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.79	4.50	4.37	4.89	4.35	4.69	4.80	4.64	4.92	5.27	4.25	4.83	4.29
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	24	21	34	20	23	29	22	25	35	16	18	15	15
	Overnight Beds (General Occupancy) - Average Occupied	≤130	144	130	149	146	143	148	152	153	144	130	135	145	135
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	98.5%	94.3%	89.1%	80.2%	88.0%	94.3%	87.5%
	All Beds - ave. beds occupied[8]	≤250	240	229	253	253	243	257	258	262	243	222	236	247	221
	% sick Leave v standard	≤3.5%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%	3.8%	4.1%	4.4%	2.7%	3.0%	3.3%	3.8%
	% Nursing agency v employee (10)	≤1.49%	12.7%	12.8%	12.4%	13.0%	11.8%	0.4%	14.5%	0.0%	0.5%	0.3%	0.3%	TBC	TBC
	% overtime v standard (medical) (10)	≤9.22%	6.9%	11.9%	9.6%	7.9%	8.3%	10.1%	8.7%	11.2%	7.4%	11.7%	6.8%	TBC	TBC
	% overtime v standard (nursing)	≤5.47%	11.6%	23.7%	14.2%	11.2%	15.7%	13.2%	15.9%	12.5%	13.1%	12.2%	9.2%	TBC	TBC

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

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	27 (211)	100% (100%)
2	761 (4,424)	35% (37%)
3	1,770 (9,947)	18% (24%)
4	1,450 (8,045)	30% (37%)
5	354 (1,957)	63% (69%)
	Mth (YTD)	Mth (YTD)

Arrivals -
Month - 4,362 (4,259)
YTD - 24,584 (25,178)

Self Referred
Month - 2,997 (2,855)
YTD - 16,255 (16,627)

GP Referred
Month - 346 (362)
YTD - 2,093 (2,490)

Other
Month - 1,019 (1,042)
YTD - 6,236 (6,061)
Current (Last Year)

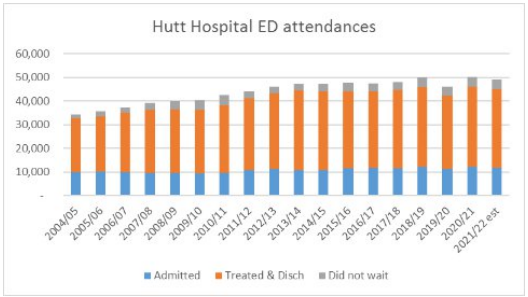
Seen in Time

Diagnosis &/or Treatment

Did Not Wait
Month - 481 (478) 11%
YTD - 2,058 (2,196) 8%

Treated & Disch
Month - 2,828 (2,750) 84% <6hr
YTD - 16,667 (16,785) 87%

Admitted
Month - 1053 (1031) 62% <6hr
YTD - 5,859 (6,197) 63%



- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - 81.66% YTD there was an improvement with Covid lockdown however has since returned to previous level December 79.75%
- **What is driving Performance**
  - High number of burn presentations in December.
  - Triage 1 cases which use the most resources and significantly disrupt the department have increased by 30% over the last 2 years (average 26 per month to 36). These fell in December to previous level
- **Management Comment**
  - Although ED continues to see lower presentations numbers, our admission rate remains stable.
  - High acuity and high occupancy in the hospital has continued to put pressure on this target.
  - Operations Centre has commenced a major project to find issues and solutions.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

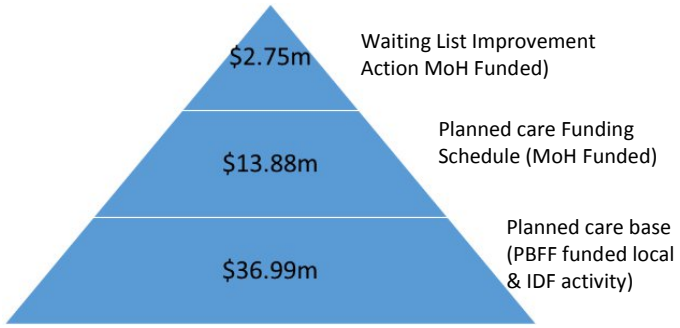
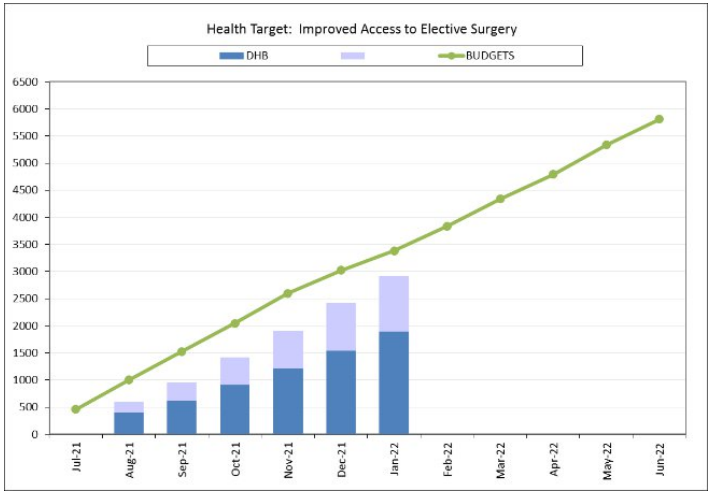
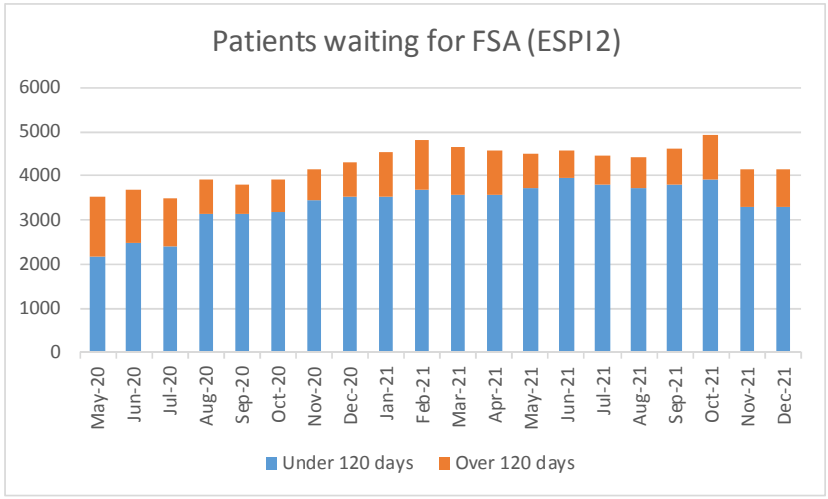


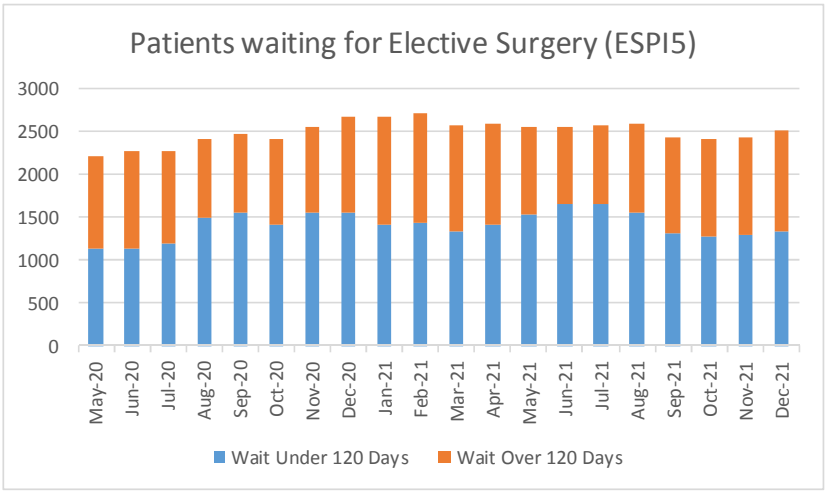
Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 97%



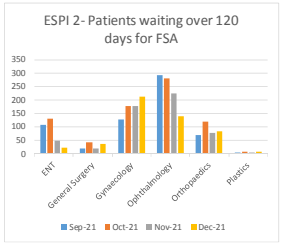
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 96 behind plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 97% as per figure 2.
  - YTD results are impacted by the Covid-19 lock down and preparations for the NZNO and MERAS strikes (which were cancelled).
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases.
  - The Ministry of Health have confirmed Quarter one payments – July at volume delivered, August and September at full funding. This is positive for HVDHB as July target was met.
- **What is driving performance?**
  - The orthopaedic initiative to reduce ESPI 2 $275k in 2020-2021 is continuing in the new financial year with funding carried over. This model is significantly assisting in reduction of the orthopaedic ESPI 2 waitlist.
  - Our 2 DHB outsourcing process has progressed with the next step Statements of Work (SOW) being developed with three private provider. It is anticipated that outsourcing against the SOW will commence in Quarter 3
  - Completed design of Optometrists in cataract First Specialist Assessment and surgical follow which will reduce the ESPI 2 waitlist by 200 patients in 2021-2022. EOI completed and contracting underway with activity to start in February
  - Capital investment of $3,647k to establish a 5 room procedure suite. The Minister of Health approved funding for the build and concept plans have been finalised. Building work has commenced with estimated completion December 22.

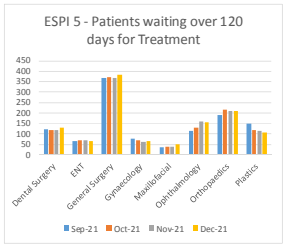
Planned Care – waiting times-

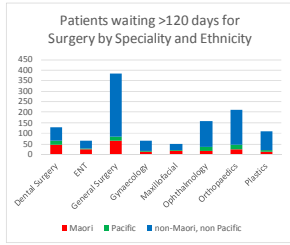




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA increased by 0.1% (6) this month. The number waiting over 120 days fell by 1% (6)
  - The number waiting for elective surgery rose by 73 to 2,505 and the number waiting over 120 days rose by 29 to 1,169
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

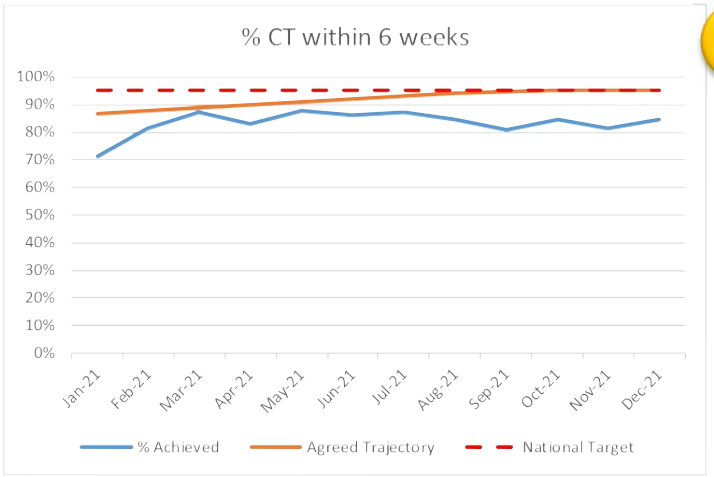


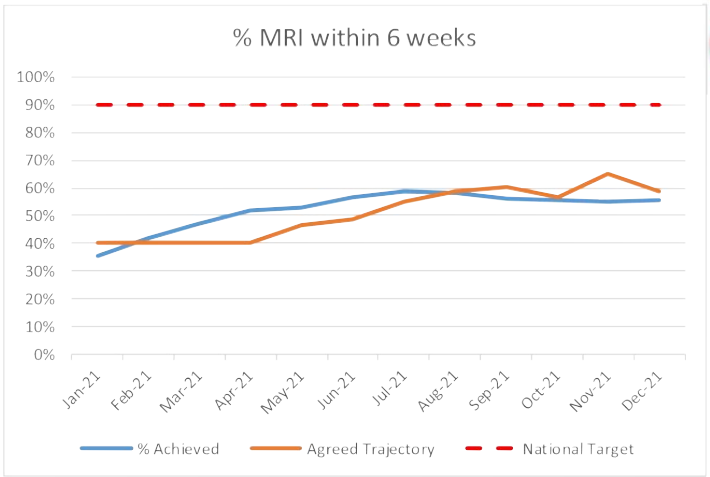




- **What is driving performance?**
  - Impact of COVID lockdown and preparations for the NZNO and MERAS strikes and the public holiday in October
  - Work continues on system improvements to address our waiting list management along with a strong focus to maximise clinic capacity and improve scheduling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

CT & MRI wait times

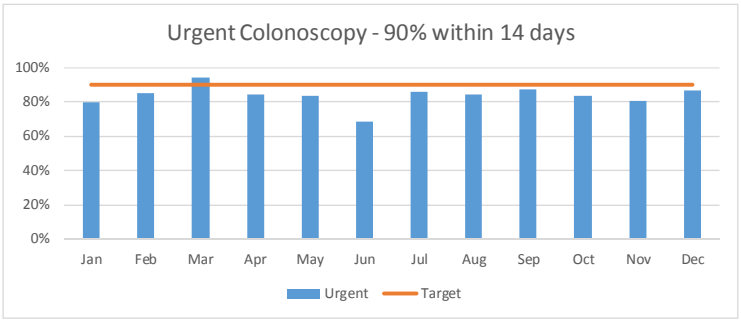


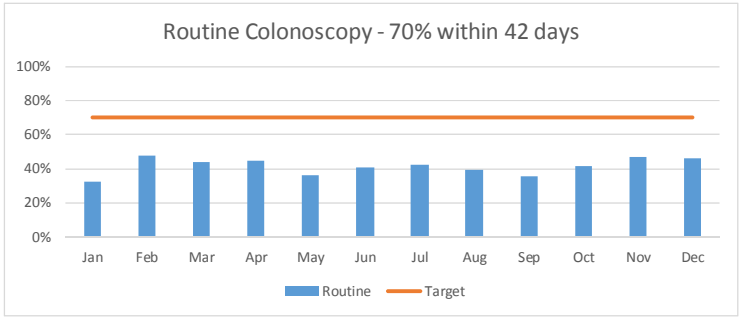


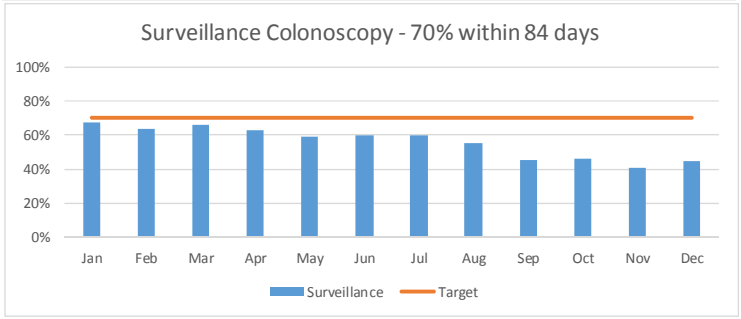
- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is improving.
  - CT wait times remain close to target.
- **What is driving performance?**
  - CT performance continues to improve with 83.5% scanned and reported within 6 weeks.
  - MRI performance is just below the newly agreed (with MOH) trajectory with 54% scanned and reported within 6 weeks. Outsourced scans/reports have been delayed due to capacity issues with the external provider.
  - Covid-19 Response meant only Urgent patients were scanned from 18 August 2021 (P1 and P2 priority), with most outpatient work deferred.

- **Management comment**
  - Actions currently underway:
    - CT weekends lists
    - Voluntary overtime weekend MRI day lists
    - MOH additional Planned Care trajectory funding assumption of additional revenue is being used to outsource 40 MRIs per month & the reading of 100 CT scans per month

Colonoscopy Wait Times







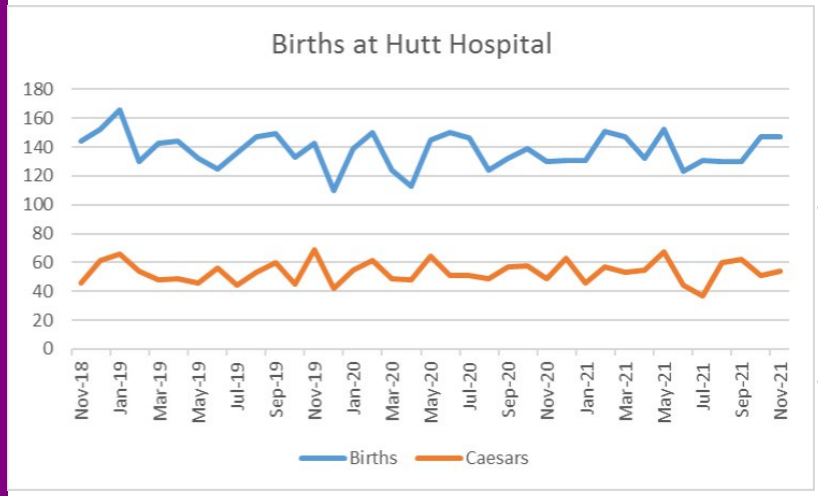
Urgent 84% YTD

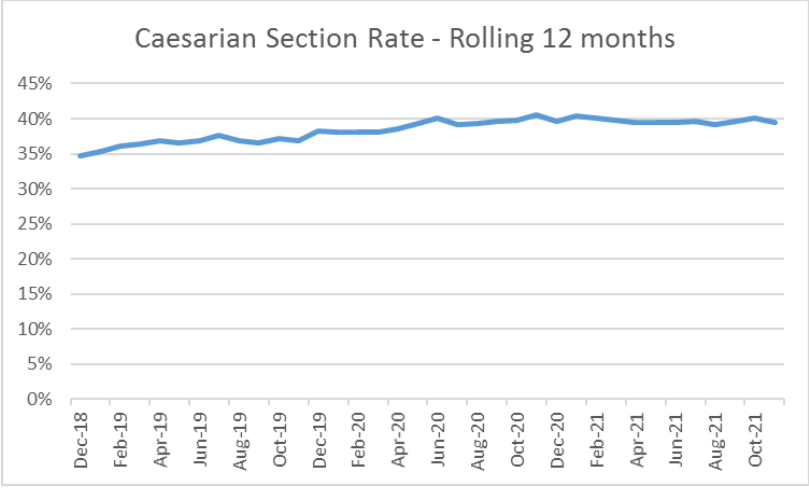
Routine 41% YTD

Surveil 49% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The service is balancing the overall improvement in performance with a trajectory to full compliance within the coming months.
  - August sees an improved performance across the urgent wait times and a similar outcome to June for routine and surveillance
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - We have adapted the way Maori and Pacifica patients are booked, prioritising contact and booked as soon as referral is received. There is a total of 7 Maori or Pacific patients who are overdue across all categories, 2 did not attend their booked procedures, prompting further follow up and 5 are self-deferred.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - Revised trajectories due to the hospital alert level changes are now seeing full recovery by February 22

Maternity

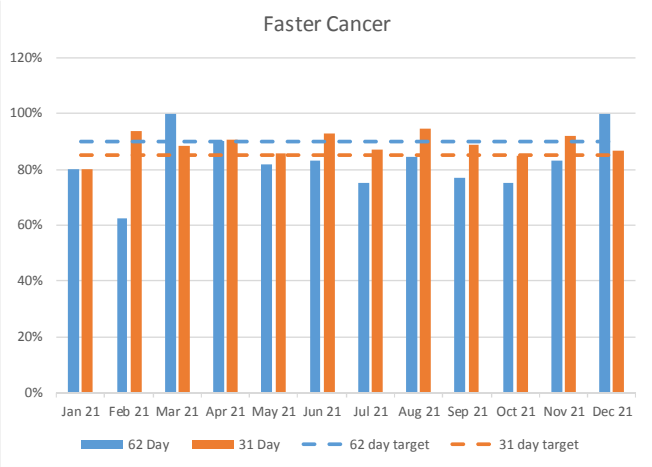


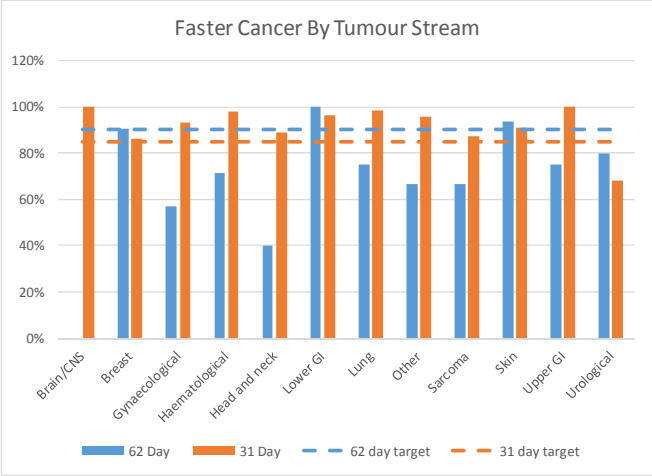


Due to Coding Lag these graphs run 1 month behind

- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - Hutt Valley DHB continues to progress the birthing optimisation project and audit of caesarean cases that focuses on the Robson 10 criteria for caesarean sections and pathways for optimal birth. This is a six month audit with analysis completed for first the period from April-June 2021.
- **Management comment**
  - The Senior Midwives, Service Group Manager and Director of Midwifery have worked in partnership with MERAS to design a work programme aimed at improving the retention and recruitment of our Midwives.
  - Midwifery workforce vacancies remain an issue. Active recruitment and retention planning is underway. The casual Midwifery Support Worker role is now implemented with 9 new staff employed (all are student midwives).
  - With the closure of Te Awakairangi Birthing Centre and upcoming Xmas period plans have been developed for managing the impact of increased births between October to February.
  - The Clinical Head of Department will step down in March 2022 and we are exploring how best to obtain the right leadership going forward for this critical area
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU). Phase One of building work (CMT space) is complete. Phase Two (MAU) – Work commenced on 17 January. An upgrade of rooms 1-6 in the post-natal ward has also commenced.

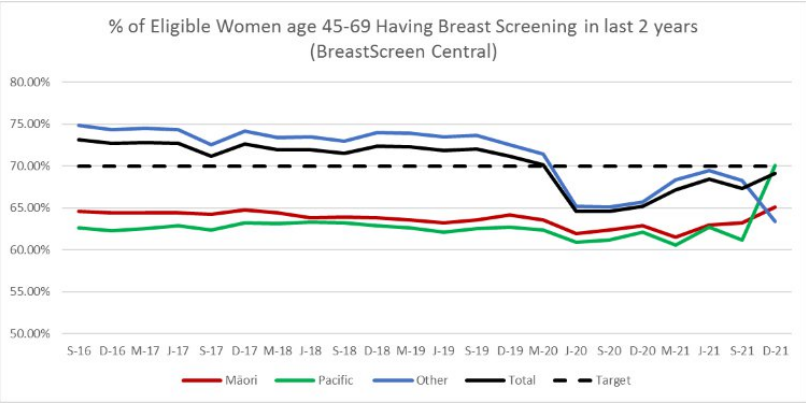
Faster Cancer Treatment

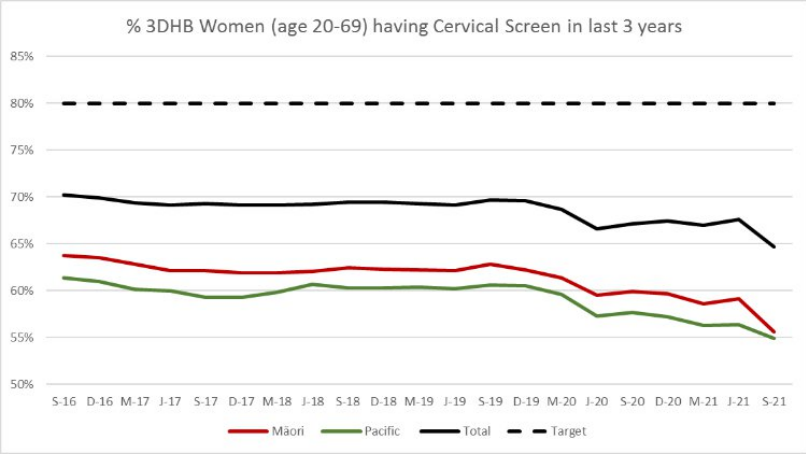




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have to wait from a date of decision to treat to receive their first treatment (or other management) for cancer is 31 days. Target compliance is 85% of patients start within 31 days.
- **Why is it important?**
  - Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.
- **How are we performing?**
  - 88.9% of patients met the HVDHB 62 day pathway for November - (1 out of 9 patients breached due to capacity related issues post lockdown). 91.9% for the 31 day target pathway was achieved.
  - There were no Maori patients who breeched in December.
- **What is driving performance?**
  - The first component of assessment from referral is well achieved and the latter part of treatment is the area needing focus.
- **Management Comment**
  - Individual breaches are viewed through MDT across both DHBs.

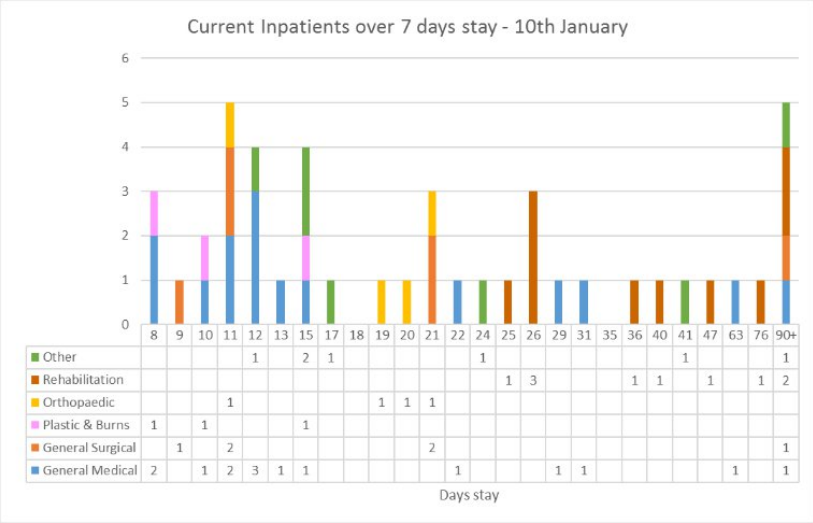
Screening

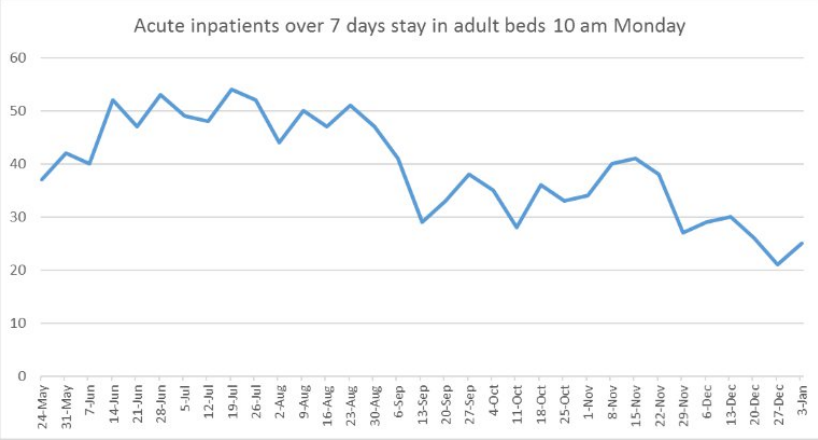




- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 45-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - Cervical Screening coverage in September continued to be impacted by COVID, priority population clinics had to be deferred resulting in the loss of 140 screens in September.
- **What is driving performance?**
  - In December 82 priority women attended their first breast screen (51 Maori and 31 Pacific). In addition 330 priority women attended for their subsequent screen (219 Maori and 111 Pacific).
  - Social distancing is impacting Mobile unit capacity
  - The service continues to provide Saturday and evening sessions on a (staff) volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued. The replacement Breast Radiologists are awaiting Medical council signoff and it is hoped they will start January.
  - Symptomatic Services are running Saturday clinics for new referrals until the service can return to all day Monday clinics with the arrival of two new breast radiologists in the New Year.
- **Management Comment**
  - The service is on track to make up screening numbers that were deferred from recent hospital alert level response, with extended clinics on weekends and evening.
  - 'Free Cervical Screening' after hour evening clinics and Saturday clinics targeted at wāhine Māori, Pacific and Asian women continues to be a focus through to December.
  - Māori, Pacific and Asian women continue to be identified through the PHO data matching and prioritised for screening in both Cervical and Breast Screening.

Long Stay inpatients





- **What is this measure?**
  - For medical and surgical these are patients who have stayed more than 7 days. For rehabilitation and neonates where stays are longer these are cases staying over last year's average.
- **Why is it important?**
  - These patients are reducing the ability of the hospital to cope with acute demand. Longer stays are often associated with deconditioning and adverse outcomes for the patient.
- **How are we performing?**
  - On 10th Jan there were 44 current long staying patients; most were acute adults. There was a reduction in occupancy with Covid-19 but not as marked as last year.
- **What is driving performance?**
  - A group of extremely complex patients remain unable to be discharged because community services and supports are reluctant to support these patients on discharge either due to extremely high needs, complex behaviour, housing issues, or health and safety concerns for service staff.
- **Management comment**
  - A dedicated role to work with these and similar patients is planned to work with clinical, NASC, and commissioning staff to put sustainable different discharge arrangements in place for these folk. Enhanced Early Supported Discharge for mild-moderate stroke patients and some medical patients will go live in August. This will support earlier discharge for this group of patients and better hospital flow over all.
  - A new facility has been opened to support a small number of the most complex patients and allow them to be discharged from the hospital. The first of these cases was discharged in December.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for December 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										
48,455	42,249	6,206	40,470	7,986	Devolved MoH Revenue	261,026	253,497	7,529	243,547	17,479	516,065	506,994	9,071	489,113	26,952
1,942	1,775	167	1,896	46	Non Devolved MoH Revenue	11,897	10,046	1,851	11,589	308	22,030	20,179	1,851	21,680	350
606	572	34	504	102	ACC Revenue	3,167	3,666	(498)	3,656	(488)	6,478	6,976	(498)	7,129	(652)
435	503	(68)	622	(188)	Other Revenue	2,997	3,027	(30)	3,402	(405)	6,012	6,054	(42)	7,483	(1,471)
9,783	9,557	227	9,115	669	IDF Inflow	57,405	57,339	66	57,718	(312)	114,834	114,678	156	111,945	2,889
1,101	1,025	75	1,243	(142)	Inter DHB Provider Revenue	7,343	6,151	1,192	5,931	1,412	13,794	12,302	1,492	13,197	597
62,323	**55,681**	**6,641**	**53,850**	**8,473**	**Total Revenue**	**343,835**	**333,726**	**10,109**	**325,842**	**17,993**	**679,212**	**667,183**	**12,029**	**650,547**	**28,665**
					Expenditure										
					Employee Expenses										
5,991	5,762	(228)	5,305	(686)	Medical Employees	32,788	32,917	129	31,438	(1,350)	64,894	65,245	352	62,678	(2,216)
12,351	6,502	(5,850)	6,089	(6,262)	Nursing Employees	43,132	37,055	(6,077)	36,555	(6,577)	80,359	73,986	(6,373)	72,415	(7,944)
2,579	2,683	104	2,439	(140)	Allied Health Employees	15,169	15,375	206	14,854	(314)	30,317	30,467	150	28,663	(1,654)
917	850	(67)	811	(106)	Support Employees	5,264	4,849	(416)	4,703	(561)	10,134	9,619	(514)	9,579	(554)
2,257	2,395	138	2,340	83	Management and Admin Employees	13,276	13,756	480	13,593	317	26,227	27,053	826	26,733	507
24,095	**18,192**	**(5,903)**	**16,983**	**(7,112)**	**Total Employee Expenses**	**109,628**	**103,952**	**(5,677)**	**101,144**	**(8,485)**	**211,930**	**206,370**	**(5,560)**	**200,068**	**(11,861)**
					Outsourced Personnel Expenses										
109	205	96	714	605	Medical Personnel	1,289	1,229	(60)	3,489	2,200	2,518	2,458	(60)	5,973	3,455
131	15	(116)	701	570	Nursing Personnel	363	90	(273)	3,008	2,645	453	181	(273)	6,407	5,954
91	60	(31)	515	425	Allied Health Personnel	151	358	207	2,124	1,973	363	715	353	4,561	4,198
78	42	(36)	28	(50)	Support Personnel	387	254	(133)	287	(100)	640	507	(133)	491	(150)
677	621	(56)	575	(102)	Management and Admin Personnel	4,130	3,729	(401)	3,030	(1,099)	8,244	7,457	(787)	7,031	(1,212)
1,086	**943**	**(142)**	**2,533**	**1,448**	**Total Outsourced Personnel Expenses**	**6,319**	**5,659**	**(660)**	**11,939**	**5,619**	**12,218**	**11,318**	**(900)**	**24,463**	**12,245**
1,304	950	(354)	671	(633)	Outsourced Other Expenses	5,793	5,723	(70)	5,052	(741)	11,855	11,454	(401)	13,157	1,302
2,764	2,487	(277)	2,712	(53)	Treatment Related Costs	16,156	14,831	(1,326)	15,962	(195)	33,044	30,698	(2,347)	33,080	36
2,043	2,057	14	2,244	201	Non Treatment Related Costs	12,462	12,355	(107)	13,407	945	24,872	24,765	(107)	36,000	11,127
12,043	11,991	(52)	10,154	(1,889)	IDF Outflow	71,570	71,947	377	56,368	(15,203)	142,707	143,894	1,187	108,813	(33,894)
19,992	19,548	(444)	19,356	(636)	Other External Provider Costs	118,181	116,280	(1,900)	114,839	(3,342)	237,218	231,201	(6,017)	223,654	(13,563)
2,109	2,027	(82)	1,938	(171)	Interest, Depreciation & Capital Charge	12,114	12,159	45	12,270	156	24,127	24,321	195	23,537	(590)
65,435	**58,195**	**(7,240)**	**56,591**	**(8,844)**	**Total Expenditure**	**352,223**	**342,906**	**(9,318)**	**330,979**	**(21,245)**	**697,971**	**684,022**	**(13,949)**	**662,772**	**(35,199)**
(3,113)	**(2,514)**	**(599)**	**(2,741)**	**(371)**	**Net Result**	**(8,388)**	**(9,180)**	**791**	**(5,136)**	**(3,252)**	**(18,759)**	**(16,839)**	**(1,920)**	**(12,226)**	**(6,534)**
					Result by Output Class										
(917)	(1,449)	532	(1,143)	226	Funder	(7,077)	(7,686)	609	1,276	(8,353)	(15,196)	(14,012)	(1,184)	11,939	(27,136)
103	7	96	179	(76)	Governance	437	52	385	377	60	497	112	385	1,261	(764)
(2,299)	(1,073)	(1,226)	(1,778)	(521)	Provider	(1,749)	(1,546)	(202)	(6,789)	5,040	(4,060)	(2,939)	(1,121)	(25,425)	21,366
(3,113)	**(2,514)**	**(599)**	**(2,741)**	**(371)**	**Net Result**	**(8,388)**	**(9,180)**	**791**	**(5,136)**	**(3,252)**	**(18,759)**	**(16,839)**	**(1,920)**	**(12,226)**	**(6,534)**

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $10,109k
- Personnel and outsourced Personnel unfavourable ($6,337k)
  - Medical favourable $69k; Nursing unfavourable ($6,349k); Allied Health favourable $413k, Support Staff unfavourable ($549k); Management and Admin unfavourable $79k; Annual leave Liability cost has increased by $3,421k since December 2020
- Outsourced other expenses unfavourable ($70k)
- Treatment related Costs unfavourable ($1,326k)
- Non Treatment Related Costs unfavourable ($107k)
- IDF Outflow favourable $377k
- Other External Provider Costs unfavourable ($1,900k)
- Interest depreciation and capital charge favourable $45k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $6,641k for the month
  - Devolved MOH revenue $6,206k favourable, Driven by the additional funding for the Nurses MECA Settlement $5,421k.
  - Non Devolved revenue $167k favourable driven largely by Public Health COVID-19 funding $357k, and other variances.
  - ACC Revenue $34k favourable.
  - Other revenue ($68k) unfavourable for the month.
  - IDF inflows favourable $227k for the month reflecting current year wash-ups.
  - Inter DHB Revenue favourable $75k.

COVID–19 Revenue and Costs

YTD Result - December 2021	Funder	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19	2,774	86	1,679	4,540
Expenditure				
Employee Expenses				
Medical Employees		44	315	359
Nursing Employees		68	719	787
Allied Health Employees		16	836	852
Support Employees		23	0	23
Management and Admin Employees		66	203	270
Total Employee Expenses	**0**	**217**	**2,074**	**2,291**
Expenses				
Outsourced - Provider	0	0		0
External Providers - Funder	2,774			2,774
Clinical Expenses - Provider	0	2	19	21
Non-clinical Expenses- Provider	0	155	289	445
Total Non Employee Expenses	**2,774**	**157**	**308**	**3,240**
Total Expenditure	**2,774**	**375**	**2,382**	**5,531**
Net Impact	**(0)**	**(289)**	**(703)**	**(992)**

- The December year to date financial position includes $5.5m additional costs in relation to COVID-19.
- Revenue of $4.5m has been recognised to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $1.0m deficit.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($6,045k) for the month
  - Medical personnel incl. outsourced unfavourable ($133k). Outsourced costs are $96k favourable. Medical Staff Internal are ($228k) unfavourable, driven by Surgical Registrars.
  - Nursing incl. outsourced ($5,965k) unfavourable. Employee costs are ($5,850k) unfavourable driven largely by the Settlement of the NZNO, MERAS and PSA Nurses MECA's.
  - Allied Health incl. outsourced $73k favourable, with outsourced unfavourable ($31k) and internal employees favourable $104k.
  - Support incl. outsourced unfavourable ($103k), with Outsourced ($36k) and employee costs ($67k) unfavourable, driven by Orderlies ($36k), Sterile Assistants ($11k) and Tradesmen ($15k).
  - Management & Admin incl. outsourced favourable $82k, internal staff favourable $138k, outsourced unfavourable ($56k).
  - Sick leave for December was 3.8%, which is higher than this time last year.

FTE Analysis

Month					FTE Report Dec-21	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
273	290	16	274	1	Medical	278	289	11	280	2	289	279
771	787	16	746	(25)	Nursing	761	784	22	777	15	790	763
349	365	16	335	(14)	Allied Health	349	365	17	359	10	365	352
151	148	(3)	147	(4)	Support	152	147	(5)	146	(6)	147	147
305	341	36	319	14	Management & Administration	310	340	31	328	18	338	321
1,850	**1,931**	**81**	**1,821**	**(28)**	**Total FTE**	**1,849**	**1,925**	**76**	**1,889**	**39**	**1,930**	**1,862**
					$ per FTE							
21,924	19,899	(2,025)	19,360	(2,563)	Medical	118,063	113,873	(4,191)	112,311	(5,752)	224,520	233,613
16,023	8,264	(7,759)	8,162	(7,862)	Nursing	56,665	47,294	(9,372)	47,073	(9,592)	101,657	97,019
7,380	7,346	(35)	7,270	(110)	Allied Health	43,502	42,089	(1,413)	41,414	(2,087)	82,994	86,588
6,067	5,753	(313)	5,514	(553)	Support	34,617	32,999	(1,618)	32,193	(2,424)	68,778	65,337
7,402	7,021	(382)	7,340	(63)	Management & Administration	42,846	40,404	(2,442)	41,478	(1,368)	77,549	84,263
13,027	**9,423**	**(3,604)**	**9,324**	**(3,703)**	**Average Cost per FTE all Staff**	**59,275**	**53,993**	**(5,281)**	**53,544**	**(5,730)**	**109,788**	**110,832**

Medical under budget for the month by 16 FTE, driven by SMOs under budget by 16 FTE.

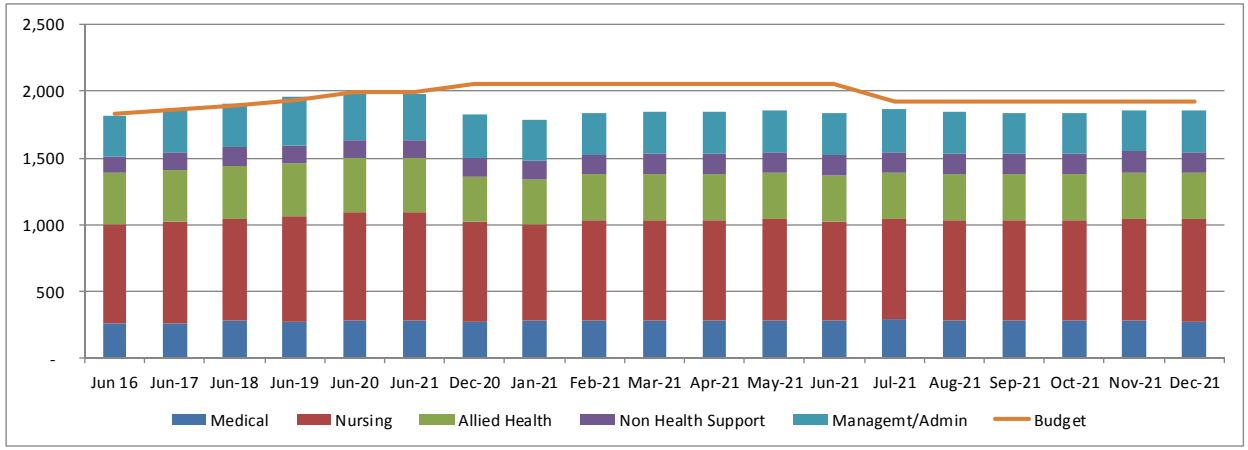
Nursing under by 16 FTE for the month the contribution to movements were; Internal Bureau Nurses, Midwives and HCA's are over budget (20) FTE mostly driven by General Surgery (2) FTE, General Medical (5) FTE, ED (5) FTE and other variances. This is offset by Midwives 6 FTE and Registered Nurses 31 FTE and HCA's. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review. The $/Fte has been materially impacted by the MECA settlements.

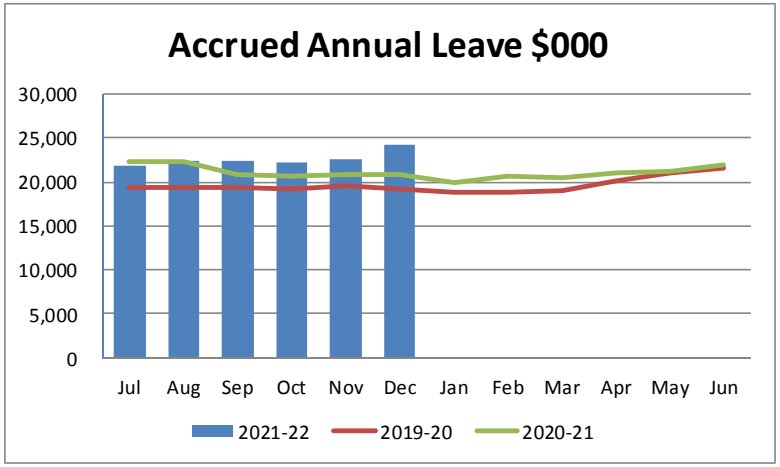
Allied FTEs are under by 16 FTEs for the month, driven by Regional Public Health 3 FTE, Community Health 7 FTE and other variances.

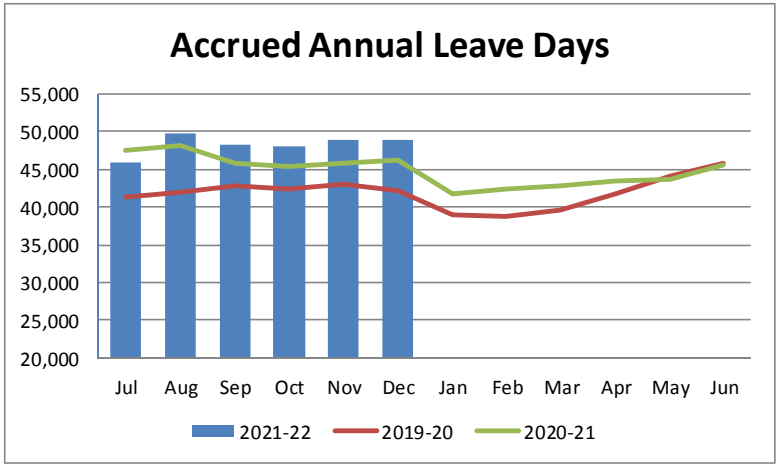
Support FTEs are over budget (3) FTE, variances include Food Services (3) FTE, and Orderlies (4) FTE, offset by other variances.

Management & Admin are under budget by 36 FTEs driven by SPO 3 FTE, Quality 6 FTE, Communications 2FTE, Surgical Women's & Children's 4 FTE, Medical and Acute 8 FTE and Regional Screening 2 FTE, Public Health 1 FTE, Procurement 3 FTE and other variances.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($354k) for the month, due to unfavourable variance for Outsourced Clinical Services ($492), driven by Radiology and scans ($107k) and outsourced Orthopaedic procedures ($274k).
  - Treatment related costs ($277k) unfavourable for the month driven Treatment Disposables ($211k), Pharmaceuticals ($87k and other minor variances.
  - Non Treatment Related costs favourable $14k.
  - IDF Outflows ($52k) unfavourable for the month.
  - Other External Provider costs unfavourable ($444k), mostly driven by Residential Care (121k), Disability Support (74k) and COVID related payment to PHO's ($593k), offset by other variances. .
  - Interest, Depreciation & Capital Charge unfavourable ($82k), driven by Depreciation $147k, reflecting delays in the Capital programme, offset by changes to the Capital Charge ($257k).

Section 5

Additional Financial Information & Updates

Financial Position as at 31 December 2021

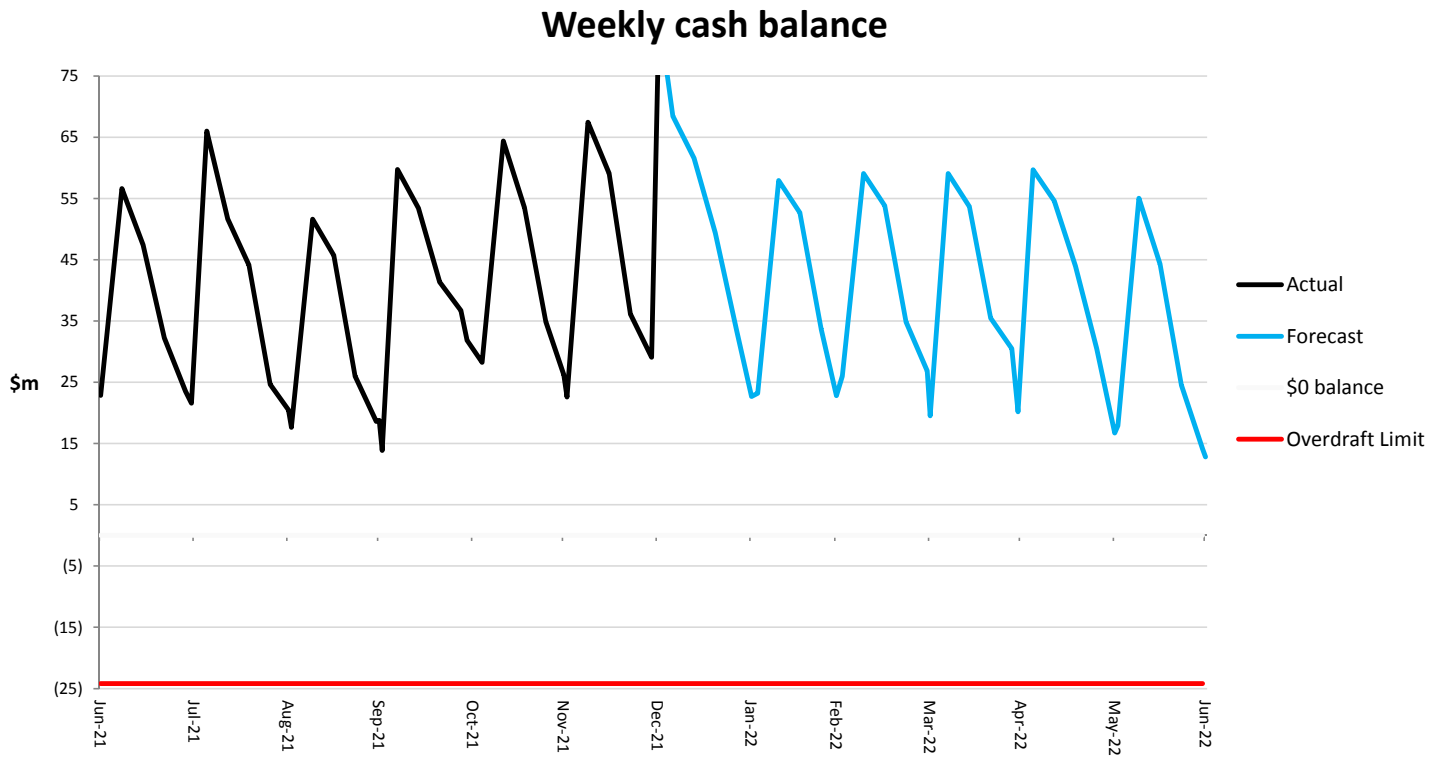
$000s	Actual	Budget	Variance	Jun 21	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	75,872	3,323	72,549	22,890	52,982	Average bank balance in Dec-21 was $50.6m
Bank - Non DHB Funds *	6,786	5,831	955	5,236	1,550	
Accounts Receivable & Accrued Revenue	34,186	24,681	9,505	33,457	729	
Stock	2,131	2,614	(482)	2,322	(191)	
Prepayments	2,156	1,161	995	1,241	915	
Total Current Assets	**121,131**	**37,610**	**83,521**	**65,146**	**55,985**	
Fixed Assets						
Fixed Assets	219,434	239,812	(20,378)	223,741	(4,306)	
Work in Progress	11,871	7,905	3,967	9,218	2,654	
Total Fixed Assets	**231,306**	**247,717**	**(16,411)**	**232,958**	**(1,653)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,243	1,266	(23)	1,221	23	
Total Investments	**2,393**	**2,416**	**(23)**	**2,371**	**23**	
Total Assets	**354,830**	**287,743**	**67,087**	**300,476**	**54,355**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	133,603	77,223	(56,380)	79,873	(53,730)	Includes Holidays Act Provision of $31.6m
Crown Loans and Other Loans	21	3	(17)	42	21	
Capital Charge Payable	4,410	4,001	(408)	0	(4,410)	
Current Employee Provisions	30,026	28,199	(1,827)	27,029	(2,997)	
Total Current Liabilities	**168,059**	**109,426**	**(58,633)**	**106,944**	**(61,115)**	
Non Current Liabilities						
Other Loans	136	178	42	136	0	
Long Term Employee Provisions	9,150	8,972	(178)	9,150	0	
Non DHB Liabilities	6,786	5,831	(955)	5,236	(1,550)	
Trust Funds	1,225	1,226	1	1,221	(4)	
Total Non Current Liabilities	**17,297**	**16,207**	**(1,091)**	**15,743**	**(1,554)**	
Total Liabilities	**185,356**	**125,633**	**(59,723)**	**122,686**	**(62,670)**	
Net Assets	**169,474**	**162,110**	**7,364**	**177,789**	**(8,315)**	
Equity						
Crown Equity	158,709	156,918	1,790	158,709	0	
Revaluation Reserve	146,362	146,288	74	146,289	73	
Opening Retained Earnings	(127,208)	(131,916)	4,708	(114,982)	(12,226)	
Net Surplus / (Deficit)	(8,388)	(9,180)	791	(12,226)	3,837	
Total Equity	**169,474**	**162,110**	**7,364**	**177,789**	**(8,315)**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 31 December 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	43,244	43,894	45,475	46,806	43,735	96,487	(2,648)	44,128	44,282	44,201	44,152	44,282
Receipts from Other DHBs (Including IDF)	10,208	7,504	10,523	14,609	9,547	16,266	10,647	10,647	10,647	10,647	10,647	10,647
Receipts from Other Government Sources	492	664	623	610	968	762	658	725	613	653	613	725
Other Revenue	4,907	(460)	(4,228)	3,218	(523)	(4,710)	271	113	113	116	113	113
Total Receipts	**58,851**	**51,602**	**52,392**	**65,243**	**53,727**	**108,805**	**8,928**	**55,612**	**55,654**	**55,616**	**55,525**	**55,766**
Payments for Personnel	(17,569)	(16,888)	(20,053)	(16,260)	(16,277)	(23,368)	(17,544)	(16,875)	(19,248)	(17,659)	(18,438)	(18,436)
Payments for Supplies (Excluding Capital Expenditure)	(9,630)	(5,793)	(2,437)	(3,561)	(7,839)	(6,430)	(5,822)	(5,944)	(5,944)	(6,049)	(6,071)	(5,532)
Capital Charge Paid	0	0	0	0	0	0	(4,410)	0	0	0	0	(4,150)
GST Movement	(848)	8	828	983	(2,263)	2,776	0	0	0	0	0	0
Payments to Other DHBs (Including IDF)	(11,963)	(11,858)	(11,945)	(11,140)	(12,003)	(11,963)	(11,856)	(11,856)	(11,856)	(11,856)	(11,856)	(11,856)
Payments to Providers	(18,965)	(17,180)	(19,750)	(21,339)	(19,739)	(19,247)	(19,987)	(18,949)	(19,858)	(20,248)	(20,518)	(20,255)
Total Payments	**(58,974)**	**(51,712)**	**(53,358)**	**(51,317)**	**(58,120)**	**(58,232)**	**(59,619)**	**(53,624)**	**(56,905)**	**(55,812)**	**(56,882)**	**(60,230)**
Net Cashflow from Operating Activities	**(123)**	**(110)**	**(966)**	**13,926**	**(4,393)**	**50,573**	**(50,691)**	**1,988**	**(1,251)**	**(196)**	**(1,357)**	**(4,464)**
Investing Activities												
Interest Receipts	23	23	22	31	33	43	21	21	21	21	21	21
Dividends	0	0	0	0	0	0	4	4	4	4	4	4
Sale of Fixed Assets	0	0	0	0	0	1	0	0	0	0	0	0
Total Receipts	**23**	**23**	**22**	**31**	**33**	**44**	**25**	**25**	**25**	**25**	**25**	**25**
Capital Expenditure	(1,192)	(1,007)	(783)	(823)	(1,280)	(995)	(2,926)	(2,256)	(2,256)	(2,905)	(2,256)	(2,914)
Increase in Investments and Restricted & Trust Funds Assets	(24)	7	(8)	(23)	19	5	0	0	0	0	0	0
Total Payments	**(1,216)**	**(999)**	**(791)**	**(846)**	**(1,261)**	**(989)**	**(2,926)**	**(2,256)**	**(2,256)**	**(2,905)**	**(2,256)**	**(2,914)**
Net Cashflow from Investing Activities	**(1,193)**	**(976)**	**(769)**	**(815)**	**(1,228)**	**(945)**	**(2,901)**	**(2,231)**	**(2,231)**	**(2,880)**	**(2,231)**	**(2,889)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	0	4,000	0	5,000
Total Receipts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,000**	**0**	**5,000**
Interest Paid on Finance Leases	(0)	(0)	(0)	(0)	(0)	(0)	(2)	(2)	(2)	(2)	(2)	(2)
Total Payments	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**	**(2)**
Net Cashflow from Financing Activities	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(2)**	**(2)**	**(2)**	**3,998**	**(2)**	**4,998**
Total Cash In	58,874	51,625	52,415	65,275	53,761	108,849	8,953	55,637	55,679	59,641	55,550	60,791
Total Cash Out	(60,189)	(52,711)	(54,149)	(52,164)	(59,381)	(59,221)	(62,547)	(55,882)	(59,163)	(58,719)	(59,140)	(63,146)
Net Cashflow												
Opening Cash	22,890	21,575	20,489	18,754	31,865	26,245	75,872	22,278	22,033	18,549	19,471	15,881
Net Cash Movements	(1,316)	(1,086)	(1,734)	13,111	(5,621)	49,628	(53,594)	(245)	(3,484)	922	(3,590)	(2,355)
Closing Cash	**21,575**	**20,489**	**18,754**	**31,865**	**26,245**	**75,872**	**22,278**	**22,033**	**18,549**	**19,471**	**15,881**	**13,526**

Weekly Cash Flow – Actual to 31 December 2021



Note

- the overdraft facility shown in red is set at $24.2 million as at December 2021
- the lowest bank balance for the month of December was $22.6m

Capital expenditure – Actual to 31 December 2021

Project description	Budget rolled over from 2020/21	New budget for 2021/22	Prior year approved projects budget	Prior year approved projects spend	Committed costs from prior year approved projects budget	Total maximum spend in 2021/22	Actual 2021/22 spend till date	Remaining funds available in 2021/22
	$000	$000	$000	$000	$000	$000	$000	$000
Baseline								
Buildings and Plant	4,385	7,700	3,651	2,719	931	13,017	1,419	11,598
Clinical Equipment	629	6,043	3,824	974	2,850	9,522	2,128	7,394
Information Technology (Hardware)	1,211	1,828	862	408	454	3,493	423	3,070
Intangible Assets (Software)	56	2,853	356	185	170	3,079	42	3,037
Baseline Total	**6,282**	**18,425**	**8,691**	**4,287**	**4,405**	**29,112**	**4,011**	**25,099**
Strategic								
Buildings and Plant	1,065	-	-	-	-	1,065	-	1,065
Clinical Equipment	2,275	1,460	2,301	451	1,850	5,586	139	5,446
IT	722	2,145	1,066	359	707	3,575	354	3,220
Strategic Total	**4,063**	**3,605**	**3,367**	**809**	**2,558**	**10,226**	**494**	**9,732**
Pandemic								
Buildings and Plant	-	-	-	-	-	-	-	-
Clinical Equipment	-	-	-	-	-	-	-	-
IT	-	-	-	-	-	-	22	(22)
Pandemic Total	**-**	**-**	**-**	**-**	**-**	**-**	**22**	**(22)**
Total Capital (excluding MOH, Trust, Gym)	**10,345**	**22,030**	**12,058**	**5,096**	**6,962**	**39,338**	**4,526**	**34,810**

Summary of Leases – as at 31 December 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses		1,199	14,386		1/11/2020	31/10/2023	Operating
Public Trust House Lower Hutt	Community Mental Health		27,717	332,601		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		10,241	122,887		15/03/2015	14/03/2025	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,626	31,510		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		500	5,998		16/06/2020	16/05/2023	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
Pretoria St, Lower Hutt	RPH & Covid Team		8,360	100,320		1/08/2021	31/01/2023	Operating
			56,987	**683,825**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (126 Vehicles, including 2 Nissan Leaf EV's)			36,353	436,240		Ongoing	Ongoing	Operating
			36,353	**436,240**				
Equipment Leases	**Supplier**							
MRI Ingenia 1.5T	De Lage Landen (paid monthly in arrears)		22,498	269,981	1,349,905	19/09/2019	19/08/2024	Operating
Fluoroscopy Combi Diagnost R90	De Lage Landen (paid monthly in arrears)		9,753	117,037	585,185	1/08/2019	31/07/2024	Operating
Plastics Micro Power Tools	Stryker New Zealand Ltd	293,188	3,490	41,884	125,652	1/10/2018	30/09/2025	Finance
Orthopaedic Tools	Stryker New Zealand Ltd		9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Ltd		7,315	87,782	153,618	28/09/2020	28/06/2022	Operating
1 x Ultrasound Epiq (Equigroup)	Philips NZ Commercial Ltd		1,761	21,129	40,498	28/09/2020	28/08/2022	Operating
CT Scanner 128 Slice (Equigroup)	Toshiba Medical Systems		24,976	299,711	499,518	28/09/2020	28/05/2022	Operating
Philips Digital Diagnost C90 (Room 2)	De Lage Landen (paid monthly in arrears)		7,265	87,186	435,930	31/01/2020	31/01/2025	Operating
Philips Digital Diagnost C90 (Room 1)	De Lage Landen (paid monthly in arrears)		6,184	74,214	371,070	31/01/2020	31/01/2025	Operating
Philips Mobile Diagnost R2 (Resus)	De Lage Landen (paid monthly in arrears)		3,932	47,186	235,930	1/06/2020	1/06/2025	Operating
Philips Digital Diagnost C90 (ED)	De Lage Landen (paid monthly in arrears)		6,177	74,118	370,592	30/09/2020	30/09/2025	Operating
Philips Digital Diagnost C90 (Resus)	De Lage Landen (paid monthly in arrears)		3,877	46,520	232,601	31/08/2020	31/08/2025	Operating
Logiq E10 4D Ultrasound (Equigroup)	GE Healthcare Ltd		3,649	43,794	218,969	28/01/2021	28/01/2026	Operating
3 x Carestream Mobile X-ray Units	De Lage Landen (paid monthly in arrears)		9,960	119,517	597,586	27/04/2021	27/04/2026	Operating
2x Digital Diagnost C90 (Room 3 & Room 4)	De Lage Landen (paid monthly in arrears)		11,552	138,623	693,114	13/05/2021	13/05/2026	Operating
		293,188	**131,412**	**1,576,974**	**6,668,212**			
Total Leases			**224,752**	**2,697,039**				

Treasury as at 31 December 2021

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$50,629	$48,524
Lowest balance for the month	$22,582	$25,670
Average interest rate	1.00%	0.84%
Net interest earned/(charged) for the month	$43	$33

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	3
Total value of transactions	$12,186 NZD
Largest transaction	$5,959 NZD

	No. of transactions	Equivalent NZD
AUD	1	$307
GBP		
SGD		
USD	2	$11,878
Total	**3**	$12,186

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	$9,996	$4,237	$463	$166	$204	$16	$1,665	$3,245
Ministry of Health	$4,099	$3,252	$0	$160	$596	$0	$68	$24
Accident Compensation Corporation	$589	$317	$0	$0	$4	$14	($2)	$256
Wairarapa District Health Board	$394	$380	$0	$6	$0	$0	$9	$0
Mental Health Solution	$208	$208	$0	$0	$0	$0	$0	$0
Health Workforce NZ Limited	$97	$97	$0	$0	$0	$0	$0	$0
Auckland District Health Board	$79	$0	$0	$79	$0	$0	$0	$0
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
Whitireia Community Polytechnic Limited	$55	$55	$0	$0	$0	$0	$0	($0)
Non Resident	$52	$0	($0)	$0	$0	$0	$0	$53
Total Top 10 Debtors	**$15,630**	**$8,606**	**$463**	**$411**	**$804**	**$30**	**$1,739**	**$3,577**

Board Information – Public

16 February 2022

CCDHB Financial and Operational Performance Report – December 2021	
Action Required **The CCDHB Board note:** (a) The DHB had a ($6.2m) deficit for the month of December 2021, being ($3.2m) unfavourable to budget before excluding COVID-19; (b) In the one month we incurred ($3.7m) additional net expenditure for COVID-19; (c) The DHB has an overall YTD deficit of ($14.8m) from normal operations (excluding COVID-19) which is $3.2m favourable to the underlying budget.	
Strategic Alignment	Financial Sustainability
Authors	2DHB Chief Financial Officer, Rosalie Percival 2DHB General Manager Operational Finance & Planning, Judith Parkinson 2DHB Director of Provider Service Joy Farley 2DHB Director Strategy Planning and Performance - Rachel Haggerty
Endorsed by	2DHB Chief Executive - Fionnagh Dougan
Purpose	To update the Board on the financial performance and delivery against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS.

Executive Summary

There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22.

- The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the six months month's to 31 December 2021 is $14.8m deficit, versus a budget deficit of $18m. Additional net COVID-19 related expenditure above funding, year to date is $15.3m.

  For the six month's to 31 December 2021 the overall DHB year to date result, including COVID-19 costs is $30.1m deficit.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $44.9m year to date.
- The DHB has a positive cash Balance at month-end of $57.8 million offset by positive "Special Funds" of $14.2 million net $72.1m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional

revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Hospital:

The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority.

- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity; however the latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with the same staff shortages. Worrying ethnicity differences in waiting times are not consistent across all specialties - over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.
- The national cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list is well above the target waitlist size set by the Ministry programme. We have increasing numbers of thoracic patients who require treating which impacts on our cardiac surgery volumes as the same resource is used to treat both groups of patients. Other factors impacting on our waitlist size is the reduction in surgery due to the COVID-19 Level Four lockdown and cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in the waiting time.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHB's ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2DHB Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- We remain within budget.

Funder:

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

The four main work streams are:

- Complex Care and Long Term Conditions
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- Intersectoral Priorities
  - Disability – World of Difference
  - Strengthen our response to family violence

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers for CCDHB are 102 FTE below plan year to date
Financial	Planned surplus including the children's hospital donation for CCDHB is $7 million with no COVID-19 impacts included.
Governance	This monthly report enables the Board to scrutinise the financial and operational performance.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

3.1.1 CCDHB Financial and Operational Performance Report – December 2021

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 31 December 2021

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the six months month's to 31 December 2021 is $14.8m deficit, versus a budget deficit of $18m.
- Additional net COVID-19 related expenditure above funding, year to date is $15.3m.
- For the six month's to 31 December 2021 the overall DHB year to date result, including COVID-19 costs is $30.1m deficit.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $44.9m year to date.
- The DHB has a positive cash Balance at month-end of $57.8 million and a positive "Special Funds" of $14.2 million $72.1m. It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Executive Summary continued

Hospital: The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority .

- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with the same staff shortages. Worrying ethnicity differences in waiting times are not consistent across all specialties - over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.
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- We remain within budget.

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

- Complex Care and Long Term Conditions
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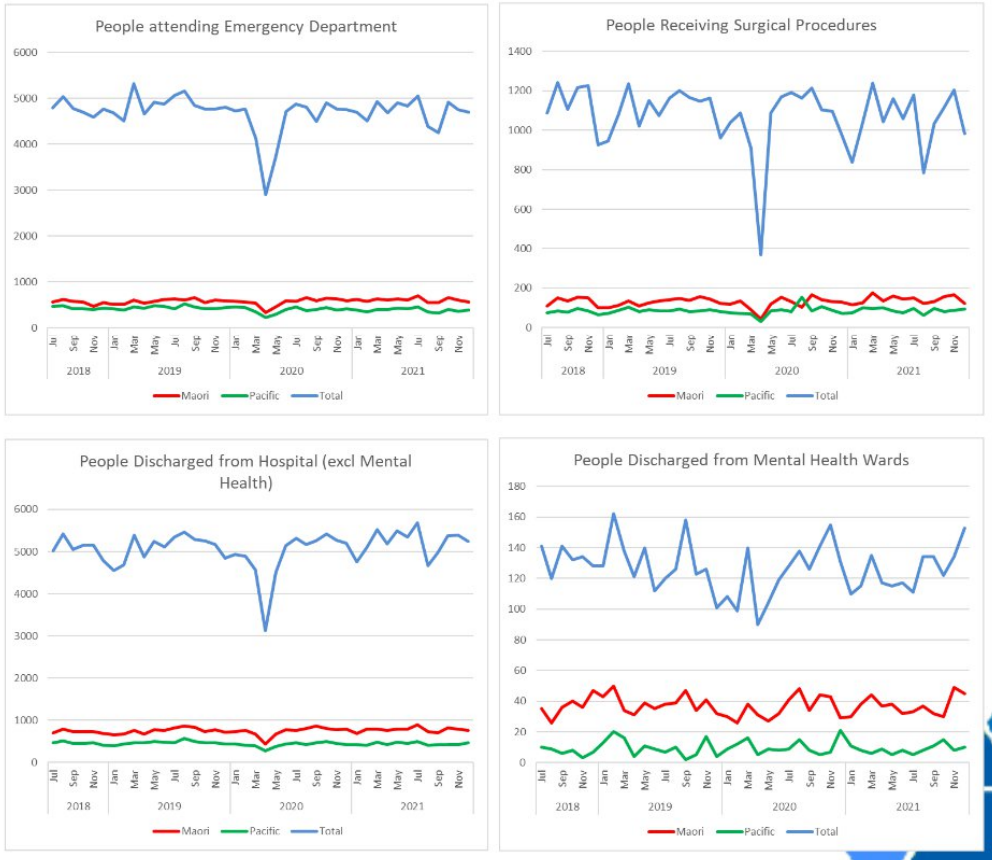
- Intersectoral Priorities
  - Disability – World of Difference

Performance Overview: Activity Context (People Served)

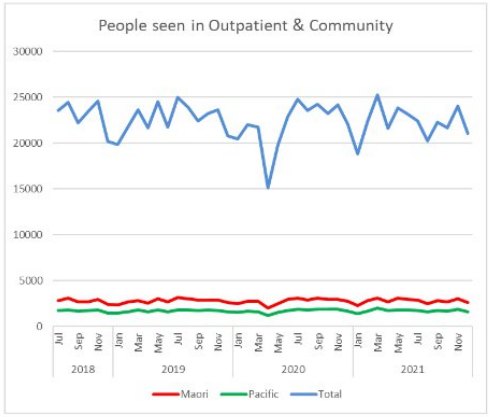
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

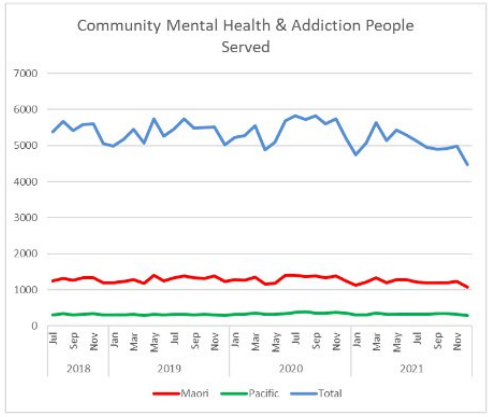
People attending ED	**4,702**	565 Maori, 383 Pacific
People receiving Surgical Procedures (in main theatres)	**983**	121 Maori, 93 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,244**	754 Maori, 463 Pacific
People discharged from Mental Health Wards	**153**	45 Maori, 10 Pacific

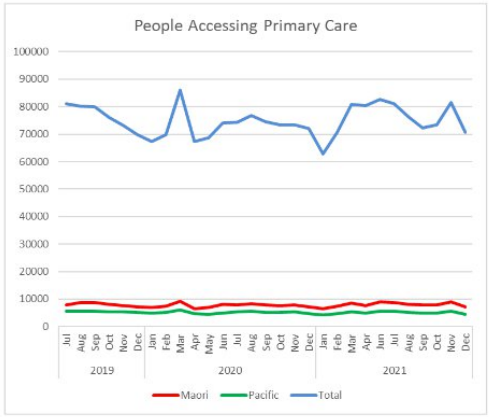


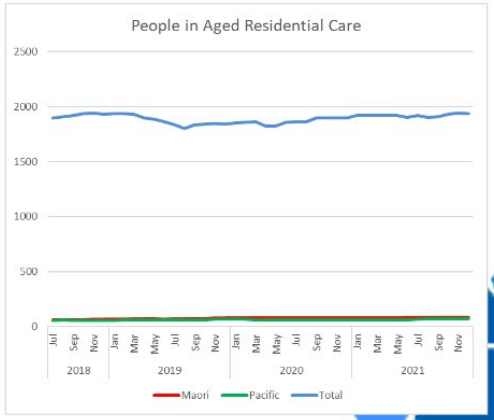
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**21,058** 2,593 Maori, 1,641 Pacific
Community Mental Health & Addiction People Served	**4,467** 1,071 Maori, 295 Pacific
People accessing primary care	**70,603** 7,172 Maori, 4,570 Pacific
People in Aged Residential Care	**1,936** 86 Maori, 72 Pacific









Financial Overview – December 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$30.1m deficit Incl. $14.8m net COVID-19 costs	$17.8m deficit Incl. $14.8m net COVID-19 costs	$12.5m deficit	$44.9m spend Incl. $25.8m strategic capex
Against a budgeted YTD deficit of $17.8m. BAU Month result was ($1.1m) favourable. YTD $3.2m favourable BAU variance.	Against a budgeted YTD deficit of ($6.0m.) BAU Month result was ($2.0m) favourable. BAU YTD ($3.0m) favourable variance.	Against a budgeted YTD Deficit of $12m. BAU Month result was $100k favourable result. YTD ($500k) unfavourable BAU variance.	Against a KPI of a budgeted baseline (non-strategic) spend of $21.1m. Strategic incorporates funded project such as Children's Hospital & ISU

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Taken
0.5% behind[1]	5,935.24[3]	($17.7m) annualised[4]
-809 CWDs behind PVS plan (-636 IDF CWDs , but -339 Hutt behind). Month result +16 CWDs excluding work in progress.	YTD 102 below annual budget of 6,037 FTE. There is 924 FTE vacancies at end of December	Underlying YTD annual leave taken is under by 5.9 days per FTE and Lieu leave taken for public holidays is short by 5.1 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 1170 cwd outsourced (616 events) ~$7.1m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.

[3] Paid FTE ignores leave balance movement which is YTD 10FTE worse than budgeted growth, Outsourced staff are also not counted in this metric which is currently $6.5m adverse to budget.

CWD – Case weights (also known as WEIS for a year) WEIS – Weighted Inlier Equivalent Separations

4 – Only annual leave & Lieu excludes long service, LILO & other types, note that public holidays build up the Lieu leave in the second half of the financial year. This assumes the YTD continues for 12 months

Hospital Performance Overview – December 2021

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
65.7%	708	775**	4
29.3% below the ED target of 95% Monthly +3.9%	Against a target of zero long waits a monthly movement of +28	Against a target of zero long waits, a monthly movement of +78 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
0.5% behind[1]	3,834.31[3]	$6,350*
-809 CWDs behind PVS plan (-636 IDF CWDs , but -339 Hutt behind). Month result +16 CWDs excluding work in progress.	YTD 4.90 above annual budget of 3,829 FTE. 450FTE vacancies at month end.	Against a national case-weight price per WEIS of $6,100.*to Nov 2021

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 1,394 cwd outsourced (689 events) ~$8.5m dollars at WEIS price. This is largely Cardiothoracic sent to Wakefield and Orthopaedics sent to Southern Cross.
[2] An SSE is classified as SAC1 or SAC2 serious adverse events per HQSC
[3] Paid FTE ignores leave balance movement which is YTD 12 FTE worse than budgeted, Outsourced staff are also not counted in this metric which is currently $1.3m adverse

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

Section 2.1

Funder Performance

Executive Summary – Funder Performance

- The net unfavourable YTD variance in the Funder Arm of ($0.5m) consists of a favourable revenue variance of $65.7m offset by an unfavourable cost variance of ($66.2m) mainly due to unbudgeted COVID revenue and costs as set out below.
- COVID-19 accrued and paid revenue of $46.2m is offset by COVID-19 costs of ($46.2m). MoH has agreed to a full cost recovery for the COVID-19 response. The ongoing demand for managed isolation facilities and community surveillance continues. The COVID-19 Care in the Community (CIC) planning phase has been accelerated. The COVID-19 testing and vaccination programmes are still the main focus with the booster injection phase continuing. In anticipation of the possible Omicron spread into the community, the programmes continue to be managed using community sites, some with drive through options, which can be ramped up or down at short notice. Equity priorities for Māori, Pacific and vulnerable communities are part of all the programmes to make sure vaccinations and community care is delivered promptly and that those populations are not at risk.
- The cost of funding BAU community services is ($2.2m) unfavourable to budget. Some of these costs have offsetting revenue $2.8m. Additional Age Residential Care costs reflect the impact of stronger homecare support services. These are offset by lower costs in Primary Care demand driven services such as immunisations, urgent dental services.
- The volume throughput in HHS is still lower that target due to IDF flow related to lockdowns since August. The funder paid $4.6m less to the Provider Arm for services and received ($4.2m) less IDF revenue from other DHBs. The Funder Arm had to pay an additional wash-up of ($0.7m) for 2020-21.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach which is being led out by the Community Commissioning Forum as part of the 2DHBs Strategic Priorities. The four main work streams are:
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Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Dec 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
76,176	76,176	72,885	(0)	3,291	- Base Funding	457,055	457,055	437,310	(0)	19,745
5,506	5,292	5,940	214	(434)	- Other MOH Revenue - Funder	34,403	31,753	39,280	2,650	(4,877)
21,310	0	0	21,310	21,310	- Other MOH Revenue - MECA	21,310	0	0	21,310	21,310
9,326	0	0	9,326	9,326	- COVID Revenue from MOH	46,160	0	0	46,160	46,160
50	46	177	4	(127)	- Other Revenue	335	277	1,115	58	(779)
2,890	2,892	2,941	(2)	(51)	- IDF Revenue Inflows PHOs	17,677	17,351	18,134	326	(456)
23,176	23,133	19,830	43	3,345	- IDF 2021-2022 wash-up provision	134,001	138,795	110,734	(4,794)	23,267
138,433	**107,539**	**101,773**	**30,895**	**36,660**	**Total Revenue**	**710,942**	**645,231**	**606,573**	**65,711**	**104,369**
					Internal Provider Payments					
839	839	824	0	(15)	- DHB Governance & Administration	5,033	5,033	4,942	0	(91)
55,009	54,757	51,092	(252)	(3,917)	- DHB Provider Arm Costs - HHS	348,812	352,961	325,518	4,149	(23,294)
11,562	11,558	7,767	(4)	(3,795)	- DHB Provider Arm Costs - MHAIDS	69,373	69,347	46,605	(26)	(22,769)
793	793	977	0	184	- DHB Provider Arm costs - Corporate	4,897	4,897	5,862	0	965
21,310	0	0	(21,310)	(21,310)	- DHB Provider Arm costs - MECA	21,310	0	0	(21,310)	(21,310)
4,556	0	0	(4,556)	(4,556)	- DHB Provider Arm costs - COVID	10,597	0	0	(10,597)	(10,597)
94,070	**67,947**	**60,660**	**(26,123)**	**(33,410)**	**Total Internal Provider**	**460,023**	**432,238**	**382,927**	**(27,784)**	**(77,096)**
					External Provider Payments:					
6,617	6,571	8,045	(47)	1,427	- Pharmaceuticals	39,697	39,424	40,704	(273)	1,007
6,691	6,550	6,676	(140)	(14)	- Capitation	40,140	39,303	40,220	(838)	80
7,441	7,454	7,683	13	241	- Aged Care and Health of Older Persons	44,984	44,723	43,516	(261)	(1,468)
3,742	3,184	3,438	(558)	(304)	- Mental Health	19,650	19,104	17,808	(547)	(1,842)
776	879	764	103	(12)	- Child, Youth, Families	5,294	5,276	4,718	(18)	(576)
676	921	570	244	(106)	- Demand driven Primary Services	4,870	5,525	3,743	655	(1,128)
2,809	2,746	2,366	(64)	(443)	- Other services	16,913	16,474	14,071	(439)	(2,842)
4,002	4,002	3,809	0	(193)	- IDF Outflows Patients to other DHBs	24,011	24,011	22,894	0	(1,117)
4,837	5,190	5,250	353	413	- IDF Outflows Other	31,577	31,139	31,826	(439)	248
37,592	**37,496**	**38,601**	**(96)**	**1,009**	**Total External Providers**	**227,137**	**224,978**	**219,499**	**(2,159)**	**(7,638)**
4,770	0	1,160	(4,770)	(3,609)	- Community COVID Testing & Vax	31,201	0	6,774	(31,201)	(24,427)
(0)	0	0	0	0	- Community COVID Maori & Pacific	4,362	0	1,351	(4,362)	(3,011)
0	0	0	0	0	- IDF Wash-up 2020-2021	696	0	0	(696)	(696)
136,431	**105,443**	**100,421**	**(30,988)**	**(32,401)**	**Total Expenditure**	**723,418**	**657,217**	**610,550**	**(66,202)**	**(112,868)**
2,002	**2,095**	**1,352**	**(94)**	**650**	**Net Result**	**(12,476)**	**(11,985)**	**(3,977)**	**(491)**	**(8,499)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 MIQ and Vaccine rollout	1,139	7,180
COVID-19 Community funding	4,770	35,563
COVID-19 HHS Funding	3,417	3,417
MECA - Additional Funding	21,310	21,310
PHOs volume variances offset	134	1,255
Mental Health, Aged Care, Family CFAs	47	1,575
CWD IDF 2021/22 below target	77	(4,589)
Year to Date Revenue Variances	**30,895**	**65,711**

External Revenue Variances

- COVID-19 actual funding and accrued provision of **$46.2m** in support of GP assessment testing, vaccine rollout, quarantine hotel staffing & response funding for Maori and Pacific groups. The DHB will be fully funded for all COVID response and vaccination rollout costs.
- PHO additional wash-ups and volume funding variance of **$1.2m**. There are increased costs of ($0.9m) offsetting this revenue.
- New funding for Mental Health and Child & Youth services of **$1.6m** has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm has not achieved IDF CWD targets by **($4.6m)** due to COVID lockdown periods since Aug 2021. MECA pay equity funding of **$21.3m** passed through to Provider Arm,

CCDHB Funder Arm net year to date variance Dec 21 is unfavourable by ($0.5m).

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 MIQ & Vaccine	(1,139)	(7,180)
COVID-19 Community funding	(4,770)	(35,563)
COVID-19 HHS Funding	(3,417)	(3,417)
MECA - Additional Funding	(21,310)	(21,310)
HHS PVS services reduced due to COVID	(257)	4,123
PHOs volume variances offset revenue	(140)	(884)
Volume driven costs	237	(75)
Aged Care and Mental Health	(193)	(1,200)
2020/21 IDF and Planned Care washup	0	(696)
Year to Date Payment Variances	**(30,988)**	**(66,202)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs **($46.2m)** due to ongoing GP test assessment claims and vaccine rollout in support of the COVID-19 response as directed by the Ministry. Community increase due to Price per Dose vaccinations cost.
- PHO Capitation expenses are **($0.9m)** unfavourable. Additional costs due to volume changes are offset by additional revenue $1.2m.
- Other Community NGO contracts have a net YTD unfavourable variance of (**$1.3m)**. Increased Aged Care volumes in home support and Pharmacy claims offsets volumes in demand driven services such as immunisations (non COVID) & child dental.

Internal Provider Payments:

- Provider Arm was paid **$4.2m** less due to lower volumes achieved related to COVID lockdown periods. MECA pay equity of (**$21.3m)** passed through to Provider Arm,

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

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Dec 2021 $000's
Inpatient CWD	(3,880)
Outpatient Non DRG	(340)
Uncoded & PCT	(370)
Mental Health Provider	(205)
PHO Volume changes	336
Other IDF Inflows	(11)
Total per Financials	**(4,468)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($3.9m) YTD. Breakdown of the variance commented below:

- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: ($3.9m): Cardiology ($1.4m), General Surgery ($677k), Haematology ($659k), Gen Med ($523k), Spec Paediatric Surgery Neonates ($508k), Vascular Surgery ($499k), Oncology ($393k), Urology ($323k), Respiratory Medicine ($143k), Neurosurgery ($111k), Emergency Medicine ($102k), and Offset by Otorhinolaryngology (ENT) $544k, Maternity Service $246k, Cardiothoracic Surgery $166k, Gynaecology $156k,Orthopedic Surgery $136k
  - Planned Care: ($9k); Neurosurgery ($455k), Cardiothoracic ($342k), General Surgery ($274k) , Cardiology ($188k), Paediatric Surgical Services ($85k) and offset by Orthopaedic Surgery $410k, Otorhinolaryngology (ENT) $394k, Urology $311k, Ophthalmology $243k, Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry
- Non DRG inflow relates to all IDF patient visits that do not require a overnight stay

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

Commissioning: Families & Wellbeing

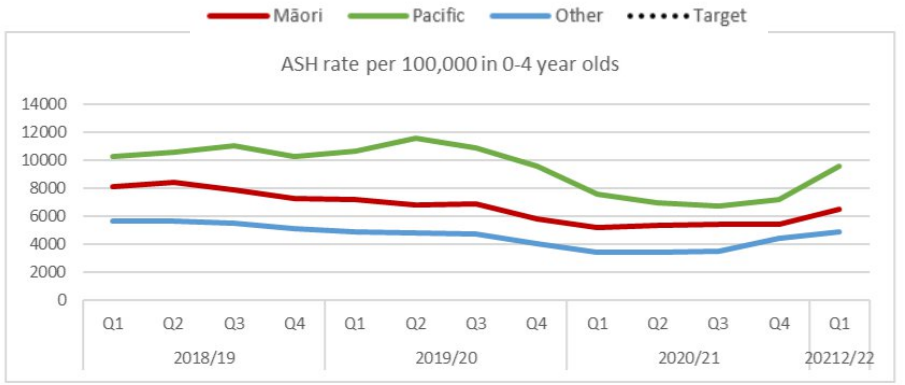
What is this measure?
- Decrease in the ambulatory sensitive hospitalisation rate (0-4 years)
- 95% of children fully immunised at 5 years
- 90% of children have their B4SC completed

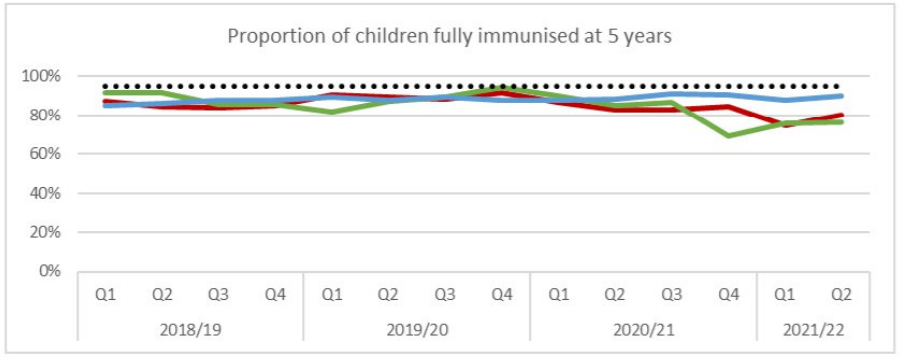
Why is this important?
- Ambulatory sensitive hospitalisations (ASH) are hospitalisations that could have been avoided through preventative care and coordinated care in the community and primary care setting.
- Children who receive the complete set of age-appropriate vaccinations are less likely to become ill from certain diseases.
- The Before School Check (B4SC) aims to identify any health, developmental or behavioural problems that may have a negative impact on the child's ability to learn and take part at school.

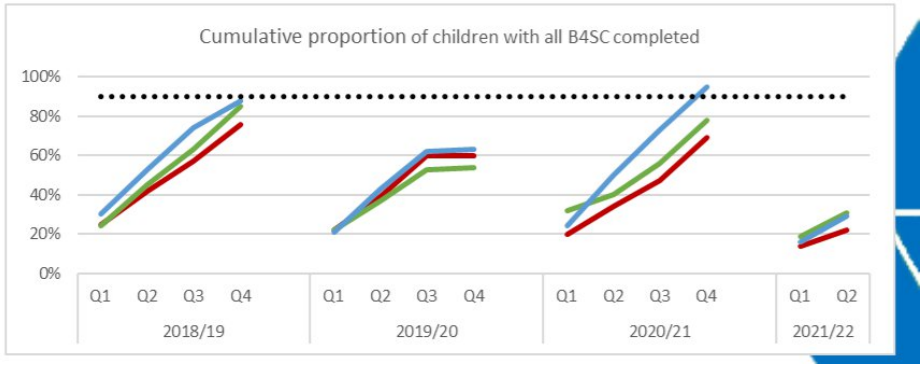
How are we performing?
- Performance for ASH rates is 6,506 for Māori, 9,593 for Pacific and 4,922 for non-Māori, non-Pacific.
- Performance is below the 95% target for Māori (80%), Pacific (76%), and non-Māori, non-Pacific (90%).
- Performance is below the 45% year to date target for Māori (22%), Pacific (31%) and non-Māori, non-Pacific (29%).

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

Management Comment
- To reduce ASH rates we have trialed after-hour GP video consults, expanding school-based health services in pre-schools and reviewing relevant respiratory health pathways.
- Our immunisation decline insights report is due to be completed in Jan 2022. We're also strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children who are yet to receive vaccinations are followed-up with by their GP.
- We are looking at a more cohesive and collaborative approach to the B4SC programme to ensure provision of an equitable service for Tamariki Māori. Plunket has also developed an Action Plan to drive its performance







Commissioning: Primary & Complex Care

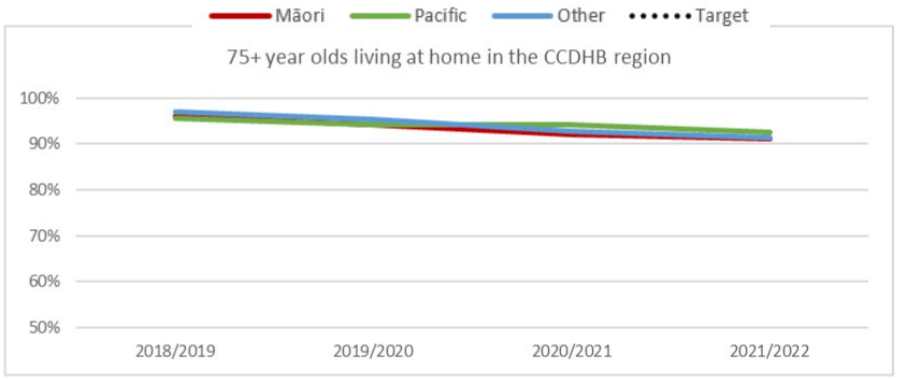
What is this measure?
Older People and Frailty
- Percentage of people aged 75+ living in their own home
- Acute bed day rate per 1,000 for people aged 75+
- Acute readmission rate for people 75+ within 28 days

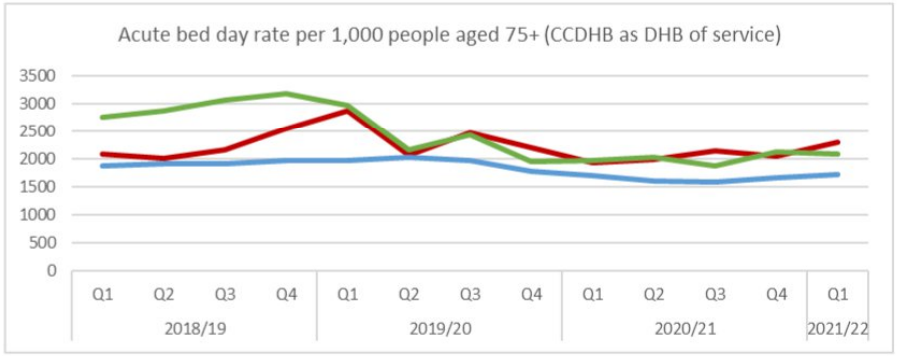
Why is this important?
- A significant pressure on our health system over the next 15 years is our ageing population.
- We can support older people to maintain their independence through prevention and early intervention activities using a range of community-based supports. Managing frailty earlier in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

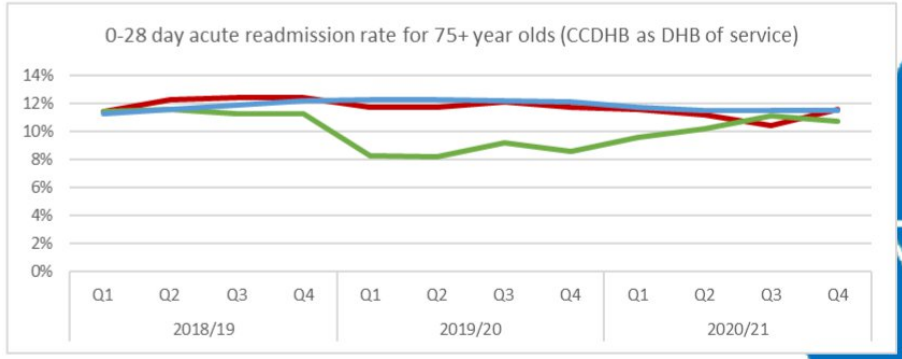
How are we performing?
- The proportion of CCDHB domiciled 75+ year olds living at home is 91% for Māori, 92% for Pacific, and 91% for non-Māori, non-Pacific.
- The acute bed day rate for 75+ year olds is 2,302 for Māori, 2,094 for Pacific, and 1,721 for non-Māori, non-Pacific.
- Performance for 0-28 day acute readmissions is 12% for Māori, 11% for Pacific, and 12% for non-Māori, non-Pacific 75+ year olds.

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

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







Commissioning: Hospital & Speciality Services

What is this measure?
Planned Care
Elective Service Performance Indicator (ESPI) 5 100% of patients given a commitment to treatment are treated within the required timeframe (120 days).

Why is this important?
Capacity constraints are driving increases in waiting lists and waiting times for surgical treatment and the DHB is not meeting the ESPI5 target. It is important to continually analyse who is waiting and ensure that this impact is not disproportionally affecting any of our communities and we are achieving the principles of
Equity: patients receive care that safely meets their needs, regardless of where they live and who they are.
Timeliness: patients receive care at the most appropriate time to support improved health.
Access: patients can access the care they need in the right place, with the right health provider.

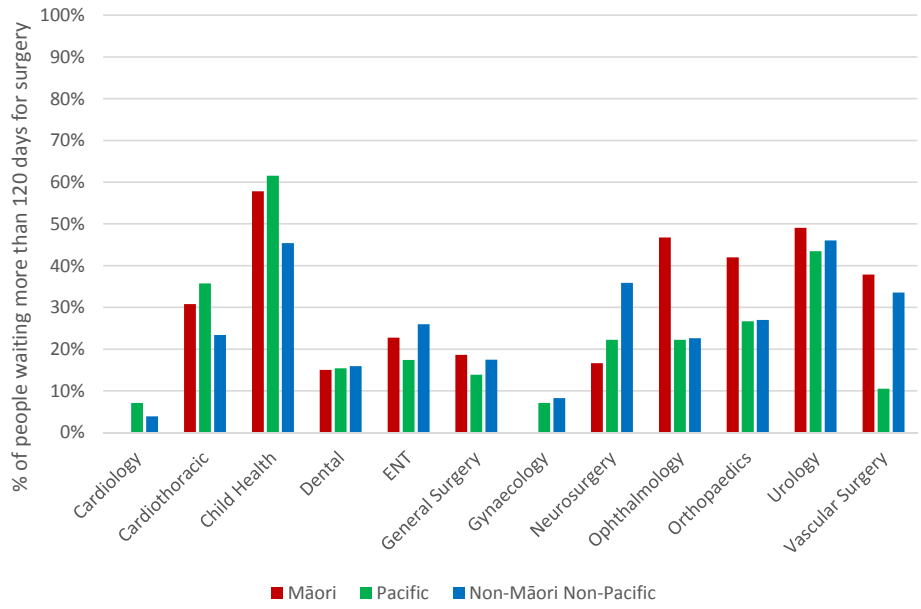
How are we performing?
We are not meeting the target and Māori are over-represented in the people waiting longer.
- One quarter of the people on the waiting list have been waiting more than 120 days for treatment however this is not equal across ethnic groups, access is better for Pacific peoples and worse for Māori.
- 32% of Māori have waited longer than 120 days compared with 27% of Non- Māori Non-Pacific people and 22% of Pacific people.
- On average Māori wait 13 days longer for surgery and Pacific people 9 days shorter than Non- Māori Non-Pacific people.

Ethnicity differences in waiting times are not consistent across all specialties, and while Pacific people overall are not waiting as long for treatment on average, some specialties have inequitable wait times.
- Māori are waiting longer for access to Cardiothoracic, Child Health, ENT, General Surgery, Ophthalmology, Orthopaedics, Urology and Vascular Surgery.
- Pacific peoples are waiting longer for Cardiology, Cardiothoracic, and Child Health.

What is driving performance?
Waiting times are increasing across specialties and ethnicities due to capacity constraints limiting delivery of planned care.
- COVID-19 continue to challenge our expected delivery of planned care due to additional precautions.
- We continue to manage workforce issues such as recruiting to key vacancies.
- CCDHB continues to prioritise ESPI-5 waitlist by clinical urgency and time on waitlist.

Management comment:
Over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.

Surgical waiting list statistics	Māori	Pacific	Non-Māori Non-Pacific	Total
Number of people on waiting list	515	287	2,271	3,073
Average number of days waiting	110	88	97	99
Median number of days waiting	80	63	72	73
% of people waiting more than 120 days (ESPI5)	32%	22%	27%	27%
Number of people waiting more than 120 days	167	64	606	837
Average wait time if waiting more than 120 days	215	201	201	204
Median waiting time if waiting more than 120 days	190	196	185	188



Commissioning: Mental Health & Addictions

What is this measure?

- Rate of access to primary care mental health and addictions services per 100,000
- Rate of access to specialist mental health and addiction services per 100,000 (DHB and NGO)
- Rate of Māori under the Mental Health Act: section 29 community treatment orders

Why is this important?

- Enrolment in a PHO and engagement with primary care supports access to specialist services. It also generates opportunities for early intervention; and integration across primary, community and specialist services.
- Better access to a broad range of services improves people's mental health and wellbeing. This includes access to specialist mental health services for people with severe mental illness.
- Reducing the rate of Māori under s29 aims to support independent/high-quality of life for Māori under compulsory community treatment, and improve equity.

How are we performing?

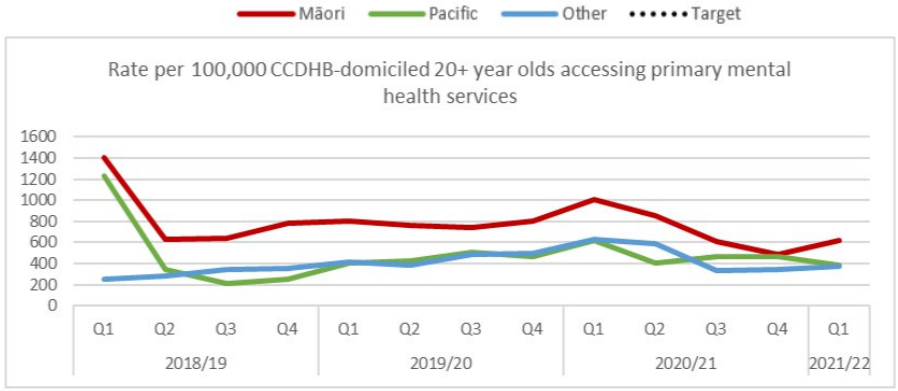
- Access rates to primary mental health care is 616 for Māori, 387 for Pacific, and 375 for non-Māori, non-Pacific.
- Access rates to specialist mental health services is 8,714 for Māori, 4,653 for Pacific, and 3,384 for non-Māori.
- The rate of Māori under s29 per 100,000 is 593; the rate of non-Māori is 169.

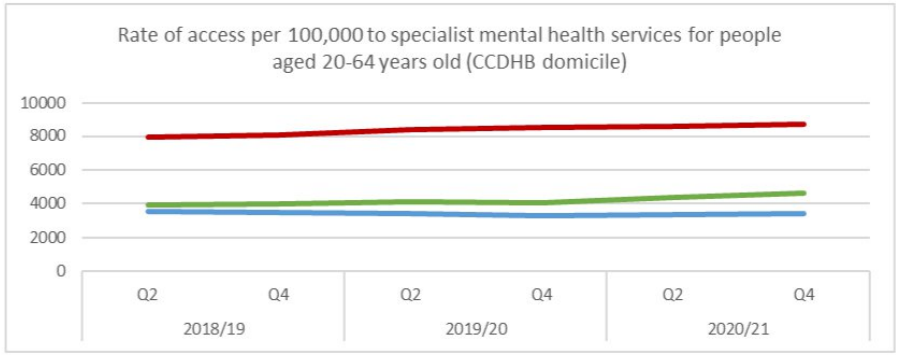
What is driving performance?

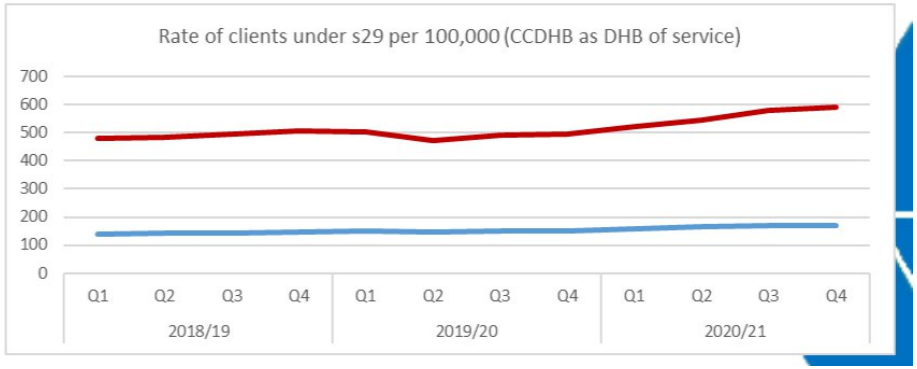
- All ethnicities, but in particular Māori, have much higher access rates to specialist mental health services provided by NGOs and DHBs. This is driven by how our mental health system has evolved over time and has resulted in a concentration of services in specialist care. Under-investment in primary mental health services means populations, and in particular Māori are unable to access and engage in prevention, early detection and management services. This is resulting in an acceleration of Māori through our system and reflected in higher rates of compulsory treatment.

Management comment

- As part of the strategic priorities work programme, we are partnering with community leaders and providers to co-develop community mental health and addiction services in localities with high levels of unmet need (Porirua) that are inclusive, accessible and well-connected to better meet population needs. This includes support for whānau ora and culturally appropriate models of care. Our key partner in Porirua is Ngāti Toa.
- In line with Te Rau Matatini best practice framework, we are implanting Kaupapa Māori mental health and addiction services in Te Awaikarangi, that support whānau Māori in a manner that preserves their unique cultural heritage, spirituality and wellbeing.
- We are implementing the new Kaupapa Māori Forensic Step Down service, in partnership with Te Waka Whaiora, by March 2022.







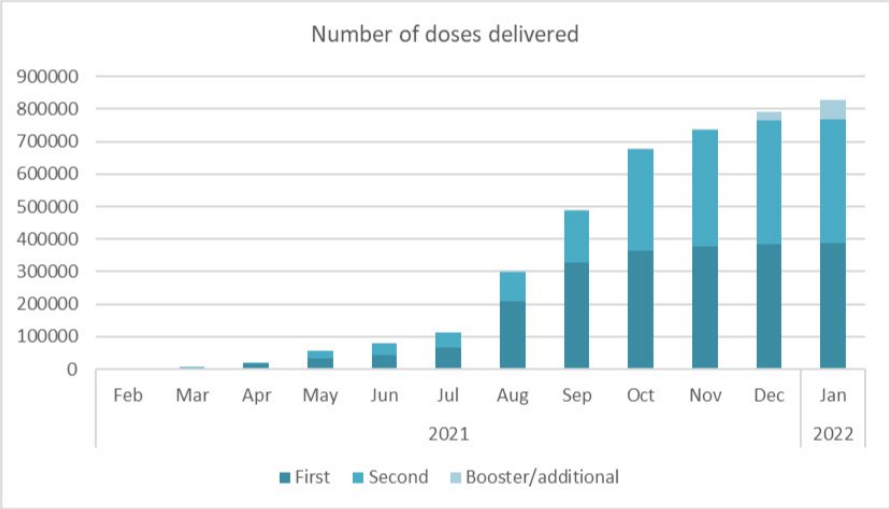
2DHB COVID-19 Response

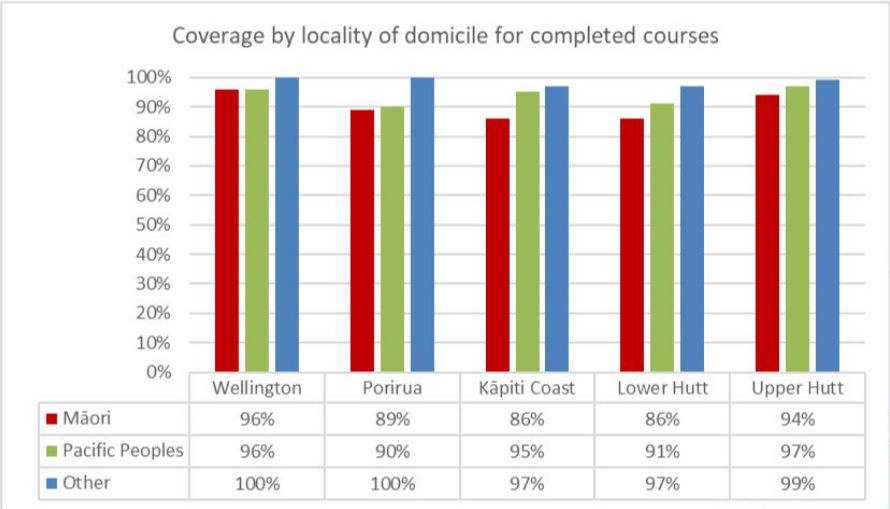
What is this measure?
- COVID-19 vaccination roll-out

Why is this important?
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 5 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- We are now implementing our vaccination programme for:
  - Boosters to the eligible population
  - Children aged 5-11 years of age
- First we are protecting those most at risk of COVID-19.

How are we performing?
- 385,231 people in the 2DHB region are fully vaccinated (96%)
  - 262,416 people in CCDHB (97%)
  - 122,815 people in HVDHB (94%)
- 41,093 Māori in the 2DHB region are fully vaccinated (89%)
  - 24,443 Māori in CCDHB (91%)
  - 16,650 Māori in HVDHB (87%)
- 26,663 Pacific Peoples in the 2DHB region are fully vaccinated (92%)
  - 17,589 Pacific Peoples in CCDHB (92%)
  - 9,074 Pacific peoples in HVHDB (92%)

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





	Wellington	Porirua	Kāpiti Coast	Lower Hutt	Upper Hutt
Māori	96%	89%	86%	86%	94%
Pacific Peoples	96%	90%	95%	91%	97%
Other	100%	100%	97%	97%	99%

Data Sources: MOH Covid-19 Vaccine Data
Date Range: 22/02/2021 to 18/01/2022
Data current at: 19/01/2022 @4:00pm

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- The impact of COVID-19 response for the newer variant Omicron planning dominates our thinking – confirming plans for service delivery alongside our COVID reality is our key priority .
- We continue to protect our planned care funding schedule as much as we can by maximising utilisation of current theatre and bed capacity as well as private hospital outsourcing capacity however this latter continues to be limited as private providers continue to work on their own backlog of deferred patients and struggle with the same staff shortages. Worrying ethnicity differences in waiting times are not consistent across all specialties - over the next few weeks we will work with the provider arm to identify the drivers of the ethnicity difference in waiting times. We will then develop a plan to address the barriers and monitor against the plan.
- The national cardiac surgery waiting list is monitored nationally across all the cardiac centres. Our wait list is well above outside the target waitlist size set by the Ministry programme. We have increasing numbers of thoracic patients who require treating which impacts on our cardiac surgery volumes as the same resource is used to treat both groups of patients. Other factors impacting on our waitlist size is the reduction in surgery due to the COVID 19 Level Four lockdown and cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in in the waiting time.
- Our Hospitals programme to ensure we provide safe, quality, complex and specialist care that achieves equity of access and outcomes continues with monthly meetings to review outputs. COVID-19 is the primary driver of risk in planned care and overall planning. Placing competing priority on staff time and resources, it creates uncertainty regarding workforce availability, increasing costs and supply logistics. Acute demand and capacity shortages are causing significant impacts on the DHBs ability to provide planned care. The ambitious timeline of the Front of Whare project and business case are highlighted as risks with resources are being prioritised to these projects to ensure delivery.
- Ongoing and intractable workforce shortages across midwifery and nursing, allied health in particular sonographer, social work, radiographers and now anaesthetists are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions. The 2D Nursing and Midwifery Recruitment and Retention Strategy, written to assist with the drive we need right now to fill vacancies in both workforces, at both DHBs and seek to retain our existing staff is being led by our Chief Nurse.
- We remain within budget.

CCDHB Contract Activity Performance

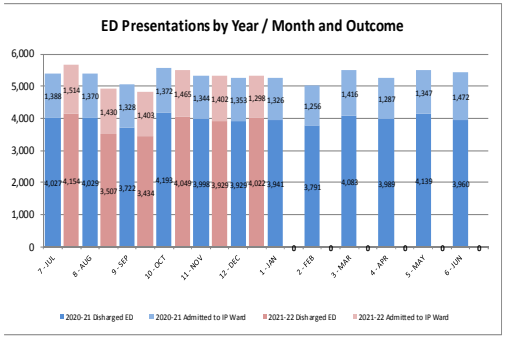
Capital and Coast DHB: December 2021

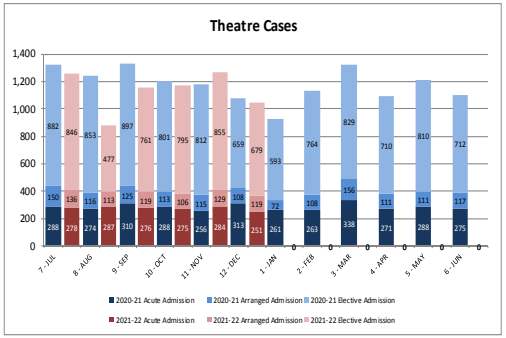
ED Presentations

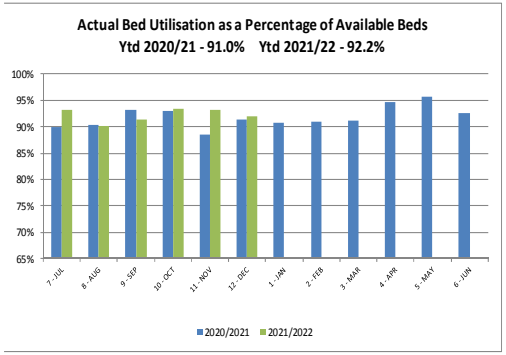
	2020/21	2021/22
YTD Totals	32,053	31,607
Change		-446
% Change		-1%

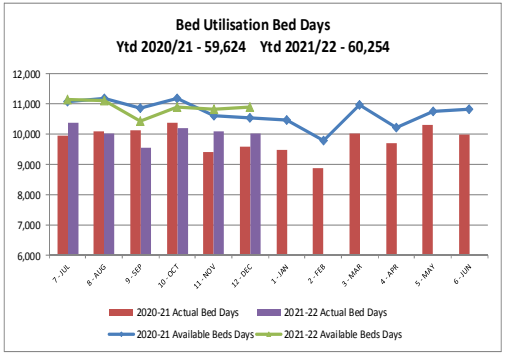
Theatre Cases

	2020/21	2021/22
YTD Totals	7,360	6,786
Change		-574
% Change		-8%









ED

- The total number of presentations to ED in December 2019 was 5,402 (this includes 382 DNWs)
- The total number of presentations to ED in December 2020 was 5,303 (this includes 463 DNWs)
- The total number of presentations to ED in December 2021 was 5,328 (this includes 502 DNWs)
- The average number of daily presentations in December 2021 was 172, this is slightly higher than the average of 171 presentations per day in December 2020.
- The number of patients with a triage level of 1-3 combined in December 2021 is 3,530 this represents 66.2% of the total presentations, this is higher than both December 2019 (61.3%) and December 2020 (64.7%).

Bed Utilisation

- The utilisation of available of adult beds in core wards in December was 91.9% which is higher than the rate of 91.3% recorded in December 2020. The number of available beds in December 2021 (352) is higher than in December 2020 (354) and can be attributed largely to more beds being available at Kenepuru.
- The number of Elective theatre cases has increased for the month of December 2021 by 3.0% (20 cases). December 2021 when compared to December 2020 saw increases most evident in Urology (22), Cardiothoracic (13) and Gynaecology (7) but countered by decreases; the most significant being in General Surgery (-14) and Orthopaedics (-7).

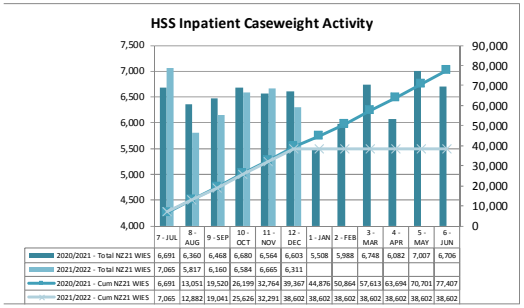
CCDHB Activity Performance

Capital and Coast DHB: December 2021

HSS Inpatient Caseweight Activity

	2020/21	2021/22
YTD Totals	39,367	38,602
Change		-765
% Change		-1.9%

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



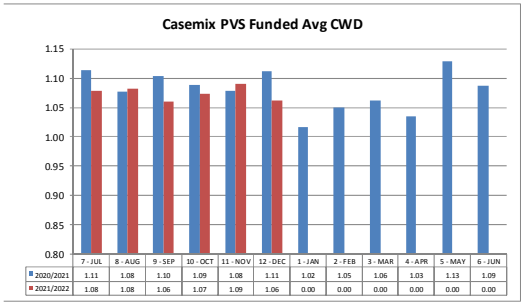
HSS Inpatient Discharges

	2020/21	2021/22
YTD Totals	36,435	36,506
Change		71
% Change		0.2%

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

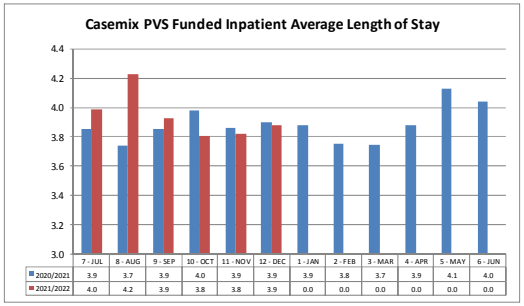
Casemix PVS Funded Avg CWD

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



Casemix PVS Funded Inpatient Average Length of Stay

	2020/21	2021/22
YTD Totals	3.89	3.94
Change		0.05
% Change		1.3%



Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (498 CWDs) with an increase in discharges; a higher ALOS and a similar average CWD. The discharge increase is driven primarily by Paediatric Medicine, Emergency Medicine and Obstetrics. The CWD increase is driven primarily by General Medicine, Paediatric Medicine, Cardiology and Orthopaedics
- Local Elective CWDs are lower than the previous financial year (-585 CWDs) with a decrease in discharges; a similar ALOS and average CWD. The discharge decrease is driven primarily by General Surgery, Cardiology, Orthopaedics and Vascular Surgery. The CWD decrease is driven primarily by Orthopaedic Surgery, General Surgery, Cardiology and Neurosurgery
- IDF acute CWDs are lower than the than the previous financial year (-264 CWDs) with a small increase in discharges; a lower ALOS and lower average CWD. The discharge increase is driven primarily by Gynaecology, Paediatric Surgery and Opthalmology. The CWD decrease is driven primarily by Haematology and Cardiothoracic Surgery.
- IDF Elective CWDs are lower than the previous financial year (-238 CWDs) with less discharges; a higher ALOS and a similar average CWD. The discharge decrease is driven primarily by Vascular Surgery, and Paediatric Surgery. The CWD decrease is driven by Cardiothoracic Surgery, Vascular Surgery and Neurosurgery.
- In combination these four admission groups equate to a decrease of 589 CWDs compared to the previous year. The services that most significantly impact this shift are General Surgery (-367), Vascular Surgery (-191), Neurosurgery (-172), Cardiothoracic Surgery (-167) and Haematology (-126) countered by increases in General Medicine (252), Paediatric Medicine (147) and Obstetrics (90).
- The decrease in General Surgery can be partly attributed to a significant acute outlier discharged in November 2020 which had a CWD value of 112.
- The decrease in Cardiothoracic Surgery is solely related to patient mix. The number of publicly funded casemix discharges between July 2021 and December 2021 Ytd has increased by 12 (3%) in comparison to the number of discharges recorded in July 2020 to December 2020.
- The decrease in Haematology can be largely attributed to a number of significant outliers discharged in 2020/2021 which saw a far greater mix of Bone Marrow Transplant and complex Leukaemia cases which have not been evident in 2021/2022
- The increases in General Medicine were apparent in July (RSV) and August and November with September 2021 and October 2021 and December 2021 sharing similar volumes with the previous year.
- The increases in Paediatric Medicine were realised in July 2021 (RSV), August 2021 (RSV) and October 2021 (patient mix) with a surprising drop off in September 2021, November 2021 and December 2021.

Discharges:

- The number of publicly funded casemix discharges for the month of December 2021 has decreased by 33 (-0.6%) in comparison to the number of discharges recorded in December 2020. This decrease in the number of discharges is most evident in General Medicine (-48), General Surgery (-27 Acute, -20 Elective), Orthopaedics (-24 Acute, -16 Elective) and Opthalmology (-20 Elective). The overall decrease was countered by increases in Obstetrics (55 Babies, 57 Mother) and Vascular Surgery (18 Acute, 14 Elective).
- The reduction in the number of elective discharges in Orthopaedics can be partly attributed to reduced outsourcing activity with 25 discharges in December 2021 compared to 49 discharges in November 2020.
- The reduction in the number of elective discharges in Ophthalmology can be partly attributed to reduced outsourcing activity with 27 discharges in December 2021 compared to 12 discharges in December 2020.
- The number of outsourced discharges recorded in December 2021 was 71 which is 51 lower than December 2020. CCDHB in December 2021 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period Dec 20 to Dec 21

Indicator	2021/22 Target	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun	2021-Jul	2021-Aug	2021-Sep	2021-Oct	2021-Nov	2021-Dec
Serious Safety Events	TBD	6	13	14	3	11	8	8	11	2	11	6	10	4
Total Reportable Events	TBD	1,514	1,425	1,483	1,458	1,426	1,540	1,369	1,487	1,260	1,169	1,442	1,459	1,376
Complaints Resolved within 35 calendar days	TBD	83.0%	93.1%	95.5%	92.3%	93.7%	93.3%	87.9%	77.1%	89.5%	88.2%	86.4%	84.3%	72.7%
% Discharges with an Electronic Discharge summary	TBD													
Emergency Presentations		5,282	5,267	5,047	5,499	5,276	5,486	5,432	5,668	4,937	4,837	5,514	5,331	5,320
Emergency Presentations Per Day		170	170	180	177	176	177	181	183	159	161	178	178	172
Emergency Length of Stay (ELOS) % within 6hrs	≥95%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%	64.0%	56.2%	66.6%	64.8%	61.9%	61.8%	65.7%
ELOS % within 6hrs - non admitted	TBD	75.6%	78.0%	72.7%	77.5%	74.0%	78.3%	75.2%	66.4%	79.3%	75.9%	72.4%	72.0%	75.5%
ELOS % within 6hrs - admitted	TBD	49.4%	52.4%	45.4%	47.2%	45.0%	45.6%	45.3%	39.6%	44.0%	41.4%	43.2%	44.9%	48.3%
Total Elective Surgery Long Waits	Zero Long Waits	300	485	525	513	515	343	362	427	549	691	696	680	708
Additions to Elective Surgery Wait List		1,287	922	1,243	1,456	1,227	1,457	1,352	1,240	937	1,119	1,036	1,358	969
% Elective Surgery treated in time	TBD	88.4%	75.5%	75.6%	72.2%	72.1%	75.0%	82.4%	83.2%	81.5%	72.4%	71.1%	75.5%	78.6%
No. surgeries rescheduled due to specialty bed availability	TBD	6	2	6	11	7	13	21	16	6	0	9	7	2
Total Elective and Emergency Operations in Main Theatres	TBD	1,002	878	1,076	1,270	1,063	1,190	1,085	1,209	807	1,062	1,145	1,229	1,001
Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	88.0%	82.0%	90.0%	88.0%	86.0%	83.0%	96.0%	85.0%	83.0%	85.0%	86.0%	92.0%	96.0%
Faster Cancer Treatment 62 Day - Referral to Treatment	90%	89.0%	88.0%	83.0%	96.0%	79.0%	84.0%	91.0%	76.0%	81.0%	87.0%	67.0%	93.0%	88.0%
Specialist Outpatient Long Waits	Zero Long Waits	314	353	355	302	244	211	265	295	412	607	735	697	775
% Specialist Outpatients seen in time	Zero Long Waits	92.8%	89.0%	88.0%	85.5%	80.0%	90.5%	90.2%	89.2%	88.4%	82.0%	80.0%	79.9%	82.5%
Outpatient Failure to Attend %	TBD	7.9%	7.3%	7.6%	7.2%	7.2%	7.4%	7.0%	7.3%	7.1%	6.2%	7.0%	7.0%	6.8%
Maori Outpatient Failure to Attend %	TBD	16.6%	16.0%	16.2%	15.6%	15.6%	15.1%	15.2%	16.7%	14.7%	15.0%	14.5%	15.8%	15.3%
Pacific Outpatient Failure to Attend %	TBD	18.7%	19.5%	17.8%	16.8%	15.7%	16.3%	15.5%	15.6%	16.7%	15.3%	17.6%	17.7%	17.2%
Forecast full year surplus (deficit) ($million)		($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($46.5m)	$1.0m	$1.0m	$1.0m	$7.0m	$3.2m	$3.2m
Contracted FTE (Internal labour)		5,257	5,256	5,344	5,346	5,366	5,364	5,340	5,335	5,363	5,386	5,413	5,437	5,459
Paid FTE (Internal labour)		5,694	5,695	5,813	5,727	5,792	5,784	5,746	5,760	5,831	5,801	5,861	5,869	5,913
% Main Theatre utilisation (Elective Sessions only)	85.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%	80.0%	79.0%	79.0%	81.0%	79.0%	80.0%	80.0%
% Patients Discharged Before 11AM	TBD	22.6%	22.3%	21.9%	23.2%	25.3%	23.6%	25.3%	20.7%	21.8%	20.5%	22.6%	23.0%	21.2%
Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	37	37	38	41	37	35	38	44	40	30	40	38	34
Adult Overnight Beds - Average Occupied WLG	TBD	360	355	373	381	381	386	387	383	355	349	362	367	363
Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	17	16	14	19	19	22	17	32	34	21	26	25	25
Adult Overnight Beds - Average Occupied KEN	TBD	64	67	71	69	72	73	73	79	83	80	82	81	76
Child Overnight Beds - Average Occupied	TBD	22	17	19	22	22	22	25	30	23	19	24	22	22
NICU Beds - ave. beds occupied	36	35	38	39	44	39	42	36	40	38	32	35	29	35
Overnight Patients - Average Length of Stay (days)	TBD	3.90	3.88	3.75	3.75	3.88	4.13	4.04	3.99	4.23	3.92	3.80	3.82	3.88
Rate of Presentations to ED within 48 hours of discharge	TBD	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%	4.0%	4.0%	4.3%	4.0%	4.2%	4.3%	4.7%
Presentations to ED within 48 hours of discharge	TBD	170	218	202	194	247	253	218	224	211	194	231	228	252
Staff Reportable Events	TBD	175	147	185	165	157	149	159	157	130	142	169	197	159
% sick Leave v standard	TBD	3.2%	2.0%	2.7%	3.5%	3.0%	3.6%	3.8%	4.3%	3.9%	2.7%	3.2%	3.6%	3.5%
Nursing vacancy	TBD	268.5	267.8	224.0	239.0	241.0	250.0	266.0	295.0	374.0	422.0	508.0	526.0	527.8
% overtime v standard (medical)	TBD	1.8%	1.8%	2.0%	1.9%	1.8%	2.0%	2.0%	2.4%	2.2%	2.0%	2.2%	2.2%	2.1%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

- Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the emergency department therefore improves the health services DHBs are able to provide.
- During the month of December 2021 there were no presentations recorded where the patient was suspected of having COVID-19.
- Throughout December Wellington stood at the 'Orange' COVID Protection Framework setting
- The average number of daily presentations in December 2021 was 172, this is slightly higher than the average of 171 presentations per day in December 2020.
- 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?

- Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.
- Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for December 2021 was 92%.
  - The total number of presentations to ED in December 2019 was 5,402 (this includes 382 DNWs)
  - The total number of presentations to ED in December 2020 was 5,303 (this includes 463 DNWs)
  - The total number of presentations to ED in December 2021 was 5,328 (this includes 502 DNWs)
- The average number of daily presentations in December 2021 was 172, this is slightly higher than the average of 171 presentations per day in December 2020.

Performance	OCT	NOV	DEC
2018-19	77%	76%	77%
2019-20	65%	68%	66%
2020-21	62%	62%	65%

Breaches	OCT	NOV	DEC
2018-19	1,152	1,200	1,137
2019-20	1,765	1,594	1,655
2020-21	1,911	1,834	1,669

ED Volumes	OCT	NOV	DEC
2018-19	4,973	4,945	5,020
2019-20	5,054	4,916	4,840
2020-21	5,003	4,828	4,826

What is driving performance?

- CCDHB SSiED performance for December 2021 is 31.9% lower than the Target for SSiED. The count of breaches in ED 1,669 in December 2021 is slightly higher than the 1,655 recorded in December 2020.
- CCDHB SSIED performance for December 2021 was 65.4%. This result is an increase on the 62.0% recorded last month in November 2021.
- CCDHB performance for ED admitted patients for December 2021 was 48%, which is 1% lower than the result for December 2020.

Management Comment

- CCDHB continues to face a significant capacity issue as demonstrated by the consistently high occupancy rate and the bed blockage experienced across hospital flow as a consequence. Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for December 2021 was 92%.
- The number of admissions decreased by 40 when you compare December 2020 to December 2021, and the percentage of admissions decreased from 33.6% in December 2020 to 32.6% in December 2021.
- The average number of beds utilised by planned admission for December 2021 was 66 per day which is lower than December 2020.
- In view of addressing bed blocks, the Complex Care Forum has been working closely with Clinicians to facilitate supported discharge at an early stage in order to vacate beds and facilitate flow of patients from ED. Similarly Clinicians are encouraged to do early rounding and nurse-led discharge processes are being reinforced.
- Charge Nurse Managers from General Medicine are meeting on a daily basis at 8am in view of assessing planned discharges and ensuring that a proper follow up is in place with the Medical Team.
- Working Groups have been set up in relation to the Front of Whare project in order to identify the barriers and confirm the need for improved resources (facilities and personnel). On the other hand, work is in progress for the setting up of a new Minor Care Unit which in turn will free up 6 bed space in EDOU. This work is inextricably linked to other ongoing work to assess and address overall hospital capacity.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

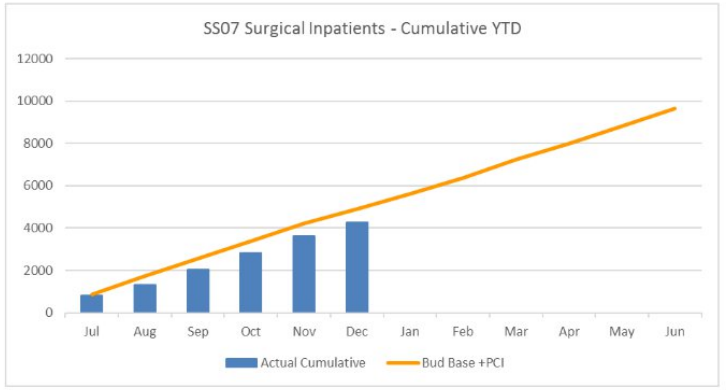
- Year to date we are reporting 634 discharges behind our target of 5,248 equating to 88%
- Total Planned care results for December month end show us 1 ahead of the planned 756.
- Our in-house elective surgical PUC results were 42 discharge ahead of the planned 445 and outsourcing adverse 72 to the planned 124. Elective non-surgical PUC met the planned 11, arranged surgical PUC 24 and arranged non-surgical 1 ahead of the month's plan.
- IDF outflow results are 6 ahead of the planned 74 for December, elective surgical PUC 16 ahead of the planned 62 which offset the 10 adverse results of the other IDF measures.
- Minor procedures in-house reporting 190 over the planned 379 for December.

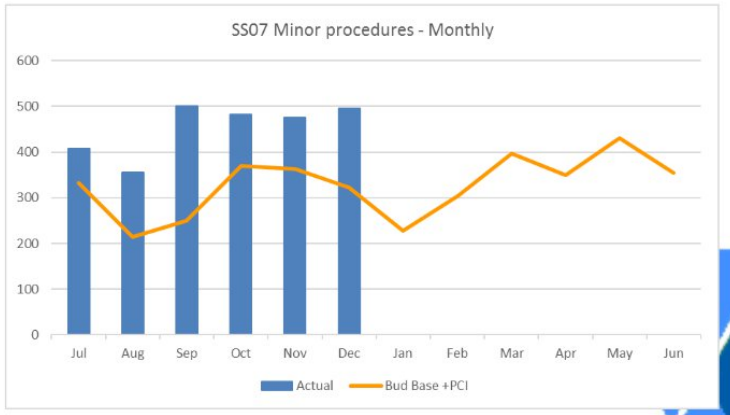
What is driving performance?

- December in-house discharges were met, however due to past contractual constraints and capacity issues we have been unable to meet our outsource planned volumes. We anticipate ongoing deficits in outsourced volumes even with new panel agreements being in place.

Management Comment

- We managed to increase our surgery throughput in December, however not enough to make a significant difference to the back log from being in Covid readiness in previous months. Significant work is being done in the Covid readiness space around screening pre surgery, to ensure surgery continues as much as possible when we experience a surge in Covid positive cases.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.





Planned Care – Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

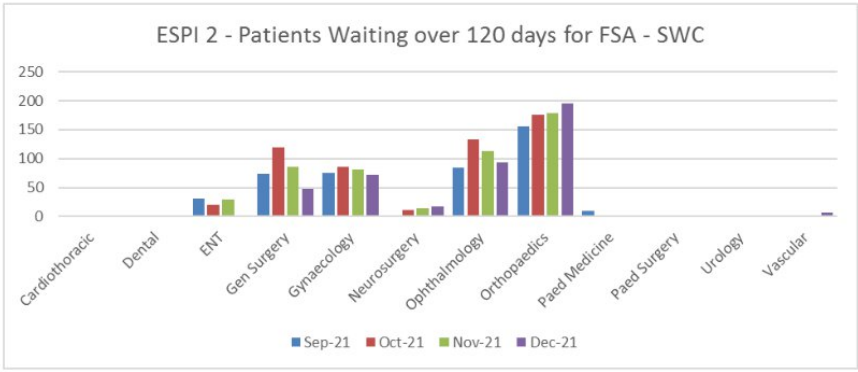
- December EPSI 2 results show a decline from the previous month. The drivers of this adverse result are Cardiology, Dermatology and Orthopaedics, Additional outpatient clinics continue to run to address our long waiting patients.

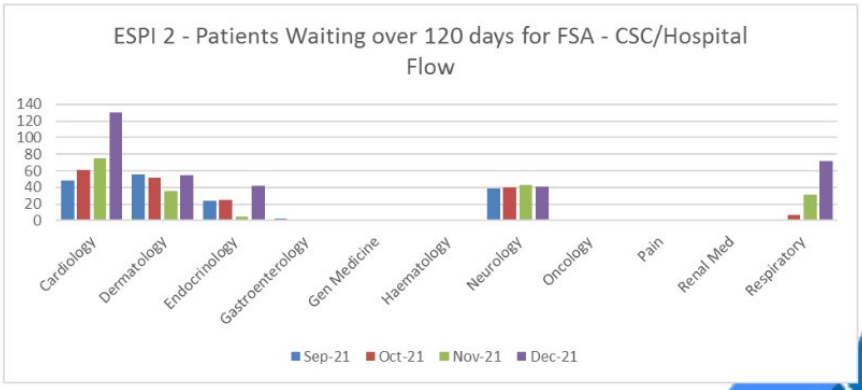
What is driving performance?

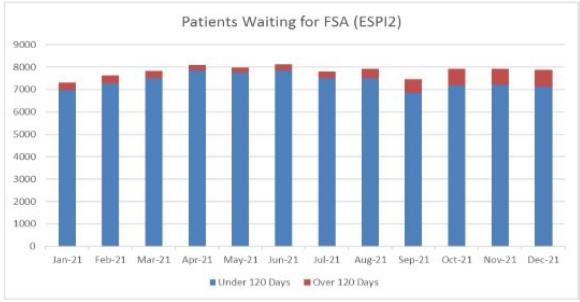
- Cancellation of face to face consultations is the cause of our deterioration earlier in the year. We continue to address the back log.

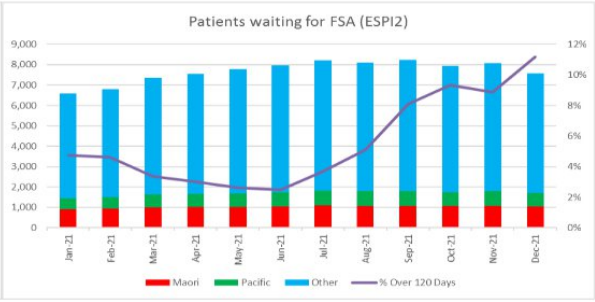
Management Comment

- All services have continued with Zoom clinic and telephone calls to patients where appropriate. Those patients cancelled due to COVID readiness continue to be rescheduled in clinical urgency. Face to face clinics have resumed.









Planned Care – Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- CCDHB performance in ESPI 5 is shown in the table below. We have been non-compliant at an organisational level since January 2019. December is reporting 671 non-compliant, showing we held out position from the previous month. We anticipate this will deteriorate in January, due to the number of public holidays, and staff leave.

What is driving performance?

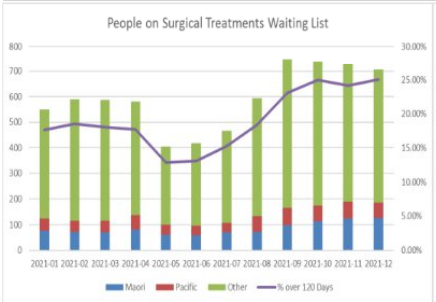
- Cancellation of theatres session is the main driver of our results, we continue to be prepared for Covid admissions, and currently we are experience staff shortages and cannot operate to capacity.

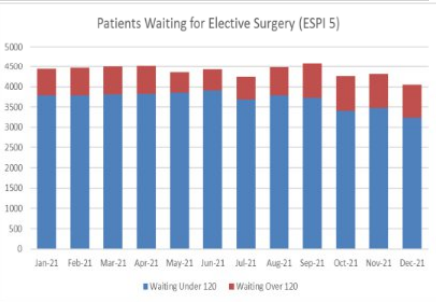
Management Comment

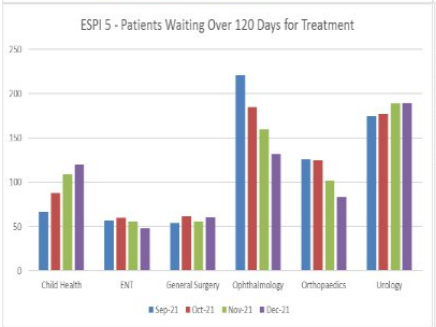
- December theatre session increased from the previous month, however not to capacity. Our private providers have a longer theatre closure period in December/January which limits our outsource capacity.
- Urology and Ophthalmology have run successful theatre sessions on a Saturday so we will continue to facilitate this and get more specialities on board when staffing allows.
- The cardiac surgery wait list is well above outside the target waitlist size set by the MoH. However while not part of the cardiac surgery measures, the cardiothoracic service also provides surgery to patients with thoracic disease which is usually cancer. We have increasing numbers of thoracic patients who require treating which impacts on our cardiac surgery volumes as the same resource is used to treat both groups of patients. Other factors impacting on our waitlist size is the reduction in surgery due to the Covid 19 Level Four lockdown and insufficient capacity in ICU with cancellations due to insufficient ICU capacity. We have been utilising as much private capacity as we can but this is insufficient to reduce the waitlist; a clinical team is looking at other options to support reduction in in the waiting time.

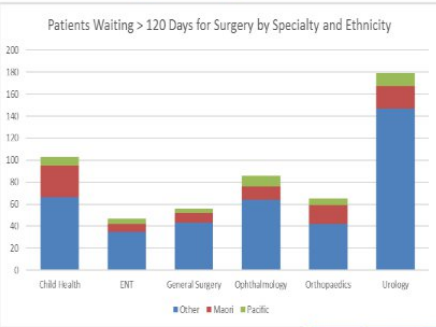
Table Three: CCDHB Performance in ESPI 5

ESPI 5 monitoring 20/21	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec*
Organisation wide	**-525**	**-513**	**-515**	**-343**	**-362**	**-427**	**-549**	**-691**	**-696**	**-674**	**-671**
Cardiology	-12	-19	-9	-2	-2	-4	-4	-6	-5	-8	-5
Cardiothoracic	-8	-7	-4	-3	-4	-7	-12	-22	-23	-26	-34
Dental	-34	-36	-21	-18	-21	-15	-29	-45	-39	-38	-39
ENT	-23	-33	-32	-32	-31	-34	-40	-52	-56	-50	-44
General Surgery	-91	-54	-58	-30	-24	-34	-42	-47	-57	-53	-54
Gynaecology	-9	-10	-16	-5	-9	-16	-22	-25	-14	-12	-8
Neurosurgery	-18	-16	-10	-3	-3	-4	-5	-12	-13	-10	-16
Ophthalmology	-107	-102	-121	-87	-100	-95	-134	-155	-121	-97	-77
Orthopaedics	-41	-34	-38	-30	-39	-65	-89	-98	-96	-71	-56
Paediatric Surgical	-12	-15	-15	-16	-17	-24	-28	-38	-63	-83	-98
Urology	-114	-139	-142	-101	-106	-120	-128	-164	-166	-173	-174
Vascular Surgery	-56	-48	-49	-16	-6	-9	-16	-27	-43	-53	-66









MRI and CT Waiting Times

What is this measure?

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

Why is this important?

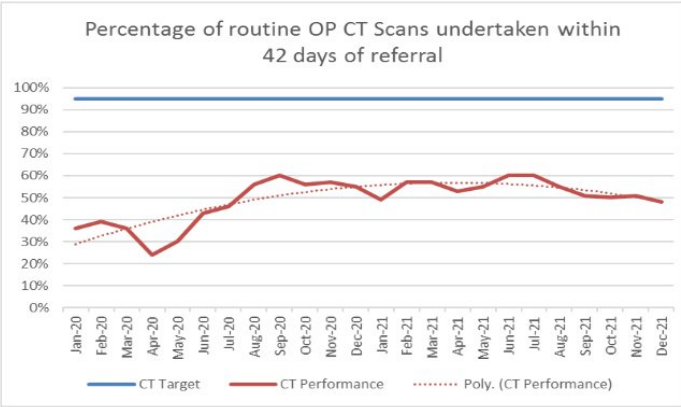
- Delayed diagnosis can lead to poorer health outcomes as a patient's condition may deteriorate while waiting. The period of 6 weeks (i.e. 42 days) is generally accepted as the reasonable clinical timeframe to receive imaging results for non-acute outpatient referrals.

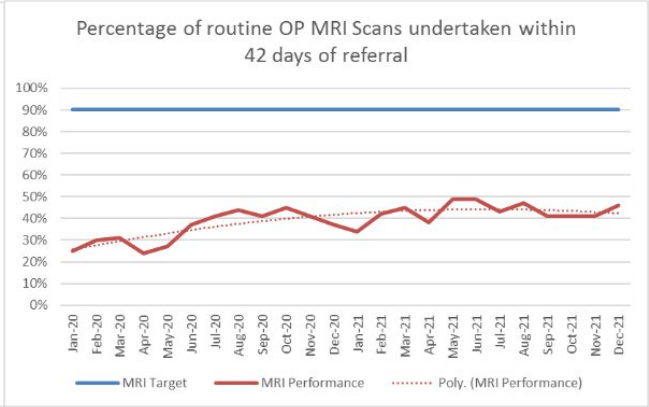
How are we performing?

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

What is driving Performance?

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





Management Comment

- With current waiting times there is risk of patient harm including disease progression, while waiting for imaging appointments. The service continues to prioritise based on clinical urgency and process images for inpatient and ED patients within expected timeframes in order to maximise inpatient flow.
- The Radiology service has received over 12 resignations from within the technical team (MIT – Medical Imaging Technologist) workforce since Easter 2021. This is over 20% of MIT workforce that due to a number of reasons we were unable to fill. A large number of positions have been filled at the end of 2022 as we employ graduating students.
- Unfortunately, we expect waiting times to increase steadily. Small increases in internal capacity with high technical team staff will not match the increase in demand so will not be able to attack the backlog waiting lists.
- Outsourcing continues at the maximum capacity across service providers available within the region and far in above DHB of $1.2m per annum (project spend 2021/22 $4.7m). Even at this rate of outsourcing we will not improve waiting times for the foreseeable future due to increased demand and imaging complexity.
- With current waiting times there is risk of patient harm including disease progression, while waiting for imaging appointments. The service continues to prioritise based on clinical urgency and process images for inpatient and ED patients within expected timeframes in order to maximise inpatient flow.

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- The proportion of patients waiting less than 90 days for angiography is 97.4% this month.

What is driving performance?

- 3 patients did not meet target this month. 1 due to capacity, 2 were rescheduled due to patient illness and logistics

Management Comment

- Additional interventionist is due to commence work in August 2022.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

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

National Performance	68.4% (498/728)
Central Region	68.6% (96/140)
CCDHB	91.1% (41/45)
Hawkes Bay	60.9% (14.23)
Hutt Valley	52.4% (11/21)
Mid Central	69.0% (20/29)

As a region we did not achieve the target. Only CCDHB achieved 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. Demand for beds has been high this month. Other factors include regional decision making timeframes, and timing of presentation.

Management Comment

- We have created additional capacity in the Transit Lounge capacity which we are using on a daily basis both for cardiology and cardiothoracic patients. Requested cardiac monitoring equipment will widen the criteria of patients who can go there and will free up more beds on the Cardiac ward. This equipment has not yet been installed
- We have been using beds in Hutt CCU for surgical waiters on a frequent basis.
- Hutt valley DHB are increasingly taking their patients back post procedure saving beds in the cardiac ward.
- Improvements have been made in repatriation of patients to the regions.
- A Cardiothoracic CNS has been employed and will help to reduce LOS and improve criteria led discharge.
- We have submitted plans for an additional 6 beds on the ward and Hutt are doing the same.
- A pilot to develop a Rapid Access Chest Pain Service is in progress which will provide alternatives to ED and avoid a small number of admissions.

- While these actions are in progress, we continue to remain short of beds and there are times when patients wait longer than desired for admission or transfer to Wellington. There are still physical limitations in where we can provide additional bed spaces in the short term.

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 compliant with the 62 day target for December at 85% which is above the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.

- CCDHB is compliant with the 31 day indicator for December at 96% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.

- However, there will be a number of patients meet criteria to be included in the indicators, ie those that entered the system in December and meet criteria, who are yet to be identified. Those patients will be known to the team later in January. There are currently only 25 patients that meet criteria for the 62 day pathway; and 73 patients that meet criteria for the 31 day pathway.

What is driving performance?

- The context is that for the patients known to the Cancer Coordination team, acute demand and staffing vacancies continue and are having a negative effect upon access to FSA, diagnostic services (imaging & pathology) and surgical services. Pathology reporting time is lengthening and PET scan disruption prior to Christmas had an impact on patients receiving timely appointments.

- There has been an influx of referrals for some tumour streams in the lead up to Christmas, with limited capacity to meet this increase demand. Overall there is increased pressure on services due to the limited service delivery from reduced staff resources and service closures over Christmas. The full extent of the impact upon all patients that meet 31 and 62 day criteria will be known in late January.

Management Comment

Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

CCDHB missed the Ministry of Health target for urgent colonoscopies with a performance of 87% (target 90%). This was an improvement on the 77% achieved in November 21. For diagnostic waits, we achieved 51% (target 70%) in November, which was an improvement on the November performance of 49%.

We met the Ministry of Health target for surveillance achieving 74% (target 70%). This is an improvement from the November performance of 69%.

What is driving performance?

The improvement in performance over the last 2 months is a result of a number of factors which have led to an increase in the number of patients receiving treatment. This includes the continued impact of outsourcing and the slight improvement in RN staffing which had resulted in fewer lists being cancelled.

Management Comment

While we failed to achieve 2 of the 3 MOH targets, the trajectory is positive and the December figures are encouraging, despite a number of sessions being cancelled because of the public holidays.

While we remain vulnerable to cancelled sessions because of the difficulties we are encountering with RN recruitment, we have had approval to outsource an additional 300 cases to the end of June 22.

Figure Seven: Colonoscopy – Wait Time Indicator

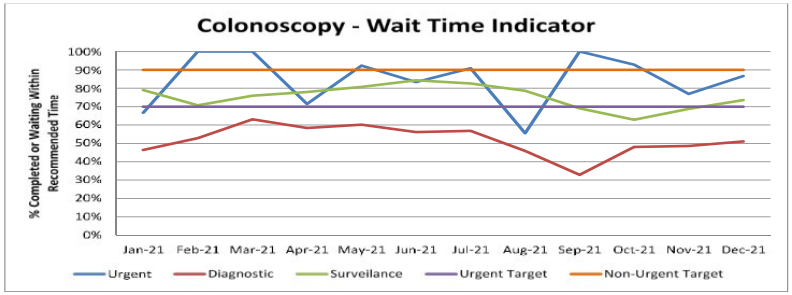
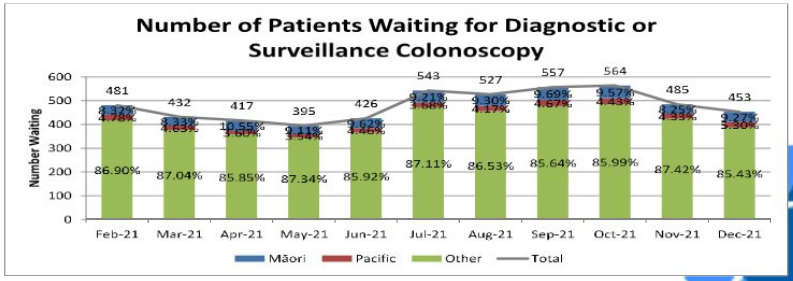


Figure Eight: Number of Patients Waiting for Diagnostic or Surveillance Colonoscopy



Maternity and Neonatal Intensive Care services

Maternity

What is the issue?

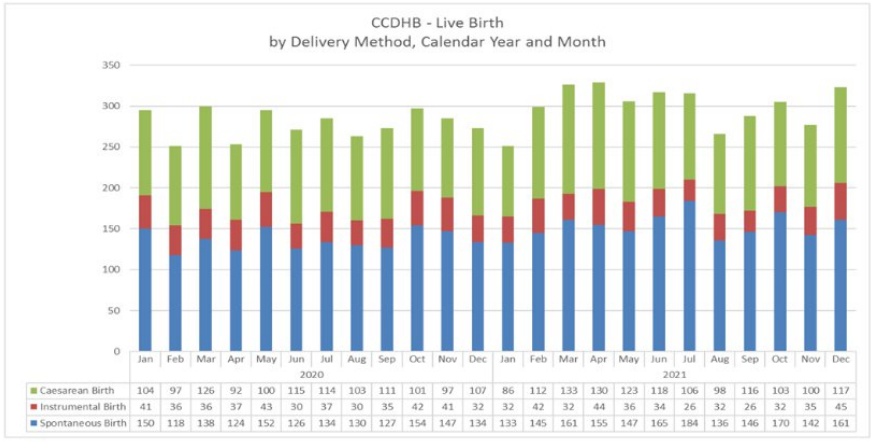
- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal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

WHS Management Comment

- 320 births across all units for December. Bed utilisation for WRH Birthing Suite and WRH postnatal and antenatal ward remains high (127%) for December. 50 postnatal women were transferred from WRH to birthing units in Kenepuru and Paraparaumu.

- The vacancy rate for 4NM and WRH Birthing Suite continues to trend up 39% for December, with 4 more resignations over xmas/new year this rate will continue to rise over the next few weeks. With high CMT volumes over December and January, the service continues to be anxious about these volumes and is currently trying to work through how to best manage this expected demand.

- The service is working with HVDHB and a recruitment agency to support the appointment of overseas and local midwives. An advertising campaign has been finalised and agreed. The service has had a small interest in Australian new graduate midwives wishing to begin their practice here.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2020												2021											
Caesarean Birth	104	97	126	92	100	115	114	103	111	101	97	107	86	112	133	130	123	118	106	98	116	103	100	117
Instrumental Birth	41	36	36	37	43	30	37	30	35	42	41	32	32	42	32	44	36	34	26	32	26	32	35	45
Spontaneous Birth	150	118	138	124	152	126	134	130	127	154	147	134	133	145	161	155	147	165	184	136	146	170	142	161

Neonatal Intensive Care Unit

What is the measure?

To provide:

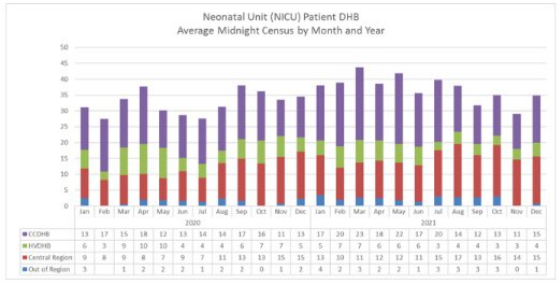
- A culturally and clinically safe 24/7 acute admitting service for infants from 23 weeks' gestation. Care is provided primarily for infants who are premature; those that require surgical intervention; perinatal intervention and support; and infants with congenital or metabolic abnormalities. These infants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

What is the issue?

- Over occupancy has been the issue in NICU for over 12 months.
- In November NICU saw a decrease in occupancy in occupancy to an average of 28 down from 32 the previous month.
- Acuity however has remained high over November with significant care hour's negative variance fro most of the month.

How are we performing?

- CCDM RN staffing has been is slow to recruit into. Four potential RNs not employed due to difficulty finding accommodation.
- NICU is safely managing the physical wellbeing of infants and families (with the above impacts).



Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- There is ongoing significant cost due to the COVID-19 response into the 2021/22 fiscal year. The DHB is being reimbursed for the large portion of the DHB COVID-19 response costs in 2021/22. The Ministry have asked DHBs to separately report unfunded net COVID-19 impacts for 2021/22, these being considered outside the DHB's responsible deficit and budgets.
- Excluding the COVID-19 net expenses the DHB's result for the six months month's to 31 December 2021 is $15.3m deficit, versus a budget deficit of $18m.
- Additional net COVID-19 related expenditure above funding, year to date is $15.3m.
- For the six month's to 31 December 2021 the overall DHB year to date result, including COVID-19 costs is $30.1m deficit.
- The DHB has submitted an Annual baseline budget of $7m surplus, excluding the $60m Donation for the Children's Hospital the underlying deficit is ($53m).
- Capital Expenditure including equity funded capital projects was $44.9m year to date.
- The DHB has a positive cash Balance at month-end of $57.8 million offset by positive "Special Funds" of $14.2 million (net $72.1m). It should be noted that there are certain financial impacts of the COVID-19 response that remains unfunded by the Ministry at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than budget due to additional revenue and delayed capital expenditure. The deficit support of $46.5m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

COVID-19 Revenue and costs

Full Last Year		Capital & Coast DHB Operating Results - $000s	Part Year to Date		
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	YTD December 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	COVID-19 change from MOH Unfunded
	(31,026)	Devolved MoH Revenue		(47,351)	
		Non-Devolved MoH Revenue			
693		Other Revenue	0		197
		IDF Inflow			4,343
		Inter DHB Provider Revenue			
693	**(31,026)**	**Total Revenue**	**0**	**(47,351)**	**4,540**
		Personnel			
(6,336)		Medical	(63)		(2,252)
(4,360)		Nursing	(1,747)		(4,872)
		Allied Health	(315)		(1,417)
		Support	(20)		(293)
		Management & Administration	(2,203)		(1,893)
(10,696)	**0**	**Total Employee Cost**	**(4,348)**	**0**	**(10,727)**
		Outsourced Personnel			
(88)		Medical	(165)		
		Nursing	0		
		Allied Health	0		
		Support	(2)		
		Management & Administration	(257)		
(88)	**0**	**Total Outsourced Personnel Cost**	**(424)**	**0**	**0**
(5,088)		Treatment related costs - Clinical Supp	(603)		
(564)		Treatment related costs - Outsourced	(323)		
(2,028)		Non Treatment Related Costs	(4,629)		
		IDF Outflow			
	(15,828)	Other External Provider Costs (SIP)		(37,024)	
		Interest Depreciation & Capital Charge			
(7,680)	**(15,828)**	**Total Other Expenditure**	**(5,555)**	**(37,024)**	**0**
(18,464)	**(15,828)**	**Total Expenditure**	**(10,327)**	**(37,024)**	**(10,727)**
19,157	**(15,198)**	**Net result**	**10,327**	**(10,328)**	**15,267**

- The year to date financial position includes $58.1m of additional costs in relation to COVID-19.
- Revenue of $47.3m has been received to fund additional costs for community providers however this has not been sufficient to over all the costs.
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – December 2021

Capital & Coast DHB Operating Results - $000s	Year to Date									Annual		
				Variance		Adjustments			Variance			
YTD December 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend MOH Funded	COVID-19 change from Trend MOH Non Funded	Actuals exc COVID	Actuals exc COVID vs Budget	Annual Budget	Last year	Last year exc COVID
Devolved MoH Revenue	558,928	488,808	476,590	70,120	82,338	47,351	0	511,577	22,769	977,615	962,513	962,513
Non-Devolved MoH Revenue	23,249	21,643	22,186	1,606	1,063		0	23,249	1,606	48,353	42,517	42,517
Other Revenue	15,617	18,898	32,975	(3,280)	(17,357)	0	(197)	15,815	(3,083)	97,051	52,921	52,921
IDF Inflow	151,679	156,147	128,868	(4,468)	22,811		(4,343)	156,021	(125)	312,294	258,694	258,694
Inter DHB Provider Revenue	9,370	9,163	17,772	207	(8,403)		0	9,370	207	18,577	42,120	42,120
Total Revenue	**758,843**	**694,658**	**678,391**	**64,185**	**80,452**	**47,351**	**(4,540)**	**716,032**	**21,374**	**1,453,890**	**1,358,764**	**1,358,764**
Personnel												
Medical	101,624	98,306	93,820	(3,318)	(7,804)	63	2,252	99,310	(1,004)	198,568	191,666	189,617
Nursing	151,076	128,645	125,254	(22,431)	(25,822)	1,747	4,872	144,457	(15,812)	264,365	256,973	247,828
Allied Health	39,488	40,217	37,524	729	(1,964)	315	1,417	37,756	2,461	81,076	74,244	72,874
Support	6,039	5,845	5,261	(194)	(778)	20	293	5,725	119	11,784	10,747	10,779
Management & Administration	48,715	46,957	40,731	(1,758)	(7,983)	2,203	1,893	44,618	2,338	95,059	83,274	83,442
Total Employee Cost	**346,941**	**319,969**	**302,590**	**(26,972)**	**(44,352)**	**4,348**	**10,727**	**331,866**	**(11,897)**	**650,852**	**616,904**	**604,539**
Outsourced Personnel												
Medical	5,332	3,167	4,494	(2,164)	(837)	165	0	5,167	(1,999)	6,302	8,145	8,145
Nursing	381	604	300	223	(81)	0		381	223	1,206	897	897
Allied Health	958	854	693	(104)	(265)	0		958	(104)	1,702	1,704	1,704
Support	161	131	216	(30)	54	2		159	(28)	262	428	428
Management & Administration	2,580	1,383	2,290	(1,196)	(289)	257		2,323	(939)	3,005	4,491	4,491
Total Outsourced Personnel Cost	**9,412**	**6,140**	**7,993**	**(3,272)**	**(1,418)**	**424**	**0**	**8,988**	**(2,848)**	**12,477**	**15,664**	**15,664**
Treatment related costs - Clinical Supp	69,106	70,168	67,671	1,062	(1,435)	603		68,503	1,665	138,237	135,244	135,244
Treatment related costs - Outsourced	15,577	15,475	12,785	(103)	(2,793)	323		15,254	220	30,750	26,761	26,761
Non Treatment Related Costs	55,877	49,232	54,404	(6,645)	(1,473)	4,629	0	51,248	(2,016)	104,120	107,768	107,768
IDF Outflow	55,588	55,150	54,178	(439)	(1,411)			55,588	(439)	110,300	108,768	108,768
Other External Provider Costs (SIP)	207,808	169,828	173,446	(37,979)	(34,362)	37,024		170,784	(956)	339,657	338,357	338,357
Interest Depreciation & Capital Charge	28,594	26,691	28,026	(1,904)	(568)			28,594	(1,904)	60,468	55,798	55,798
Total Other Expenditure	**432,550**	**386,544**	**390,509**	**(46,007)**	**(42,042)**	**42,579**	**0**	**389,971**	**(3,428)**	**783,532**	**772,695**	**772,695**
Total Expenditure	**788,903**	**712,653**	**701,091**	**(76,251)**	**(87,812)**	**47,351**	**10,727**	**730,825**	**(18,173)**	**1,446,861**	**1,405,263**	**1,392,898**
Net result	**(30,060)**	**(17,995)**	**(22,700)**	**(12,066)**	**(7,360)**	**0**	**(15,267)**	**(14,793)**	**3,201**	**7,028**	**(46,499)**	**(34,135)**
Funder	(12,476)	(11,985)	(3,977)	(491)	(8,499)					(9,420)	8,007	
Governance	216	(7)	331	223	(115)					(7)	649	
Provider	(17,800)	(6,003)	(19,054)	(11,797)	1,255					16,455	(55,155)	
Net result	**(30,060)**	**(17,995)**	**(22,700)**	**(12,066)**	**(7,360)**					**7,028**	**(46,499)**	

Note
Adjustments are made for COVID-19

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($30.1m) compared to a budget deficit of ($18m).
- Included within this result is recognition of the adjustment to an estimated net impact of COVID-19 of ($15.3m).
- Excluding the COVID-19 above this brings the year to date deficit to ($14.8m) being $3.2m favourable to budget.
- Revenue is favourable by $16.8m YTD, after excluding COVID-19 revenue, this is on budget.
- Personnel costs including outsourced is ($30m) unfavourable YTD, excluding COVID-19 related costs of ($15.5m) and Pay Equity ($17.0m) Personnel is Breakeven YTD. Currently the DHB has a large number of vacancies which has been offset by ($17.1m) of vacancy savings targets.
- Treatment related clinical supplies is $1.2m favourable including favourable variances for Implants/Prostheses & Treatment disposables as volumes were down through the COVID-19 ($463k)
- Outsourced clinical services is unfavourable YTD by ($220k); unfavourable due to radiology services including CT scans and MRI
- Non treatment related costs ($6.6m) YTD unfavourable, however after excluding COVID-19 related costs of ($4.6m), the unfavourable variance was due to additional depreciation on 30 June building revaluation, seismic assessments costs, catch-up of deferred maintenance & Capital Charge
- The funder arm is favourable YTD due to additional revenue from spend requirements for the community COVID-19 response which is fully funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $64.2m favourable YTD
- The variance is due to revenue for special MHAIDS additional funding $2m, Pay Equity funding $17m The funder is also favourable by $65.7m revenue and the provider arm is favourable by $25.9m, however with offsetting community cost and COVID-19 related costs'

Personnel (including outsourced)

- Medical Personnel is ($1.6m) unfavourable for the month, ($5.6m) YTD. The unfavourable position for the month is driven by a ($333k) budget adjustment with MOH, leave liability movement and vacancies across other services, most notably MHAIDS offset by centrally held vacancy savings targets and increased outsourcing in SWC & MHAIDS
- Nursing Personnel is ($14.3m) unfavourable to budget for the month. ($22.2m) YTD is driven by a ($333k) budget adjustment with MOH, Pay Equity $17m. Operationally nursing across the hospital is on budget, however the variance is a result of COVID-19 related costs and front loading of vacancy savings.
- Allied Personnel labour is ($115k) unfavourable to budget for the month driven by a ($167k) budget adjustment with MOH, $600k YTD as a result of vacancies.
- Support Personnel labour is ($110k) unfavourable to budget for the month, ($224k) YTD
- Management/Admin Personnel is unfavourable in the month by ($849k), ($2.6m) YTD Operationally across the hospital Management/Admin is favourable to budget, however the variance is a result of front loading of vacancy savings and increased outsourcing as a result of Vacancies and COVID

Section 4

Financial Position

Cash Management – 31 December 2021

Month : Dec 2021					Capital & Coast DHB Statement of cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Dec 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating activities					
237,823	116,074	205,310	121,749	32,513	**Receipts**	855,510	696,445	767,764	159,065	87,746
					Payments					
89,966	54,654	60,126	(35,312)	(29,840)	Payments to employees	335,442	327,926	296,928	(7,516)	(38,514)
73,823	60,941	20,587	(12,881)	(53,235)	Payments to suppliers	437,261	366,646	382,116	(70,616)	(55,145)
-	-	-	-	-	Capital charge paid	-	11,102	12,110	11,102	12,110
(22,688)	-	20,060	22,688	42,748	GST (net)	(21,439)	-	(17,179)	21,439	4,259
141,101	115,595	100,774	(25,506)	(40,328)	**Total payments**	751,265	705,673	673,975	(45,591)	(77,290)
96,722	479	104,537	96,244	(7,815)	**Net cash flow from operating activities**	104,245	(9,229)	93,789	113,474	10,456
					Investing activities					
4	16	34	12	30	**Receipts**	49	94	150	45	102
					Payments					
7,925	11,255	6,017	3,330	(1,908)	Purchase of fixed assets	44,925	67,528	29,604	22,603	(15,321)
7,925	11,255	6,017	3,330	(1,908)	**Total payments**	44,925	67,528	29,604	22,603	(15,321)
(7,921)	(11,239)	(5,984)	3,342	(1,878)	**Net cash flow from investing activities**	(44,876)	(67,434)	(29,454)	22,648	(15,220)
					Financing activities					
-	-	-	-	-	Equity - capital	-	39,815	-	(39,815)	-
-	7,730	-	(7,730)	-	Other equity movement	28,229	46,380	2,971	(18,151)	25,257
-	-	-	-	-	Other	-	-	-	-	-
-	7,730	-	(7,730)	-	**Receipts**	28,229	86,195	2,971	(57,966)	25,257
					Payments					
-	-	8	-	8	Interest payments	-	-	8	-	8
-	-	8	-	8	**Total payments**	-	-	8	-	8
-	7,730	(8)	(7,730)	8	**Net cash flow from financing activities**	28,229	86,195	2,963	(57,966)	25,266
88,801	(3,030)	98,545	91,855	(9,684)	**Net inflow/(outflow) of CCDHB funds**	87,598	9,532	67,299	78,156	20,502
(16,655)	(11,572)	(13,010)	5,082	3,645	**Opening cash**	(15,452)	(24,134)	18,236	(8,682)	33,688
237,827	123,820	205,344	114,031	32,543	Net inflow funds	883,788	782,733	770,885	101,144	113,105
149,026	126,850	106,799	(22,176)	(42,227)	Net (outflow) funds	796,190	773,201	703,587	(22,988)	(92,603)
88,801	(3,030)	98,545	91,855	(9,684)	**Net inflow/(outflow) of CCDHB funds**	87,598	9,532	67,299	78,156	20,502
72,146	(14,603)	85,535	86,749	(13,389)	**Closing cash**	72,146	(14,603)	85,535	86,749	(13,389)

Capital and Coast DHB
Reconciliation of net cash flow to operating balance

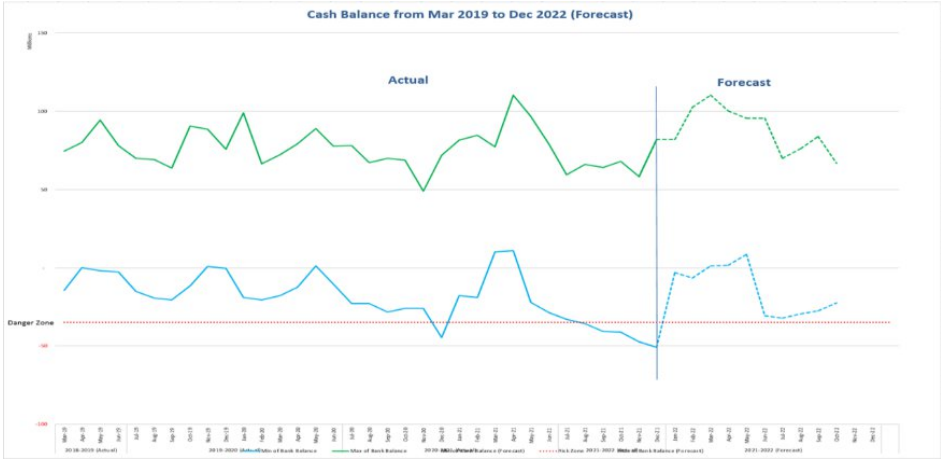
	YTD Dec 2021 Actual $000	Budget $000	Variance $000
Net cashflow from operating	104,245	(9,229)	113,474
Non operating financial asset items	17	-	17
Non operating non financial asset items	(1,743)	-	(1,743)
Non cash PPE movements			
Depreciation & Impairment on PPE	(18,019)	(21,348)	3,328
Gain/Loss on sale of PPE	-	-	0
Non cash PPE movements	(18,019)	(21,348)	3,328
Working capital movement			
Inventory	1,127	-	1,127
Receipts and prepayments	21,192	-	21,192
Payables and accruals	(136,881)	1,091	(137,971)
Total working capital movement	**(114,561)**	**1,091**	**(115,652)**
Operating balance	**(30,061)**	**(29,486)**	(575)

1. The net cash flow from operating activities is favourable to budget due to COVID-19 revenue for the month. This is slightly higher than expected payments to suppliers.
2. The net cash flow from investment activities is less than budget due to lower spend on capital activity then budgeted.

Debt Management / Cash Forecast – 31 December 2021

Accounts Receivable
31-Dec-21

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	34,708	29,870	9	2621	506	1702	25,113
Other DHB's	3,745	1,611	228	152	137	1617	3,283
Kenepuru A&M	204	33	22	20	129		202
ACC	98	10	-30	16	32	70	35
Misc Other	3,305	922	129	496	- 3	1761	4,178
Total Debtors	42,060	32,446	358	3,305	801	5,150	32,811
less : Provision for Doubtful Debts	(4,183)						(4,157)
Net Debtors	37,877						28,654



Debt management

1. The MOH overdue is for invoices on hold due to contracts not yet signed by MOH, reports not yet provided by CCDHB or disputed invoices.

2. The single largest debtor in 'Other DHB's' outstanding is HVDHB with $1.44m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $112k

4. 'Misc Other' debtors includes non resident debt of approx. $1.89m. About 86.74% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash management

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

Balance Sheet / Cashflow – as at 31 December 2021

Nov-21	Month : Dec 2021					Capital & Coast DHB Statement of financial position
				Variance		
Actual	Actual	Budget	At Dec 2020	Actual vs Budget	Actual vs Dec 2020	YTD Dec 2021
13	13	31	31	(17)	(17)	Bank
2	57,977	824	72,616	57,153	(14,639)	Bank NZHP
14,025	14,156	13,561	12,889	595	1,267	Trust funds
89,755	77,289	63,930	62,299	13,358	14,990	Accounts receivable
10,246	10,521	9,466	9,491	1,055	1,030	Inventory/stock
13,380	12,855	7,902	10,191	4,952	2,664	Prepayments
127,421	**172,811**	**95,714**	**167,516**	**77,097**	**5,295**	**Total current assets**
493,577	490,385	555,196	512,500	(64,811)	(22,115)	Fixed assets
16,058	5,875	5,875	14,796	-	(8,920)	Work in progress - CRISP
124,809	142,740	103,005	76,940	39,735	65,800	Work in progress
634,444	**639,000**	**664,076**	**604,236**	**(25,076)**	**34,765**	**Total fixed assets**
1,150	1,150	1,150	1,306	-	(156)	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,306**	**-**	**(156)**	**Total investments**
763,015	**812,961**	**760,941**	**773,058**	**52,021**	**39,904**	**Total assets**
30,694	-	29,019	-	29,019	-	Bank overdraft HBL
94,403	200,491	72,575	174,555	(127,916)	(25,936)	Accounts payable, accruals and provisions
7,540	9,048	11,102	9,483	2,054	435	Capital charge payable
593	593	593	593	-	-	Insurance liability
34,168	12,326	11,441	119,322	(885)	106,996	Current employee provisions
177,308	182,318	180,467	65,516	(1,852)	(116,802)	Accrued employee leave
21,474	18,485	22,515	7,242	4,030	(11,244)	Accrued employee salary & wages
366,180	**423,262**	**327,713**	**376,711**	**(95,549)**	**(46,551)**	**Total current liabilities**
110	112	92	104	(20)	(8)	Restricted special funds
605	605	605	605	-	-	Insurance liability
6,222	6,222	6,564	6,564	343	343	Long-term employee provisions
6,937	**6,939**	**7,262**	**7,274**	**323**	**335**	**Total non-current liabilities**
373,117	**430,200**	**334,974**	**383,985**	**(95,226)**	**(46,216)**	**Total liabilities**
389,898	**382,760**	**425,966**	**389,073**	**(43,206)**	**(6,312)**	**Net assets**
866,187	865,597	908,427	817,122	(42,830)	48,475	Crown equity
-	-	-	-	-	-	Capital repaid
(590)	(929)	7,730	-	(8,659)	(929)	Capital injection
130,659	130,659	130,659	130,659	-	-	Reserves
(606,358)	(612,567)	(620,850)	(558,709)	8,283	(53,858)	Retained earnings
389,898	**382,760**	**425,966**	**389,073**	**(43,206)**	**(6,312)**	**Total equity**

Balance Sheet

1. Accounts payable, accruals and provisions are higher than the budget mainly due to January funding received in advance (approx. $90.5m) is grouped under this.
2. Bank NZHP is favourable to budget due to January funding was received in advance.
3. Fixed assets is under budget while WIP is over budget caused by the backlog of capitalisation to be finished in the coming month
4. Unfavourable variance in Crown entity is because the deficit support budgeted in July 2021 has yet to receive.

Cash flow

1. Net cash flow from operating activities is favourable to budget due to January funding was received in advance.
2. Net cash flow from investment activities is less than budget due to lower spend on capital activity than budgeted.

Financial ratios

1. Current ratio – this ratio determines the DHB's ability to pay back its short term liabilities. DHB's current ratio is 0.41 (November - 0.35).
2. Debt-to-equity ratio - this ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 1.12 (November - 0.96).

Note

The statement of financial position is subject to change, due to the 30 June 2021 revaluation of land and buildings which is yet to be recorded in CCDHB's financial statements. This is awaiting final audit sign off. Changes will be reflected in the statement of comprehensive revenue and expense for 30 June 2021.

Capital Expenditure Summary on Prior Year Approved December 2021

						Forecast						
Prior Year Projects	Approved Budget Value	Spend to 30 Jun 2021	Carry Forward to FY2021/22	Spend to Dec 2021	To Spend	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Carry Forward
Buildings	33,242,453	16,721,683	16,520,770	3,333,090	13,245,567	1,777,947	1,820,689	1,835,251	1,425,219	1,321,718	1,155,703	2,519,000
Clinical Equipment	8,797,244	3,557,763	5,239,481	3,905,113	1,367,035	136,020	245,827	119,923	92,608	86,860	51,015	-
ICT	4,788,297	2,540,611	2,247,686	1,221,912	1,025,773	161,600	191,202	197,266	175,093	153,253	145,490	-
Other Equipment	3,448,310	681,043	2,767,268	701,997	2,085,637	181,844	217,956	249,553	320,392	269,836	7,750	937,346
Grand Total	50,276,303	23,501,099	26,775,204	9,162,112	17,724,012	2,257,410	2,475,674	2,401,993	2,013,311	1,831,667	1,359,959	3,456,346

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

- $26.8m in approved but incomplete projects was carried forward from the previous year to FY2020/21
- Total cash spend for the half year to December 2021 was $9.2m
- A further $12.3m is forecast to be spent by 30 June 2022, leaving an estimated $3.5m to be carried forward to FY2022/23
- The cash spending forecast will be reviewed monthly and adjusted to reflect changes from both internal and external factors (workforce, logistics, supply chain)

Capital Expenditure Summary 2021/22 December 2021

					Forecast					
Current Year Projects	Approved Budget Value	Spend to Dec 2021	To Spend	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Carry Forward
Buildings	9,943,936	2,506,804	7,437,132	609,212	623,531	1,254,608	1,310,504	1,307,677	1,008,580	1,322,921
Clinical Equipment	9,604,851	5,117,185	4,487,665	160,664	403,468	662,571	1,248,848	994,036	579,247	367,993
ICT	9,532,460	2,194,524	7,337,936	149,517	160,537	548,741	768,905	704,543	493,618	4,512,082
Other Equipment	777,844	379,564	398,280	64,171	77,964	101,482	157,245	100,357	22,825	-
Grand Total	29,859,091	10,198,078	19,661,014	983,564	1,265,499	2,567,402	3,485,501	3,106,613	2,104,269	6,202,997

Key highlights to FY2021/22 Capital plan:

- $68.7m was approved by the Board in the FY2021/22 Capital Plan, which includes $25m in equity funding from MoH, which has been approved
- The development of business cases from the 2021/22 Capital Plan are at various stages with $30m having been approved to December 2021
- Total cash spend for the half year to December 2021 was $10.2m
- Business units have indicated a further $13.5m will be spent by 30 June 2022, and $6.2m carried forward to next financial year
- The cash spending forecast will be reviewed on a monthly basis and adjusted to reflect our capacity to submit business cases for approval, procure and install projects

Board Information – Public

16 February 2022

2DHB COVID Update

Action Required

The Boards note:

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

Strategic Alignment	We are focussed on achieving equity, clinical excellence, and workforce resilience to ensure the needs of our populations are met during this next phase of COVID resilience across New Zealand. Our priorities give effect to the Government's plans for COVID preparedness for the people of our two DHBs.
Endorsed by	Fionnagh Dougan, Chief Executive, CCDHB and HVDHB
Purpose	This paper updates the Boards on progress with our 2DHB's preparedness for the next phase of the COVID pandemic in Aotearoa.

Executive Summary

The introduction of the government's Covid Protection Framework, and COVID Omicron as the dominant variant in the community, is the focus of this stage of our 2DHB preparation and response management. As we reported in December nationally, regionally and locally the health sector has been planning for the management of sustained COVID outbreaks in our communities. At the end of January the Ministry of Health announced that the omicron variant has become the dominant variant in the community and at the border. We have been preparing to support our health system to manage a sustained omicron community outbreak which will have increased rates of hospitalisation (due to the volume of cases in the community) and increased pressures on our community providers (to assist people with COVID to isolate at home).

In mid-January the government communicated the three phases of managing an omicron response and we have been working at a local, regional and national level to ensure that we are prepared to implement our response in each of these phases. Vaccination remains critical to reduce the impact of community outbreak and we are focusing on ensuring we have high levels of booster and child (5-11yrs) immunisation. Other public health measures such as mask wearing and social distancing remain important but the focus of public messaging has shifted to everyone being prepared to self-isolate at home. For the wider health system ensuring our care in the community response is well coordinated and supported will be key to our success in this next phase.

Over the past two years we have continuously reviewed and updated our COVID readiness plans, that process has continued as we review our readiness to deal with omicron. We have taken learnings from national, regional and overseas to ensure our preparedness. We have implemented a whole ELT working group to have oversight of this next phase of the readiness and there is a significant body of work underway to ensure we are well prepared with strong clinical governance and executive oversight.

Consistent with our wider work programme our focus will strongly remain on delivering equitable health outcomes and intensifying support for Māori, Pacific people and those living with disability, mental illness and addiction.

Our priorities remain to:

- *Continue our successful vaccination programme to achieve and maintain equitable high levels of COVID vaccination.*
- *Ensure we have capacity in our public health systems to surge with demand and maintain a skilled public health and contact tracing workforce.*
- *Ensure we have capacity in our community health system to surge with demand for COVID testing, and deliver COVID Care in the Community including delivering manaaki and integrating the welfare response.*
- *Ensure capacity and capability in our hospital and specialist services to respond to any significant change if COVID cases requiring specialist care.*
- *Ensure capacity and capability in our mental health and addiction services to care for COVID cases in appropriate models of care.*
- *Develop sufficient capacity across all of these services to ensure health service delivery is maintained where at all possible.*
- *Ensure effective working relationships and connections to the development of the Regional Hub and across the wider social and emergency response sector.*

We are working closely with the Ministry to ensure that there is sufficient funding to meet the costs associated with implementing the COVID Care in the Community programme, our DHB provider arms to have the resources and facilities that they need to provide COVID related care, and sustained funding for our PHOS and NGOs to deliver the community testing, the extended vaccination programme, COVID Care in the Community and the manaakitanga programme.

Strategic Considerations

Service	Maintaining service delivery across hospital, primary and community services will inform this work and we will ensure a strong focus on looking after the health needs of our populations during any sustained COVID resurgence.
People	The Pro-Equity priority is woven through all work programmes and will contribute to our goal of achieving health equity and optimal health for Māori, Pacific peoples, and disabled people by 2030.
Financial	While we have asked for additional funding as part of the national process. We will prioritise this work and make funding and investment decisions that help us effectively prepare. We continue to ensure we have resources (including executive time) targeted to this work.
Governance	A governance structure to support implementation and alignment of this programme is being put in place.

Engagement/Consultation

Patient/Family	ELT has agreed that a dedicated communications and engagement approach will be critical to the success of this work and dedicated resources are in place to ensure regular and frequent updates to our staff, stakeholders, and communities.
Clinician/Staff	
Community	

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
N/A	COVID preparedness activity dilutes our focus from other delivery.	Fionnagh Dougan	Clear communication and prioritisation will help us focus on the priority areas while meeting the needs of our populations.	Medium Risk	Low Risk
	COVID events overwhelm our health service delivery systems	Fionnagh Dougan	Ensuring the creation of sustainable capacity that can surge, whilst maintaining service delivery.	High Risk	Medium Risk

Preparedness work

Our planning is now focused on responding to the change in national direction; moving from an elimination to a resilience strategy that reflects the government's three-phased approach to managing the spread of omicron in our community.

Modelling
Modelling continues to play an important role in our planning. We work with the national models for the COVID-19 Omicron variant and use inputs from Te Pūnaha Matatini and the Ministry of Health to inform our model localised to the 2DHB context. Our 2DHB model has been shared with other DHBs.

Our modelling is used to understand the potential demand under different scenarios. Our model uses the latest data on the severity and transmissibility of the COVID Omicron variant. As the disease evolves, and our understanding grows, our model and projections will change. With the guidance of a Data Governance Group, SPP analytics is layering in information such as vaccination rates (including boosters and paediatric vaccines), weightings for different levels of susceptibility and risk (e.g. social interaction and hospitalisation), to refine and inform the model outputs. Outputs for this information are provided by ethnicity and locality.

At a macro level the model estimates numbers of potentially infected people and gives an indication of the numbers that may need care in the community, hospital and intensive care. The model works to a moderate set of assumptions and gives us an indication of what the worst and best case scenarios might be.

Models are a useful planning tool but they rely on assumptions across a range of variables that play into the different scenarios. For example; the effectiveness of public health measures, the growing body of knowledge for treatment and management of COVID-19 patients and vaccination levels. Models are therefore continuously improving point in time assessments which we reference for our planning assumptions.

The current 2DHB modelling for the COVID Omicron projects that, under our two dose and booster vaccination coverage (as at late January), our modelling for the COVID-19 Omicron variant projects up to 65,000 cases across our 2DHB region over a three-month period.

This is broken down by

- Between 19,300 and 25,700 will be actively managed by the community. The majority of cases will self-manage at home.
- 470 will require hospital-level care including 14 in ICU across our Hospital Network
- Peak hospital occupancy for people admitted for COVID-19 Omicron is projected to be 45 including 2 in ICU.

Mask use and booster vaccinations matter. If everyone who is eligible receives a booster vaccination, our modelling for the COVID Omicron variant projects up to 59,800 cases across our 2DHB region over a three-month period. This is broken down by:

- Between 17,800 and 23,800 will be actively managed by the community. The majority of cases will self-manage at home.
- 300 would require hospital-level care including 10 in ICU
- Peak hospital occupancy for people admitted for COVID-19 Omicron is projected to be 20 including 1 in ICU.

Due to the nature of the COVID Omicron variant, our modelling projects the need for hospital and ICU care will be low in relation to overall cases in line with the overseas experience and evidence.

These outputs from the model are being used to inform planning for both the primary & community and hospital responses, which are described in more detail below. Our planning and responses will continue to adapt to new information, particularly as outputs from the model are refined and improved.

Hospital & Specialist Resilience

Planning for the increase in COVID cases requiring specialist care is the focus of our hospital escalation plans. There are four critical parts:

- Development of pathways that interface with community services for specialist assessment pre hospital. Planning the detailed model is ongoing; we are drawing heavily from the experiences in Auckland that recognise the need for specialist advice and support for community based patients with complex needs and comorbidities. This interface work is led by our CMO and involves clinicians from hospital and community across out six localities.

- Developing greater inpatient capacity both in the short and medium term. There is good progress with this planning and readiness work. This relates to both the management of patients in hospital but also how we manage the flow of patients in and out of hospital and facility changes needed to support this. We continue to work on our acute flow action plan, ensuring we have appropriate inpatient facilities and plans and dedicated high dependency care.

- Ensuring the delivery of planned care, including elective surgery, cancer services and cardiac surgery, as well as other planned care as much as is practicable. Our work in this area includes working closely with the private sector, and making better use of telemedicine and remote consultations.

- Addressing ongoing workforce issues is a key challenge. We continue with our nursing recruitment and retention work, return to work programmes, improved systems and processes that support recruitment and retention of the workforce. Our international recruitment efforts are ongoing, as is our work to look at models of care that support our nursing workforce with additional ancillary roles. Workforce capacity and fatigue are national issues and we are contributing to the national discussions on how we can effectively address key workforce

issues. One key aspect of our omicron workforce planning has been reviewing how we will manage patient care when we have higher levels of staff absenteeism with staff contacting COVID and/or being impacted by close contact isolation requirements. This is an area where there has been significant national policy development to ensure we mitigate this issue at each phase of the omicron response.

Community and Public Health Response

Planning and implementing our community response includes ensuing our Public Health, primary care and community services are able to respond to the new COVID care in the community model, whilst sustaining their other services.

The COVID Care in the Community model includes a strong manaakitanga component. Manaakitanga is the support for individuals and families who are managing at home, when COVID positive. Welfare requirements will be coordinated by the manaakitanga response and resourced by MSD after the first 48 hours. To stand up our the Care in the Community model we have work streams focusing on; manaakitanga, the clinical care continuum including escalation to hospital level care and ensuring there are strong coordination functions across our localities (Hub and Spoke model).

We continue to work with our Iwi and our Māori and Pacific providers, Disability support community, PHOs, NGOs, and other partners to increase and enhance access to services in the community. In doing so, we aim to enable people to remain well at home, or to access the services and support they need close to home, and not reach the point where they become so unwell that they require hospital level care. This not only improves health outcomes for our communities, it also reduces the rate of admissions to our hospitals. We have previously shared the high level Care in the Community model in diagram one below.

Our 2DHBs have established a Hub and Spoke model for delivery of Care in the Community, this involves a central coordinating hub and six localities (spokes) working together. The operating model was agreed across our community providers prior to Christmas, they are critical to running of the spokes. There has been a positive and constructive engagement with all our providers and currently we have four of our six locality spokes delivering Care in the Community. The 2DHB coordination hub for our 2DHB's is established. We are continuing to recruit to our full complement but have a core staff in place. MSD and other agencies will assign staff to the central hub to ensure effective coordination.

Diagram one: The Nationwide Community Care Model – (Note: this model does not include the role of tertiary hospitals. There is a separate work stream to ensure effective coordination across our tertiary providers)

Community care - welfare and wellbeing
Supporting COVID-19-positive whānau to be cared for at home means providing support with other important things in life, like staying connected, having your daily needs met, and feeling safe.
- Income support
- Home and community support services including options for care delivered in the home
- Provisions
- Whānau Ora support
- Child wellbeing
- Mental health
- Disability
- Aged care
- Family and sexual violence support
- Continuity of care and communications

Public Health
As we care for whānau at home, we care about protecting everyone in the community. This means ensuring that having COVID-19-positive people at home does not increase spread in the community. Our public health response is critical in supporting this approach, from identifying people and tracking the path of infection, to preventing further spread.
- Quarantine/isolation (MIQF and home)
- Testing
- Contact identification
- Genome sequencing
- Vaccination
- Contact tracing
- Clearance/assessment of end of infectious period

Primary care clinical support
COVID-19 can make people very unwell, very quickly, but not everyone who is COVID-19 positive will need the same type or intensity of care. Primary and community care, in partnership with whānau, needs to be enabled to drive approaches to care at home, with effective pathways to hospital care when needed.
- Clinical pathways for COVID-19, and for safely managing other illness in the home
- Resources/supplies - equipment, medicines, options for hands-on care
- Continuation of care – co-morbidities, treatment plans
- Triage and escalation pathways - ambulance and home visits
- Continuity of care throughout the experience – lead professional, health information, long-COVID

Secondary care
When someone with COVID-19 requires transfer to hospital, for a COVID-19-related need or not, the transfer needs to be coordinated across the system.
- Avoid unnecessary hospital presentations
- Ensure people needing hospital care get there safely and in good time
- Clinical pathways in hospital
- Safe and supported discharge, with appropriate communications

Priorities in this phase

Our priorities

As part of the nationally-led COVID resilience planning we continue to work across the priorities previously reported to the Boards. They include:

- Maintaining the momentum for pro-equity vaccination and ensuring sufficient capacity for testing for our communities (including preparing for the new approach to the use of Rapid Antigen Testing)
- Ensuring our 2DHB work force and community providers are supported to be fully vaccinated (and boosted) as per the Mandatory Vaccination Health Orders
- Strengthening the work we are doing with our Māori, Pacific and Disability community providers to enable them to be remain a key part of our overall response
- Setting up and running the end-to-end 'care in the community model' to address the patient care continuum from:
    - How we assess and support those who are COVID sick at home
    - Those that are unable to isolate at home and need access to supported isolation (SIQ)
    - Triage/Assessment and support for those who require specialist review and care in community /virtual
    - Admission for those who become so unwell they need to be hospitalised
    - Discharge from hospital care back to community
- Working with our welfare partners to ensure there are appropriate measures in place to support people with COVID and their close contacts to stay safely in the community

- Managing our hospitals' ability to deal with an omicron outbreak and increasing numbers of cases requiring hospitalisation and/or intensive care
- Ensuring sustainable staffing for Regional Public Health, our COVID Response team, clinical and administrative workforces and enhanced leadership, clinical governance, training and support.
- Ensuring we have the technology available to enable a sustained response, in particular to support care in the community.
- Maintaining the clinical governance model to support the above
- Working across our region and other tertiary providers to ensure robust decision making and transfer processes whilst maximising tertiary capacity.

Our programme of work spans these priorities and is governed by a working group from ELT to ensure integration.

We continue to work at the regional and national level to seek appropriate funding and support for this work. There have been funding allocations in the past two months made to support both implementation of Care in the Community and some critical capital works which will facilitate additional beds, ICU and other facility improvements to support our COVID readiness. As our implementation activity progresses there will be further refinement of our funding needs and we continue to work with the Ministry on the implications of all of our COVID-related costs. Most of the funding is operational and workforce related. All expenditure is being closely tracked and monitored.

Managing the Implications of the Mandatory Vaccination

We updated the Boards in December how we were implementing the Mandatory Vaccination Health Order which requires:

- Health workers must have had their first dose by 11.59pm on 15 November 2021 and
- Their second dose by 11.59pm on 1 January 2022

After these dates, any new workers covered by the Order will need to have their first dose before starting work between 12 November and 31 December, or both doses from 1 January 2022.

The Government further announced, on 21 December 2021, that COVID-19 booster vaccinations would be mandated for workforces covered by the Order. Changes to the Order have now come into law at 11.59pm on 23 January 2022.

This amendment mandates that all health care workers covered under the original order are required to receive a booster meaning that, for those vaccinated on or before the 16 August 2021, a booster vaccine must be administered by 15 February 2022. On Thursday 3 February the government announced the period for booster eligibility will be pulled forward from 4 months to 3 months. We are managing the implications of this change.

The People and Culture team are working with 20 DHB for an approach for other staff who will become eligible after that date.

As at 8 February 2022 we had the following vaccination rates overall:

	First dose	Fully vaccinated *	Received booster
CCDHB	99%	99%	82%
HVDHB	99%	99%	80%

* Fully vaccinated is defined as having received two doses of a recognised vaccine or three doses if vulnerable / immune-compromised. Our Unknown staff numbers are counted as vaccinated.

Throughout this process we have provided significant employee support and communication to enable as many health workers as possible to be vaccinated.

We also have worked in partnership with our community providers to enable them to meet their obligations under the Order. This includes ensuring business continuity is risk assessed and service delivery plans are in place.

To support service continuity each service is undertaking its own risk assessment and business continuity plans are in place to mitigate the impact of losing staff who have not been vaccinated.

Preparedness coordination and oversight

A governance structure is in place to ensure that we can align and coordinate the work that is occurring across all areas. Work is occurring at pace and decisions need to be made quickly as new policies and advice is developed nationally, and we respond to the change in COVID response management. This oversight group meets frequently to ensure timely decision making, effective risk and issue management and to provide assurance.

Performance Monitoring

Data remains critical to the success of our response. We will continue to report on the overall effectiveness of the programme such as vaccine levels, testing and other public health initiatives. We are expanding our measures and reporting to monitor progress against our new priorities such as the number of cases in care in the community (CSIQ) facilities.

Communications and Engagement

The communications and engagement approach for the COVID-19 response is now well underway with dedicated resourcing in place. The executive team are working together to inform and engage with partners, stakeholders, providers, stakeholders, staff, and the public on our preparedness and response work.

The DHB is also an active member of the Regional Leadership Group (which includes a range of central and local government agencies) and a sub-group has been formed to ensure a coordinated and well communicated regional COVID resurgence response. This group has proven to be a useful to ensure alignment of activity and shared messaging. A new regional public information management role has also been created (funded by RLG and the region's councils) to support regional stakeholder and public information. This role will work in partnership with our 2DHB communications and engagement team.

In late January we launched a regional preparedness campaign created by the 3DHBs and the Wellington Region Emergency Management Office (WREMO) which includes:

- Preparedness packs: templates for families to complete including a household plan, medical information, a shopping checklist and what to expect when isolating at home.
- Community newspaper advertising: Handy plans to tear out and fill in, sharing experiences from people who have had to isolate and advice from experts.
- A new Facebook page and website designed to be the "single source of truth" information hub around breaking information on outbreaks, vaccinations, testing, isolation, preparedness and more.
- At-a-glance graphics that describe the current regional statistics (cases, vaccination, testing, etc.), with variations to be shared with MPs and mayors as well as the general public.

The new 3DHB COVID-19 social media hub and a 3DHB COVID-19 web hub contain more details on the campaign.

COVID-19 Update

Current cases (as at 8/02/2022)

	2DHB	HVDHB	CCDHB
Number of active cases	30	8	22
Number of recovered cases	147	29	118
Number of cases deceased	2	0	2
Total number of cases	179	37	142

Vaccination – 2DHB booster dose coverage 18+ years (from 22/02/2021 to end 8/02/2021)

	2DHB	HVDHB	CCDHB
	Eligible Booster Coverage	Eligible Booster Coverage	Eligible Booster Coverage
Māori	48%	48%	48%
Pacific Peoples	49%	49%	49%
Other	55%	56%	54%
Total	54%	54%	54%

Vaccination – 2DHB Children 5-11 years (from 22/02/2021 to end 8/02/2021)

	2DHB	HVDHB	CCDHB
	Children 1st Dose Coverage	Children 1st Dose Coverage	Children 1st Dose Coverage
Māori	36%	34%	38%
Pacific Peoples	36%	37%	36%
Other	63%	60%	64%
Total	55%	51%	57%

Vaccination – 2DHB primary course coverage 12+ years (from 22/02/2021 to end 8/02/2021)

	2DHB	HVDHB	CCDHB
	Completed Course Coverage	Completed Course Coverage	Completed Course Coverage
Māori	91%	89%	92%
Pacific Peoples	94%	93%	94%
Other	98%	96%	98%
Total	97%	95%	97%

Board Information – Public

16 February 2022

3DHB Data and Digital update – Quarter 2

Action Required

The Boards note:

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

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

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

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

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

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

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

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

Executive Summary

1. The direction and workload continue to be focused around clinical workspace upgrades and clinical process improvements, improving service levels and operational efficiencies, risk management and remediation, and cyber security management and upgrades.
2. The work programme for FY 2021/22 is progressing well with ePrescribing going live in January, and the Single Clinical Portal and Regional Radiology Information System implementation progressing to plan.
3. Business cases are under development or have been approved for the cyclical replacement programmes, though hardware orders are constrained due to high global demand.
4. Engagement regionally and nationally continues with a focus on alignment of technology direction across the six regional DHBs and the Ministry of Health.
5. ICT-related COVID requests are being co-ordinated to support community isolation developments.

Strategic Considerations

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

Identified Risks

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

Attachments

1. 3DHB Data and Digital Quarterly Report – Q2 2021-2022

3DHB DATA AND DIGITAL
QUARTERLY UPDATE, February 2022

Whakahohe ai i te whānau me ngā kaimahi te matihiko me ngā tūtuki pūtanga

Enabling patient and workforce outcomes with digital solutions

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

1. EXECUTIVE SUMMARY

Welcome to the ICT Department's second quarterly report for the current financial year.

A priority focus this quarter has been centred on the COVID planning process, ensuring that we understand the requirements and that we have the right technologies and people in place ready to swing into action if and when required. We have also liaised with the Northern DHBs and with the Ministry of Health to enhanced our planning.

The Clinical Workspace upgrade project is fully under way now with internal staff and vendors working together well. There is currently no timeline change to the plan, however, we remain vigilant to the possible impact of COVID on our allocation of project staff. Other projects in the clinical workspace are also progressing well.

Keeping our computing environment safe and secure is also a priority focus and we have developed a complete 3DHB Security Strategy to co-ordinate and set direction. This has been approved through our 3DHB ICT governance committee and we have likewise presented it to the Ministry of Health and the National DHB security leads who have accepted it.

Engagement continues at pace between the ICT teams at the other three DHBs and ourselves at the Central Regional level focused around the upgrade of the regional webPAS system and the launching of a regional eReferral project. We also continue to be standing committee members for a number of national ICT groups helping to set the technology direction for HNZ.

Our staff have also been actively engaged in the development of joint regional proposals to go to the Ministry of Health to obtain funding for "shovel-ready" technology uplift projects.

2. WORK PROGRAMME UPDATES

COVID RESPONSE

3DHB ICT has set up a co-ordination team to support ICT-related requests from the 2DHB and WrDHB COVID response teams, and internal COVID planning work. This work includes liaising with the Ministry of Health on COVID systems development. Any significant unplanned COVID work may impact the clinical workspace programme.

CLINICAL WORKSPACE

3DHB Clinical Portal

Project resources have been confirmed and work has commenced. Contracts with Orion Health have been signed,

This activity will be on-going with a current planned go live for Wairarapa DHB in July 2022, Hutt Valley DHB in September 2022, then Capital & Coast DHB in February 2023.

Unplanned COVID resource demands may result in reallocation of resources.

Regional Radiology Information System (RRIS)

The RIS project team has formal agreement from HVDHB clinical heads of department to move to the Regional Clinical Portal ordering system. Early indications are that WrDHB clinical heads of department have also agreed to this.

Contingency planning in the event of HV RIS crashing without recovery has been completed for both HVDHB and WrDHB.

Go-live dates have been confirmed as CCDHB on 18 March 22, with HVDHB and WrDHB on 4 July 22.

ePrescribing

ePrescribing for outpatients planned go-live 19 January. This initiative allows clinicians to prescribe medicines electronically, removing the need to print paper prescriptions.

Clinically-led Initiatives

There has been increased number of clinically-led projects that require ICT involvement. These projects are typically equipment replacement where the new equipment has supporting software that requires security assessment, integration into other clinical applications, retention of data, and access to Wi-Fi.

We are continuing to support significant in-flight clinical projects across the three DHBs.

2. WORK PROGRAMME UPDATES

DIGITAL FOUNDATIONS

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

The ICT component of Te Wao Nui is near completion and will be complete when the as part of the final building commissioning.

Server backup upgrade project is finalising the commercial arrangements in next quarter.

HVDHB webPAS operating system upgrade is nearing completion with go-live planned for 19 Feb. Vendor resourcing capability continues to be the most significant risk to the successful delivery of this project.

DIGITAL WORKPLACE

The Digital Workplace Programme has been constrained to small deliverables as funding was not available this financial year to progress the full roll-out across the DHBs.

3DHB ICT is rolling out Microsoft Teams to key users, including staff working on the COVID response. The implementation involves configuring Teams in a minimal viable product. That allows voice, video and chat functionality, however restrict the use of the tool as an information store to ensure the DHB does not have an unmanageable document repository in breach of our Records Act requirement.

PABX infrastructure and security risk reviews have been completed. Funding has been confirmed as available within existing ICT budgets to address 3DHB Contact Centre security / stability risks and first stage deployment of a modern PABX platform.

OTHER ACTIVITY

Regional webPAS

The Central Region DHBs have proposed a cloud-based approach to managing each DHB's instance of webPAS. Both the regional infrastructure and the webPAS application need to be upgraded. ICT is considering options for the best ways to support WrDHB in a financially constrained environment, including an option to move WrDHB's set up to CCDHB.

eReferrals

MidCentral DHB has issued an RFP for eReferrals functionality on behalf of the six Central Region DHBs. 3DHB will participate in the evaluation of the RFP responses.

3. CYBER SECURITY

3DHB Security Strategy has been approved by the Digital and Data Intelligence Governance Group and is being shared nationally.

Funding confirmed late 2021 to address PABX infrastructure fragility and call centre security vulnerabilities. Work will start early in 2022.

ASSURANCE ACTIVITIES

The Security Improvement and Post-Waikato work continues with key achievements in the last quarter;

- Rollout of a modern Endpoint Detection and Response system.
- Implementation of a new 24x7 Security Operations Centre.
- Consolidation of the web proxy servers on the firewall.
- Installation of the new Proofpoint User Awareness and Training System. Planning has commenced with Learning and Development to start rolling out the system .
- Review and development of a "Fit for Purpose" Certification and Accreditation process. This is being used. Roll-out across ICT will occur during the next quarter.
- The testing of hardware tokens has been completed and will be used as part of our Multi Factor Authentication (MFA) solution for environments where MFA cell phone access is limited (e.g. police stations and prisons).
- A phishing campaign was completed resulting in an 8% failure rate. This has highlighted the urgent need to increase the user awareness

SECURITY MANAGEMENT

New Regional Chief Information Security Officer (CISO) has been appointed.. The CISO is meeting with DHBs and the Ministry of Health in his new role.

HEALTH NZ

A number of initiatives have commenced involving 3DHB ICT as we start to transition to Health NZ. These include:

- Representation on the Cyber Security Governance Group and Working Group.
- Early adoption of Microsoft Defender with MoH as part of extracting value from the new national Microsoft licensing agreement.

Supporting MoH with the development of a Sector-wide Cyber Security portal assisting with a "DHB" view of Cyber Security.

4. OTHER

REGIONAL AND NATIONAL ENGAGEMENT

Engagement regionally and nationally continues with a focus on alignment of technology direction across the six regional DHBs and the Ministry of Health.

We are actively participating in the Strategic ICT investment pillars that were created as part of the Budget 21 Health System ICT Infrastructure funding. We intend to submit requests for a portion of the remaining available funding for security, network

Our enterprise architects are driving national network, security, cloud architecture as part of the Sector Architecture Group (SAGE).

DIGITAL & DATA INTELLIGENCE GOVERNANCE GROUP

One meeting of the Digital and Data Intelligence Governance Group was held in Q2. The primary focus of that meeting was on the progress of the delivery of the key initiatives and technology strategy.

MOVE TO HEALTH NZ

3DHB Digital is working closely with the Ministry of Health and the Transition agency to prepare for Health NZ day 1.

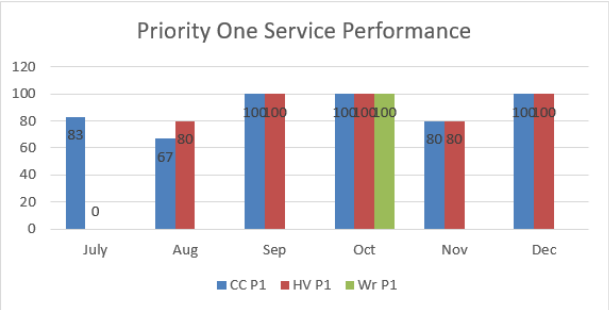
There is limited information on the national and regional structure of ICT under Health NZ. We expect more information to become available in Q3 following the appointment of the Health NZ CEO.

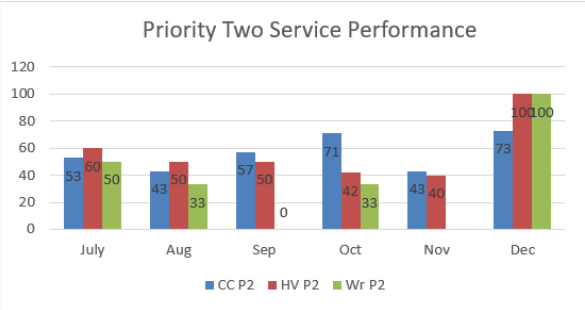
5. SERVICE ASSURANCE

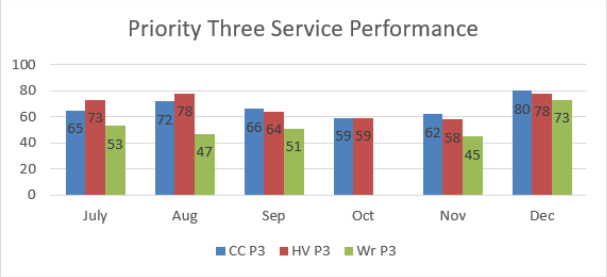
SERVICE LEVEL AGREEMENT METRICS

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

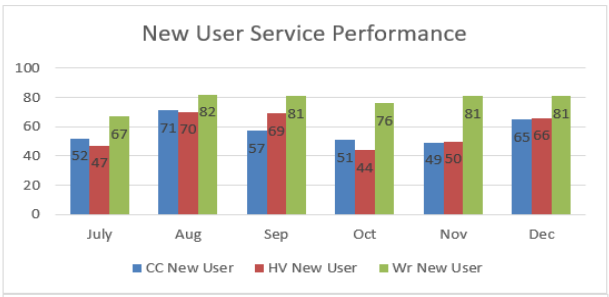
- Priority 1 (Critical) Incidents - Restoration in two hours
- Priority 2 (Urgent) Incidents - Restoration in four hours
- Priority 3 (Moderate) Incidents - Restoration in 24 business hours
- Priority 4 (Minor) Incidents - Restoration in five business days

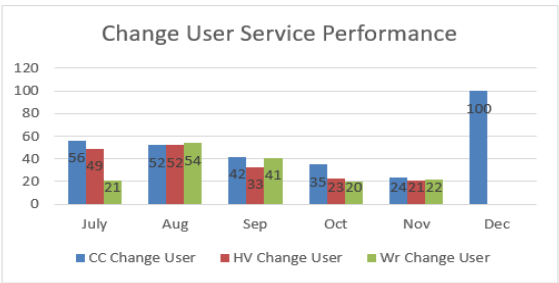


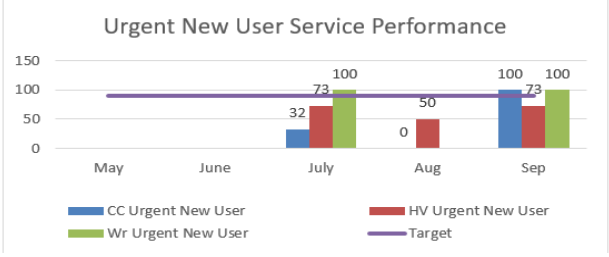




The other metrics currently being reported on reflect the speed at which user changes are being effected. Currently for all three DHBs the service level is below the required levels, however work is under way to automate simple tasks such as these in order to improve service levels.







Board Information – Public

16 February 2022

Māori Health Update – Quarter 2	
Action Required **The Boards note:** (a) the ongoing change process for the establishment of the 2DHB Māori Health Directorate (b) the update on the Iwi Māori Partnerhsip Boards (IMPBs) (c) Whare ki te Whare Kaiarahi – Navigation service.	
Strategic Alignment	Ministry of Health, Whakamaua: the Māori Health Action Plan 2020-2025 CCDHB Health System Plan 2030 (the 2030 Plan) CCDHB, Taurite Ora Māori Health Strategy 2019-2030 HVDHB, Te Pae Amorangi, Māori Health Strategy 2018-2027
Author	Arawhetu Gray, Director Māori Health Services
Endorsed by	Fionnagh Dougan, Chief Executive
Presented by	Arawhetu Gray, Director Māori Health Services
Purpose	Provide an update on the progress and performance of the two DHBs against the two Māori Health strategies.
Contributors	Māori Health Services across the two DHBs
Consultation	Not applicable

Executive Summary

1. In August 2021, the Māori Health Directorate implemented changes to the focus of the 2DHB team based at Hutt and Wellington Regional hospitals. We now have two teams:
   - Whānau Care Services / Toi Ora – focussed on patient facing services at Wellington and Hutt Valley hospitals.
   - System Change team – working across 2 DHB and focused on system change, equity, workplace change and training. We are also engaged with other directorates to improve health outcomes across SPP Mental Health and Addictions and the maternal youth and child service focus areas.
   - We are also adapting to the challenge of Covid responsiveness and staying in touch with our Maori service providers to ensure they have the resources and assistance we are able to provide.
2. Iwi Māori Partnership Boards (IMPBs) are a new feature of the Health System Reforms and will be hosted by the newly established Māori Health Authority. IMPBs must be iwi led and will operate predominantly at a Locality level supported by a dedicated core team who will carry out the work required to deliver on the IMPB's six key functions.
3. The Establishment Plan for the *Atiawa Toa Hauora Maori Partnership Board* has been approved pending a revision of the budget. Once the revised plan and budget have been resubmitted (mid Feb) and formally approved, tranche 2 funding (up to $200k) will be released by the Ministry of

Health to CCDHB who have been nominated as the fund holder until the IMPB establish themselves as a legal entity. Tranche 2 funding will support the implementation activities outlined in the plan.

4. Whare ki te Whare Kaiarahi – Navigation service. MHDG have been co-developing the Whare ki te Whare Kaiarahi – Navigation service to provide a community based service to support Māori:
   - To stay healthier at home;
   - Who are identified as at risk of admission to hospital, and are located in areas of high need; and
   - Who will benefit from a more focused wraparound Whānau Ora model of support.
5. The service supports Māori to be healthy at home, with a strong focus on prevention, improving access to existing health services, providing linkages to services, providing holistic community based care. It works with primary care and hospital based teams to keep people stay well in their homes. The service team works with individuals and the whole whānau. This service is moving into a business as usual phase with previous workforce issues being resolved

Strategic Considerations

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

Engagement/Consultation

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

Attachment/s

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

2DHB Māori Health Strategies (Taurite Ora & Te Pae Amorangi), Progress & Performance Report (2022/2023 Quarter 2)

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

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

Contents

1. Changes to the Māori Health Directorate

In August 2021, the Māori Health Directorate implemented changes to the focus of our 2DHB team based at Hutt and Wellington Regional hospitals. We have two teams:

- Whānau Care Services / Toi Ora – focussed on patient facing services at Wellington and Hutt Valley hospitals.
- System Change team – working across 2 DHB and focused on system change, equity, workplace change and training. We are also engaged with other directorates to improve health outcomes across SPP Mental Health and Addictions and the maternal youth and child service focus areas.

We are also adapting to the challenge of Covid responsiveness and staying in touch with our Maori service providers to ensure they have the resources and assistance we are able to provide.

2. Te Pae Amorangi

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

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

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

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

3. Taurite Ora

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

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

3.1 Research Advisory Group –Maori 2021 (RAG-M)

Background

The Research Advisory Group - Maori (RAG-M) is a sub-committee of the Māori Partnership Board (MPB). MPB is the Māori relationship board to CCDHB and is mandated by Mana Whenua (Te Atiawa, Ngati Toa and Te Atiawa ki Whakarongotai).

MPB identified a gap in Māori advice to researchers in the district and RAG-M was established in June 2007 to provide a more effective engagement point for researchers requiring Māori advice and input.

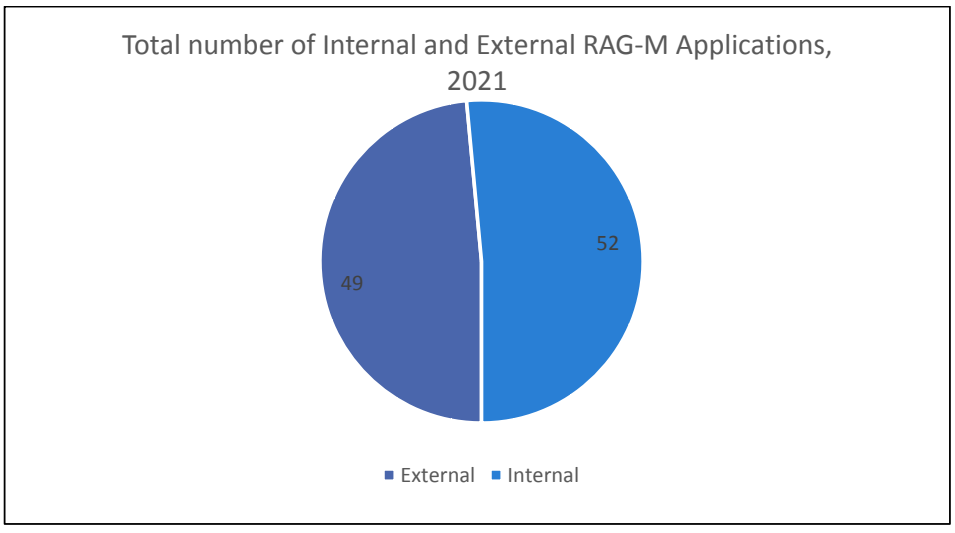
PURPOSE

The purpose of RAG-M is to provide a mechanism to engage representatives of the Māori community and provide researchers with a timely response and an opportunity to have their research proposals considered from a Māori perspective.

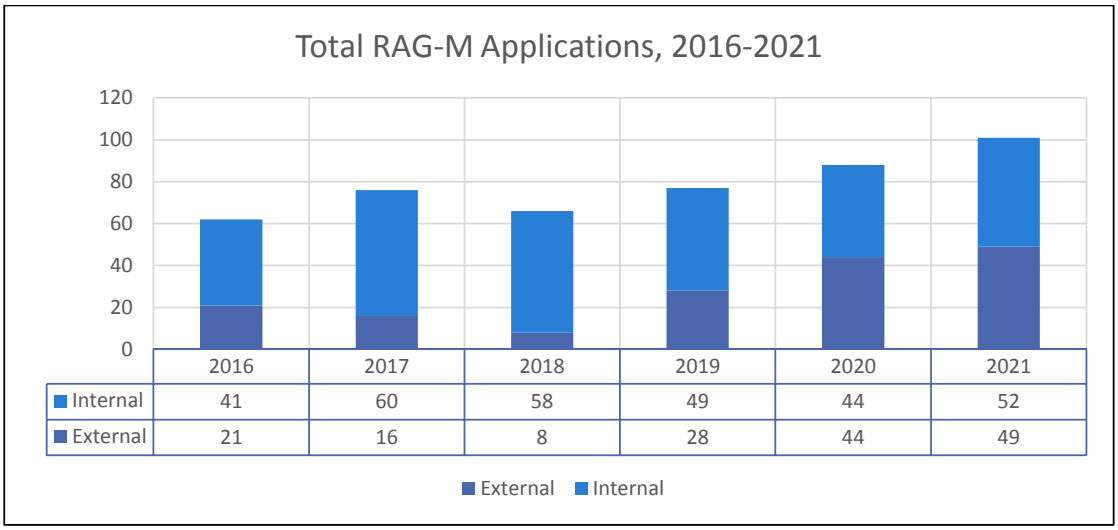
The ongoing impact of changes to the governance structure – moving from a Māori Partnership arrangement to an IMPB under the legislative changes that will come into effect on 1 July 2022, represents a change to the environment that RAG-M operates in. 2DHB will continue to support reviews and work with TUI MC and also consider recruitment of more reviewers to assist with an expected increase in applications. At February 2022, one reviewer will begin full-time PHD studies, another is expecting a pēpi, and we are unsure if and when she will return. Our reviewers carry a large workload and our 2021 data suggests that this is unsustainable. We will work with current reviewers to identify recruitment possibilities and other opportunities to ease workloads.

2021 Summary

In 2021 there were a total of 103 applications, of which 2 were withdrawn, leaving 101 processed overall. Around half of these applications were by internal researchers and half by external researchers, as shown in the following chart.



The following chart shows the total applications and the split between internal/external over the past five years. We can see that this is the most applications RAG-M has received in a year, perhaps suggesting increased engagement with Māori in health research in the region.



	2016	2017	2018	2019	2020	2021
Internal	41	60	58	49	44	52
External	21	16	8	28	44	49

In 2021, there were also several changes and updates made to the RAG-M committee processes to facilitate the review of research applications going forward. This included:

- Development of a process of the administrative steps involved in RAG-M reviews
- Updating forms and information on the CCDHB website to reflect process changes, and provide as much of the information that researchers require in advance of their application (https://www.ccdhb.org.nz/working-with-us/carrying-out-research-at-ccdhb/research-advisory-group-Māori/)

3.2 Hauora Māori training fund

The Ministry has confirmed funding for 2022/2023 will remain at the same levels as 2021/2022 for 2DHB. Funding will be released under a new service agreement in February 2022. The fund has been expanded so that training at any level, including towards a degree is eligible, as long as it results in an unregulated health and disability sector qualification.

We are actively promoting the fund internally and to our external Māori service providers. We currently have 9 applications in the pipeline and are awaiting confirmation from Ministry of new service levels that are likely to simplify the process for funding approval and broaden NCEA levels that can be funded.

3.3 Service Delivery

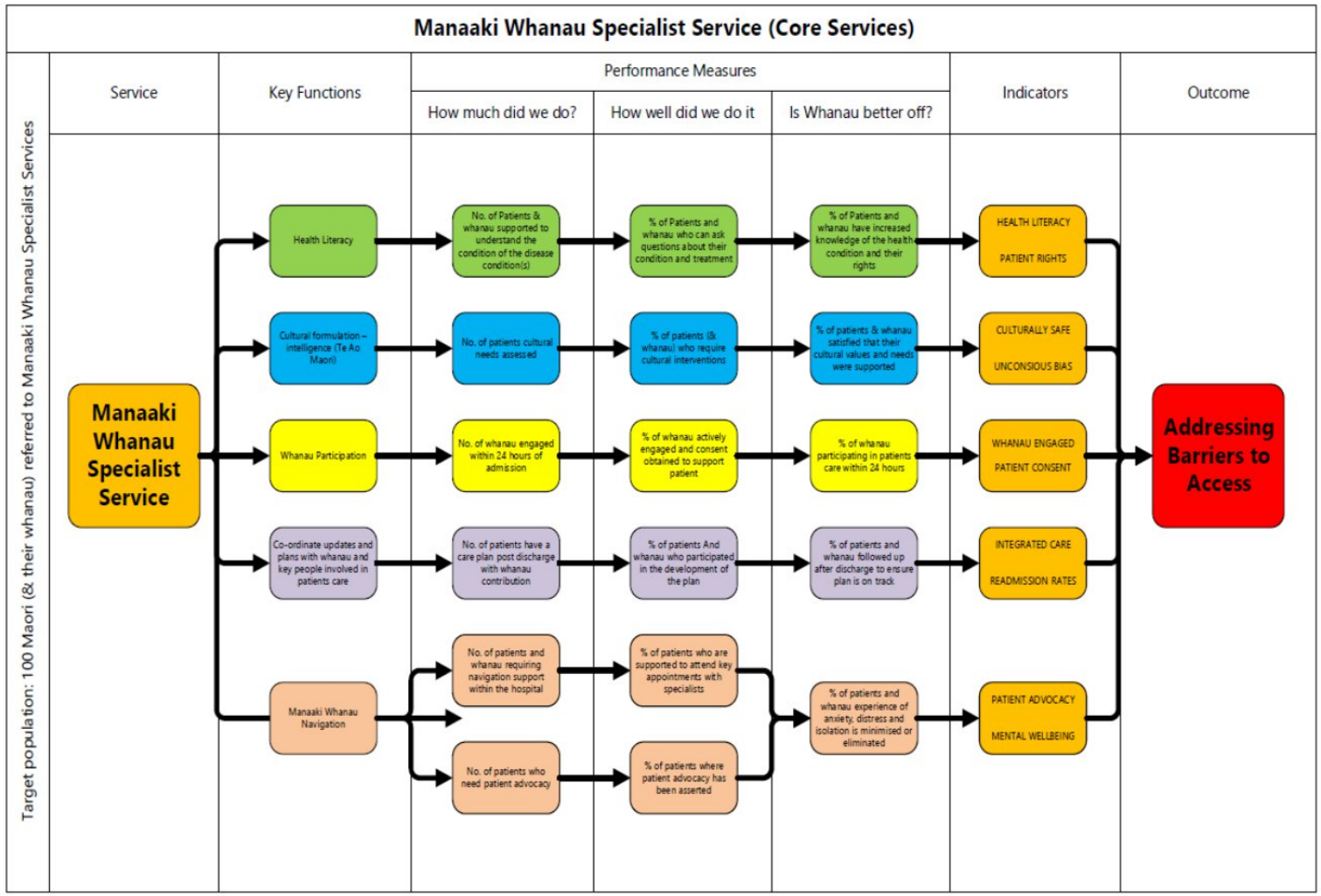
There are two teams in Service Delivery one at the Hutt Valley (Toi Ora) and one at CCDHB (Whānau Care Services). The two teams are looking at ways to work more closely and share experiences and goals.

The CCDHB Whānau Care Service

The team have been identifying measures of success starting with an assessment of our contribution to high level outcomes.

The five key areas in the Table below are mapped to function and performance measures that may be used. There is a similar chart for each of the specialist roles. They will be used to agree what the team will measure and track. Similar measures will be used for Toi Ora (HV) when we have enough suitable data to base measurement on.

Table: Whānau Care Services flow of key function and performance measures:



As part of our focus on children, we are developing support groups for Mothers and Fathers in NICU. The aim of these groups is to provide assistance to new parents to improve their self-confidence around baby.

The focus for the next quarter is to develop a dashboard with core measures to be used for reporting purposes. The team will continue to focus on Tamariki and Hapū Māmā. The Long term conditions nurse will focus on patients with renal disease in an effort to delay the need for dialysis.

An example of a successful whānau connection is as follows:

A 32 year old wahine, hapū with her first pēpi presented with complex social issues. Her pregnancy was the result of trauma and as the pregnancy was unexpected she had decided to put pēpi up for adoption. She is diabetic and was unwilling to engage with health staff. These issues were compounded by a lack of whānau and other support and she does not drive. After intense therapeutic intervention, she began showing greater self-determination which has resulted in her:

- Obtaining a restraining order against her ex-partner
- Securing safe accommodation with an aunty she reconnected with after 10 years
- Securing full-time employment once she is healed and ready to start
- She has opened up to her aunty regarding the trauma she experienced and her whānau are now supporting her to whangai pēpi
- She has started reconnecting with a wider social support base
- She is empowered to ask health staff questions and now attends all appointments and is taking her diabetes seriously
- She has engaged with Oranga Tamariki regarding the adoption process to ensure they are doing "everything by the book"
- The Whānau Services team continues to offer her support and ensure she has the space and opportunity to liaise effectively with her birth team. She is empowered by her detailed birth plan and happy knowing that staff are well prepared and aware of her situation before she has pēpi.

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

Our staff also received this feedback on behalf of Lady Tureiti Moxon via John Whaanga at the Ministry of Health:

> *"I have just spoken to my sister Ruth whom Ngahiwi and my sister Mere picked up from Wellington hospital today. I understand that your assistance was very welcome. I am amazed with work the surgeons and staff did for my sister. She looked so good and well after her procedure. Our father died of a pulmonary embolism at 52 years of age which is the age of my little sister. My sister remembered vividly everyone celebrating the fact that they had fixed her heart ❤□ issues. Would you please pass on the thanks of my whanau for the amazing work they all did.*
>
> *Arohanui*
> *Tureiti Moxon"*

The new Childrens Health Nurse has also completed orientation and is having early success with supporting whānau to engage with the hospital and attend appointments.
For example:

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

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

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

Toi Ora

The team continue to provide the service as usual. We have been working with the MHAIDS team to update technology for the two MHAIDS workers, who are based with Toi Ora, and to ensure they are able to correctly enter data.

One example of how the team make a difference is advocating with managers and clinicians to ensure they get treatment. A true life example of this occurred recently:

- A father and his daughter came to Toi Ora looking for help. The father required cataract surgery and was going to have a long wait which was impacting his employment and mental well-being. His daughter was supporting him at home, however, this meant that she was away from her own children.
- One of our team advocated on behalf of the father and as a result, his /surgery moved forward. In the time he would have waited for surgery he had had the operation and returned to work.

The focus for the next quarter to implement performance measures to be used for reporting purposes. The team will continue to focus on Community Mental health services and to introduce a service for Hapū Māmā.

4. Focus Area One: Maternal, Child & Youth

4.1 Maternity Quality and Safety Programmes (MQSP)

The Annual Report for Maternity Services 2020 has been published. This report notes the progress and projects undertaken in this area.

Link: https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/ccdhb-whs-2020-maternity-quality-safety-programme-annual-report.pdf

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

A review of this survey has led to a change in the way Maternity services is seeking feedback. It was acknowledged that the number of people participating was low and doesn't reach much more than seven in a month. It was discussed in the MQSP governance group that the purpose of the survey is to use the feedback to inform service and practice improvement projects specifically for Māori. A different way of engaging was proposed utilising the services Māori parents are already accessing. A trial is underway with the Breastfeeding Support Team in Kenepuru to ask people they are working with three questions and enable a discussion around experiences of our services. It is hoped that a more personable process will lead to more in depth feedback and better identify areas of improvement for Māori. The iPad survey remains while the trial is underway.

4.3 Maternal Wellbeing and Child Protection

The Child/Young Person Transition into Care/Uplift Policy has undergone significant changes as part of the review process which extended the project completion deadline by two months. This was due to Tranche 1 needing to review a second time and in part due to the holiday period. Below is the planned progression of the policy.

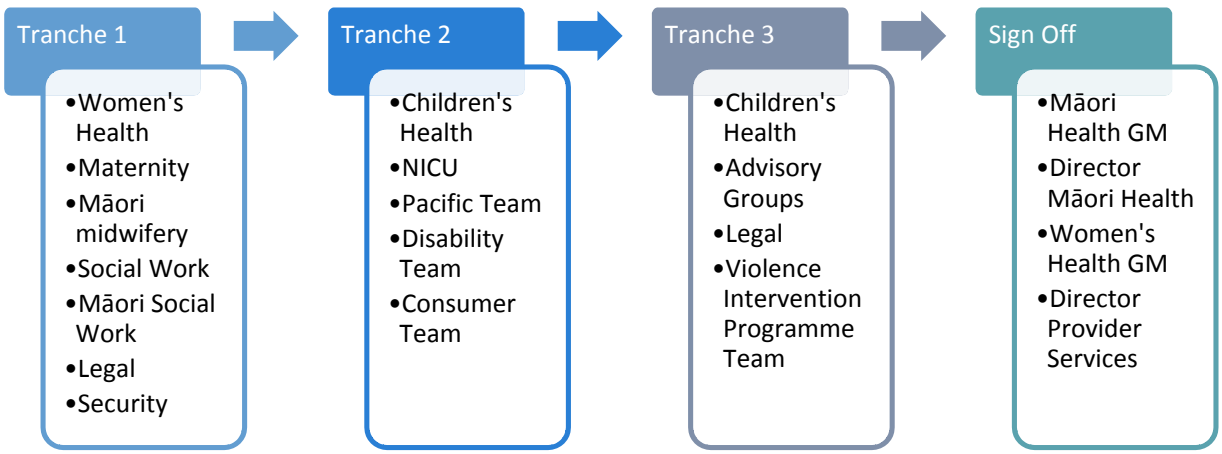


Figure 1: Review and Approval Process

Tranche 1 is complete and Tranche 2 ended 25 January 2022. Tranche 3 is expected to conclude 1 February 2022, excluding any further significant changes.

A guideline for Transitions into Care/Uplifts is in development which will outline the specifics for staff. Feedback and review on this guideline will follow after the sign off of the policy. The Care of the Vulnerable Pregnant Person guideline and Maternal Wellbeing and Care (MWC) group review is on hold until late February.

4.4 Children Clinics Service Improvement and Health Literacy

This work is currently paused while other work progresses.

4.5 Commissioning Updates for Maternal, Child and Youth

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

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

5.1 Update: Engaging Māori in Services - Ophthalmology Eye Clinic Did Not Attend (DNA) Rates

The phone call survey focused on Māori consumers was completed. 52 Māori were called, 27 answered the call and 23 agreed to be surveyed. A summary of the results of the survey are included as an attachment. The calls were made by Māori staff and there was no time limit as it was encouraged for the calls to be a conversation. A wealth of information was collected as free text answers because of this model. The survey found that 35% of respondents indicated Transportation and 30% indicated Appointment Time as their reason for not being able to attend appointments. When asked what was one thing we could change to make attending easier 40% indicated Travel Assistance while 22% said nothing, 17% said appointment options and 17% said location.

This project has moved on to Stage Four – Testing Cycles in the Model for Improvement. Five proposals were provided focused on solutions for travel or appointment times. The first test cycle was to offer taxi vouchers for Māori patients who had not attended 2 or more appointments and lived in the Hutt Valley DHB or Capital & Coast DHB regions. 15 consumers were eligible, 10 answered and 6 accepted the vouchers. As at 23 November, 2 consumers attended their appointments, 2 were rebooked due to clinician availability and 2 were rebooked as they were unwell. A final update had 4 of the 6 attended their appointments and 2 did not attend. The taxi voucher test was seen as a potential solution to offer as part of a wider range of options but did not see significant change in appointment attendance. The second test cycle proposed is a pilot for a transportation solution by way of shuttle but is still in the planning stages.

5.2 In development: Māori and Pacific Tissue Donors

Wherever we can, we ensure that we synergise our efforts with the Pacific Health team. Our teams can then leverage off our collective resources and strengthen our cultural and health outcome stories. Work is underway to look at how to encourage Māori and Pacific tissue donation, specifically eye tissue. Māori and Pacific people are disproportionally affected by Keratoconus, as young as 9 years old, and require eye tissue donation. It is understood that better matched grafts last longer than non-matched and require replacement less often. This work is being undertaken with the Pacific Health team and is in early stages of data collection.

6. 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

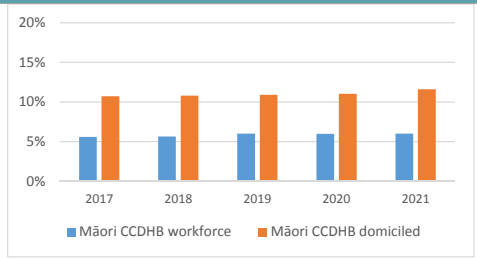
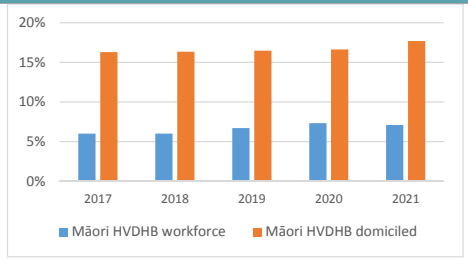
- DHBs as pro-equity health organisations
- Growing and empowering our workforce to have a strong Māori health workforce, and a workforce equipped to improve Māori health
- Strengthening commissioned services
- Accessible appointments

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 key systemic changes for ensuring the foundations for equitable health care extend across the 2DHB region.	What is our target for cultural competency training? 100% of staff? XX%	Graph showing progress Current data shows number of staff enrolled in relevant courses e.g., Te Reo Māori or other cultural competency initiatives. A target for proportion of staff could be developed from here?		Set core competencies and expectations for all staff to achieve health equity and improve Māori health outcomes. Implement a range of programmes and initiatives to support training of staff in culturally safe care and understanding Māori health equity challenges.

Māori live longer lives

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

Areas of focus

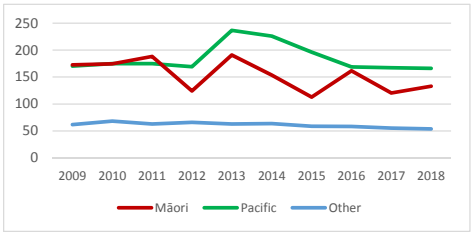
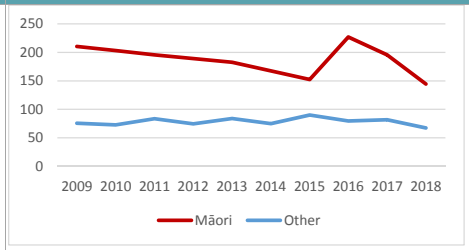
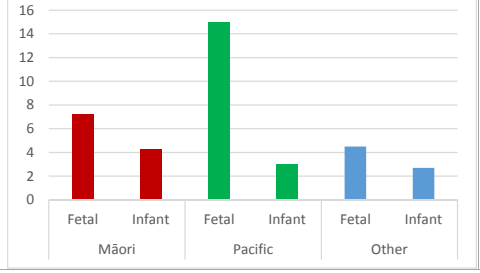
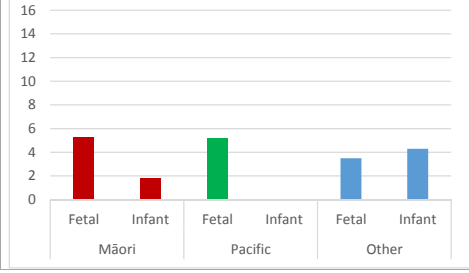
- Amenable mortality
- Maternal, child and youth
- Mental Health and Addictions

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

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

Māori have fewer avoidable hospital admissions

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

Areas of focus

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

Links to Whakamaua: Māori Health Action Plan 2020-2025

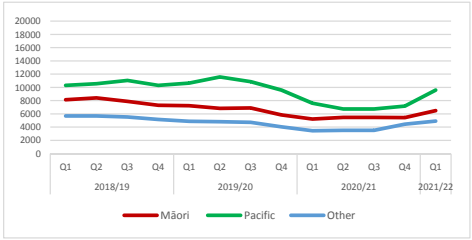
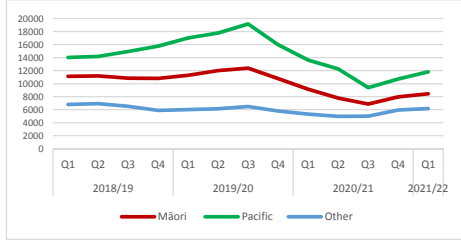
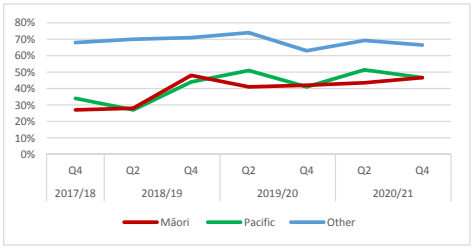
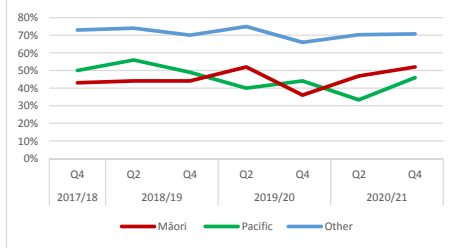
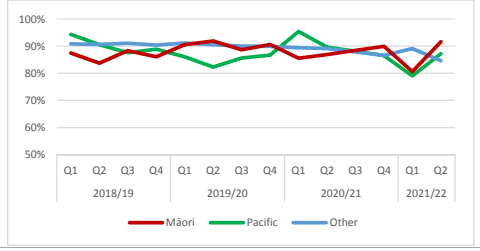
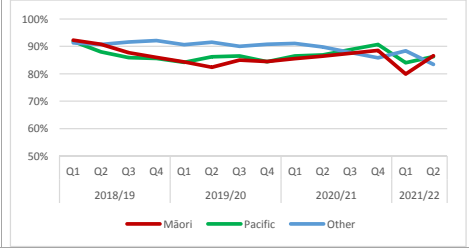
- Objective 1: Accelerate the spread and delivery of kaupapa Māori and whānau-centred services
- Objective 3: Reduce health inequities and health loss for Māori

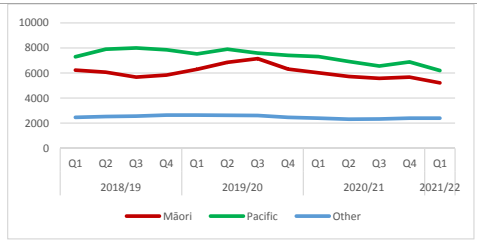
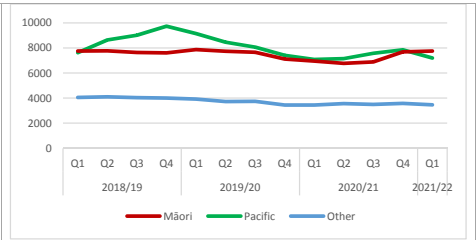
Sub-regional initiatives (2DHB)

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

Local initiatives

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

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

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

Māori have greater access to appointments

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

Areas of focus

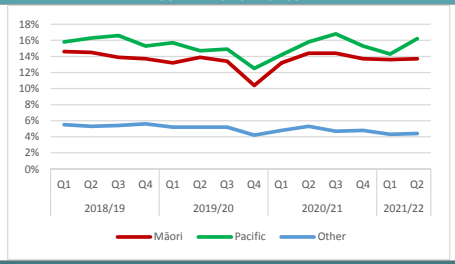
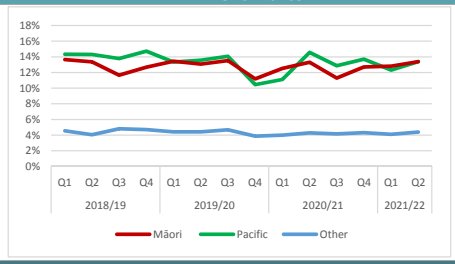
- Accessible appointments
- Did Not Attend (DNA) rates

Links to Whakamaua: Māori Health Action Plan 2020-2025

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

Sub-regional initiatives (2DHB)

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

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

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

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

Areas of focus

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

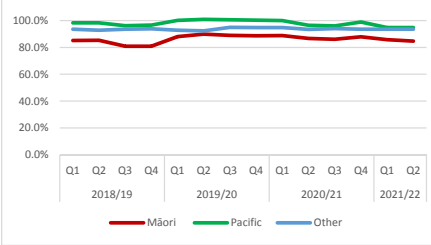
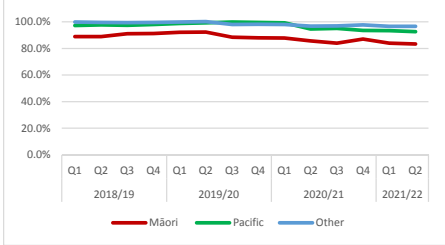
Links to Whakamaua: Māori Health Action Plan 2020-2025

- 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 • The Māori enrolment rate is equal to non-Māori enrolment rates?			
Indicator 2: Māori Health portfolio funding Increased funding to Māori health providers as a proportion of total funding	Māori health providers facilitate culturally safe access to community-based services and primary care, providing options outside of secondary care.	Increased Māori Health portfolio funding proportion			❖ Baseline and target for Hutt Valley? Baseline is given in Taurite Ora as 0.45% of the DHB budget – can be measured through DHB annual budgets?

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

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

Board Information – Public

16 February 2022

2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report November 2021 – February 2022

Action Required

The HVDHB and CCDHB Boards note:

(a) The Pacific Directorate are focussed on addressing the six priority areas defined in the Pacific Health & Wellbeing Strategic Plan 2020 – 2025. This paper provides a progress report from November 2021 – February 2022 on activities across the system to support equitable Pacific health outcomes for the six priority areas.

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

(c) The Covid-19 response for Pacific.

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

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	Merivi Tia'i - Senior Advisor Pacific Sam McLean – Principal Analyst & Team leader - Analytics
Consultation	2DHB Strategy, Planning & Performance

Executive Summary

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

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

- A high-level progress report on the status of the broader activities that the Pacific Health Strategy encompasses
- A progress report on Covid-19 response for Pacific and planning in preparation for Omicron

- A high-level dashboard and explanation of indicators that have been developed to measure progress in relation to Pacific health equity.
- Discussion of how the Pacific Directorate intends to support the organisation to achieve its Strategic Priorities through an Analytics Roadmap to highlight Pacific provider profiling and priority investment areas for Pacific 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 Pacific providers and Pacific communities. 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
Risk 1	Limited additional investment to implement the Plan	Junior Ulu Peter Guthrie	Ensure approval of funding investment for out years are sought	3	Medium risk
Risk 2	Disruptions due to COVID-19 on service provision and workforce capacity pressures	Junior Ulu Peter Guthrie	Working across systems and closely with Pacific providers to support workforce capacity innovations through collaborative workforce approaches	2	High risk

Attachment/s

1. 2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report November 2021 – February 2022.

2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 - 2025: Progress & Performance Report Nov 2021 – Feb 2022

This report provides an overview of progress made on 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

This report covers the period from November 2021 – February 2022. Recognising the short timeframe between reports, this report will focus on a high level summary against the six priority areas of the 2DHB Pacific Health and Wellbeing Strategic Plan for the Greater Wellington Region 2020 – 2025 (the Plan), as well as an update on Covid-19. We will also look forward to when we transition into Health New Zealand with initiatives to support the priority areas, as well as the 2DHB Strategic Priorities that align and complement Pacific directed activities and investments. Appendix 1 provides a dashboard of our progress against the Plan.

Learnings from Covid-19 has created a space for Pacific health providers, ethnic groups, churches and communities to implement innovative responses for health service delivery. These learnings provide a platform to strengthen a health system that does not currently work for Pacific people, as reflected in current and historic negative health statistics. The opportunities that lay ahead are significant to achieve the vision of the Plan: “Pacific peoples are empowered and enabled to live longer quality lives, supported by a culturally responsive health system”.

2. Covid-19 Response

With 3.1 million international Omicron cases reported daily and 7,797 global daily deaths, Omicron is now the predominant variant in at least 60 countries worldwide. Omicron appears to have reached an infection peak three to four weeks after it became the dominant strain. While hospitalisations have increased during Omicron surges, case hospitalisation rates are markedly lower than in previous outbreaks.

The Government’s approach to managing Omicron is based on, and is responsive to changing case numbers in the community. The three phased approach: ‘Stamp it out’; ‘Flatten the curve’; ‘Manage it’, ensures that the community is protected. Based on Delta statistics and 2DHB modelling, it is predicted that Māori and Pacific people will be affected worse than other ethnicities because of living arrangements and the highly transmissible nature of Omicron.

Our response to prepare for Omicron within the 2DHB is to strengthen boosters and paediatric (5-11 years) vaccinations. The focus for this next period is to increase uptake of vaccinations for Pacific

peoples utilising existing networks, schools, and strengthening communications via radio and social media.

3. 2DHB Pacific Strategy Work Programme – High Level Update

The Plan outlines activities and actions under six priority areas. The monitoring framework also provides context around progress of the broad activities towards meeting specific goals.

The table below provides a high level update against each goal the actions that have taken place within this reporting period (November-January) with future planning actions to 30 June 2022. The colour coding key describes the progress against each priority and goal. This high level update also addresses activities and initiatives moving forward and how we plan to strengthen goals against each priority area.

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

PRIORITY ONE: PACIFIC CHILD HEALTH AND WELLBEING	PROGRESS:	
	Update	**Future Planning**
Goal 1: To give Pacific children and their families the best possible start in life.	• Equity investments in child heath, wellbeing, maternal and antenatal services have been commissioned to support this goal. • Smoking cessation services in partnership with Kōkiri Marae is under development including negotiations on MoH funding to providers specifically for the Pacific population.	• A decrease in avoidable children hospital admissions. • Increase the number of Pacific children living in healthy smokefree, warm homes. • Improved coordination between Pacific provider systems, community, primary, secondary and tertiary sectors. • Strengthen Pacific breastfeeding services, and child immunisations services.
Goal 2: Ensure Pacific children meet key childhood developmental milestones through culturally responsive and quality services and support.	• Reduce DNA rates for appointments by increasing support for the 2DHB Pacific unit nurses to actively engage families ahead of schedule, provide translation, health education support and working with Bee Healthy to follow up high risk families.	• Increased knowledge and understanding of parents and caregivers of healthy foods to nourish young children. • Increase in number of children receiving annual dental examinations. • Strengthen support for initiatives that address family violence and work with relevant stakeholders on preventative measures. • Increased role of health services through inter-agency collaborations to support Pacific families.

PRIORITY TWO: PACIFIC YOUNG PEOPLE	PROGRESS:	
	Update	**Future planning**
Goal: Pacific young people have timely access to services and programmes that enable them to grow into healthy adults and lead productive lives.	• Funding commissioned to nursing services to target youth. • Funding commissioned for Alcohol and Other Drugs to support mental health for young Pacific people. • Establish 2DHB Pacific Youth network "Brainstrust". • Support bespoke youth initiatives developed based on recommendations from a review of Pacific youth mental health initiatives.	• Increased number of Pacific young people engaging in youth initiatives. • Increased access to youth centred health and disability services. • Collaborations with identified tertiary and secondary educational institutions to promote health as a career of choice.

PRIORITY THREE: PACIFIC ADULTS AND AGEING WELL	PROGRESS:	
	Update	**Future planning**
Goal: Pacific adults and older people are actively engaged in their health care, and live productive, active, culturally secure and quality long lives.	• Pacific National Network for Bowel screening continuing to strengthen low uptake of screening by Pacific peoples. • Funding commissioned to Pacific Health providers and civil society groups to promote Breast and Cervical screening. • 2DHB Pacific Nurse Led Integration project. • Pacific Cultural Competency Trainings.	• Increased participation of Pacific people in bowel, breast and cervical screening programmes for early diagnosis of cancer. • Pacific peoples receive cancer treatment sooner. • Increased support and uptake of risk assessment, and early intervention programmes for: diabetes checks; cardiovascular disease; respiratory disease; high blood pressure. • Increased access to medications and pharmaceuticals. • Reduced ASH rates and Pacific peoples admitted to hospital due to complications from chronic conditions. • Advanced Care Planning with Pacific families and communities.

PRIORITY FOUR: PACIFIC HEALTH AND DISABILITY WORKFORCE AND PACIFIC PROVIDERS AND NGOS	PROGRESS:	
	Update	**Future planning**
Goal: The Pacific health workforce and providers have the capabilities, resourcing, aspirations, organisational structures, professional opportunities and potential to lead, support and contribute to achieving positive health and wellbeing outcomes for Pacific peoples.	• Development of a 2DHB Pacific Workforce Framework. • Appointment of pro-equity leads: Director Pacific MHAIDS; Porirua Locality Lead, Hospital Network Lead, Maternal Health Lead. • Funding for Pacific FTE to support Stroke Central New Zealand. • Establishing a Pacific Mentoring Programme.	• Increased number of Pacific skilled workforce being interviewed for positions and employed within Health NZ. • Establish strong mentoring and leadership training pathways. • Develop a Pacific provider consortium. • Increase Pacific students undertaking health related studies. • Increase number of cadetships and relevant health scholarship.

PRIORITY FIVE: SOCIAL DETERMINANTS OF HEALTH	PROGRESS:	
	Update	**Future planning**
Goal: A health system that influences and is aligned to housing, education, employment, social services and other sectors to address inequities and achieve better health outcomes for Pacific peoples.	• Working collaboratively with interagency organisations to address social determinants of health. • Well Homes programme. • Kainga Ora to focus on addressing healthy housing for Pacific people.	• Improved access to ECE for Pacific children. • Increased number of Pacific young people achieving qualifications. • Increased number of Pacific families accessing warmer, drier homes leading to a reduction in avoidable hospitalisations. • Decreased number of reported police investigations of family violence.

PRIORITY SIX: A CULTURALLY RESPONSIVE AND INTEGRATED HEALTH SYSTEM	PROGRESS:	
	Update	**Future planning**
Goal: A culturally responsive and integrated health care system across the Wellington sub region secondary/hospital care, specialist services, and aged care that meet the needs of Pacific peoples and are delivered closer to home.	• Pacific Cultural E-Learning in place that is part of mandatory training for all staff. • Commissioned funding to enhance equity in specialist advice and ambulatory care. • Respiratory and sleep apnoea integration project.	• Performance and outcome reports show results for Pacific services actively find ways to reduce inequity of access and outcomes for their Pacific patients. • Increased use of culturally appropriate digital tools to improve the number of specialist and health care services closer to home and out in the community.

4. 2DHB Strategic Priorities

The 2DHB have four areas of focus with a pro-equity approach for the Strategic Priorities, our Hospital Network, Commissioning and Community, Mental Health & Addiction, and 'Enablers'. These enablers are improvements that support the success of focus areas and our commitment to creating a pro-equity organisation:

- Implementing our pro-equity approach across both DHBs
- Investing into Māori and Pacific service providers
- Strengthening the sustainability of Māori and Pacific service providers
- Improving accessibility for, and the experience of, disabled people.

The 2DHB Pacific Directorate is committed to delivering the 2DHB Strategic Priorities as demonstrated in the diagram below. We are producing an analytics roadmap that will capture both qualitative and quantitative data to measure the return on investments made to achieve the 2DHB Strategic Priorities.

2DHB Strategic Priorities: Pacific Analytics Road Map

January	February	March	April	May	June
•Agree analytics roadmap	•Moana Research reports on Pacific Investment for COVID-19	•Pacific Health Services •Stroke Central	•Pacific Health Plus •Vaka Tautua	•Vaka Atafaga •Catalyst Pacific	•Other providers – where to next?

January	February	March	April	May	June
•Agree analytics roadmap against Pacific Strategic	• Map strategic analytics against existing priorities	•Undertake analytics			

1

5. Next Steps

The Pacific team across the 2DHB will:

- Support Pacific people through the Covid-19 pandemic planning and responses
- Develop an 'Operational Plan' to implement future planning initiatives listed above for Health NZ
- Develop a monitoring framework for pro-equity commissioning
- Implement the Pacific Workforce Plan and the Pacific Mentoring Programme - develop FTE role
- Porirua Locality prototype - Pacific Lead FTE role established
- Hospital Network Programme – Recruit Pacific Lead FTE
- Maternal Health – Recruit Pacific Lead FTE.

6. Appendix One: 2DHB Pacific Health Dashboard

Pacific child health and wellbeing

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

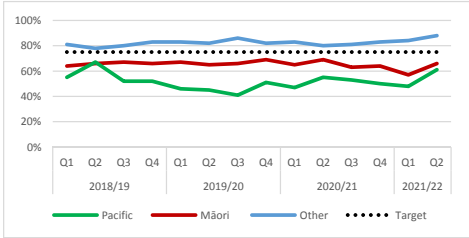
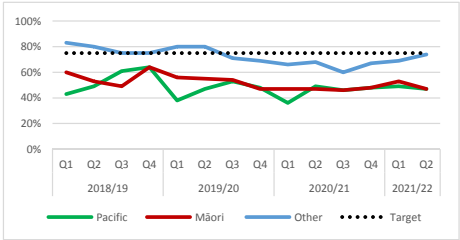
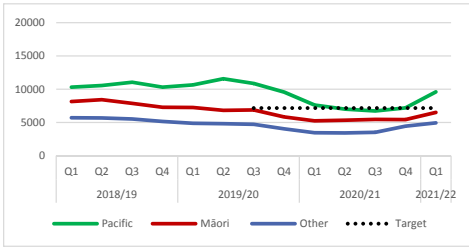
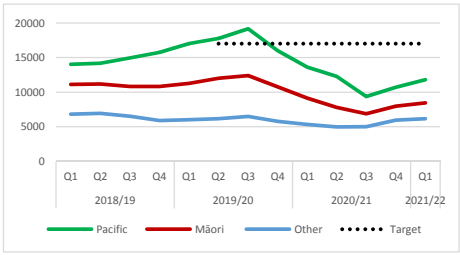
Ensure Pacific Children meet key childhood developmental milestones through culturally responsive and quality services and support.

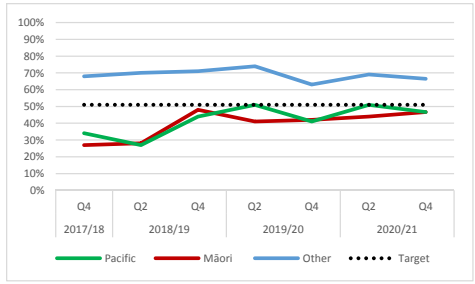
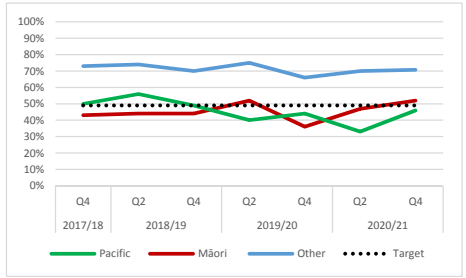
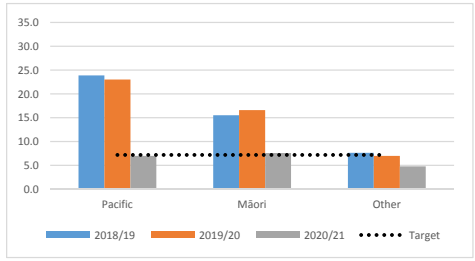
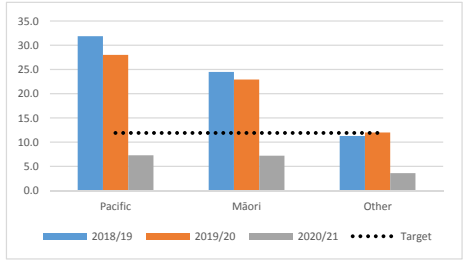
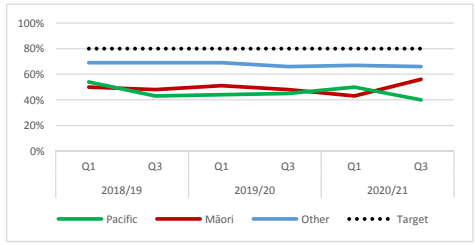
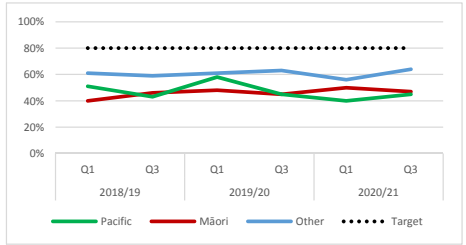
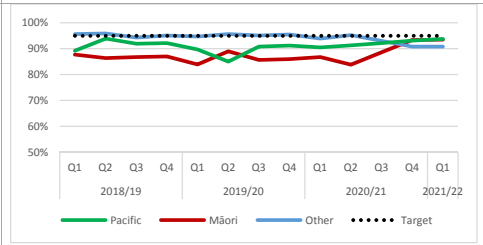
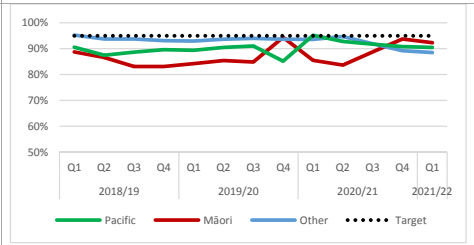
Areas of focus for the next 12 months

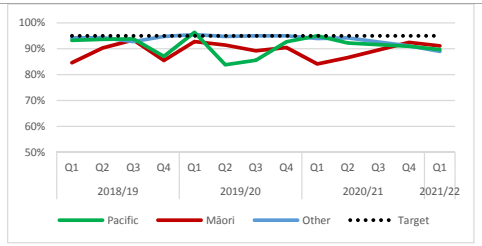
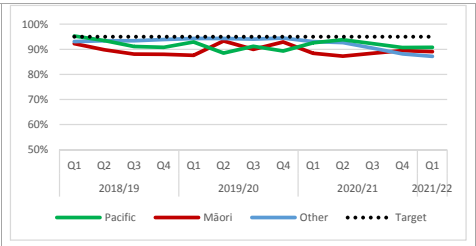
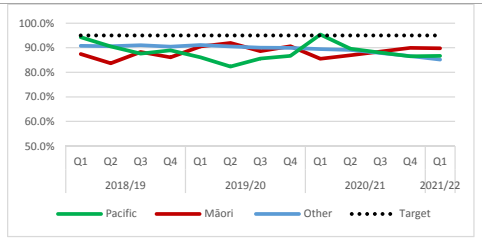
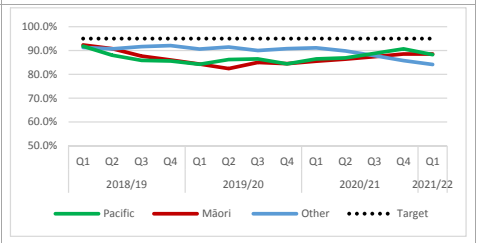
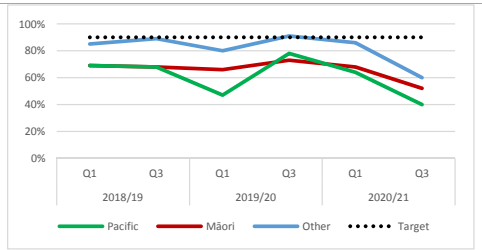
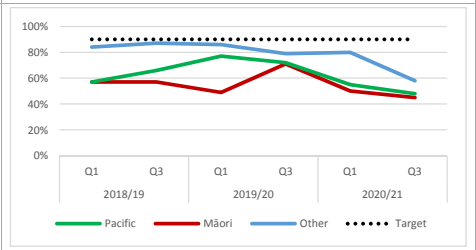
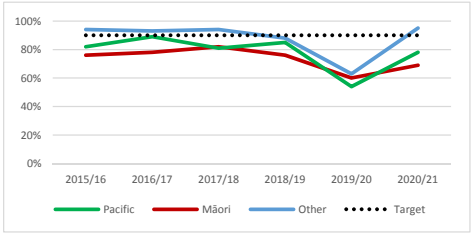
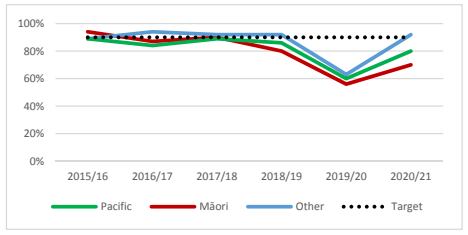
- More accessible and better engagement in reproductive, perinatal, antenatal and postnatal services for Pacific mothers.
- Increase the number of Pacific children living in healthy homes that are warm and smokefree.

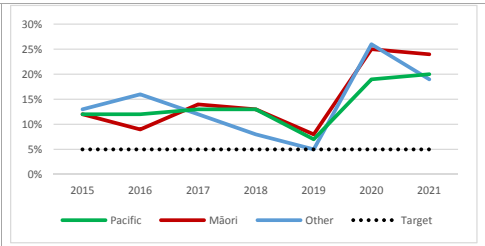
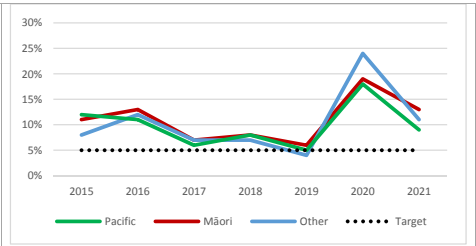
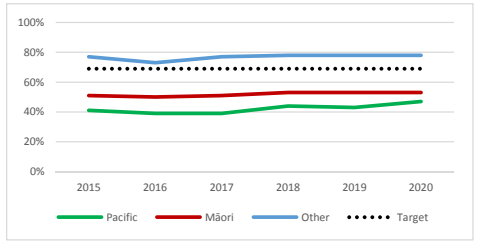
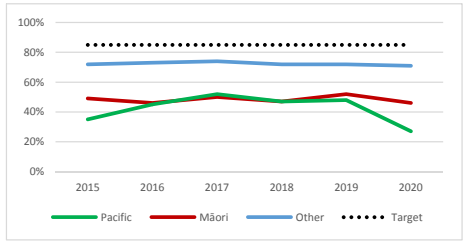
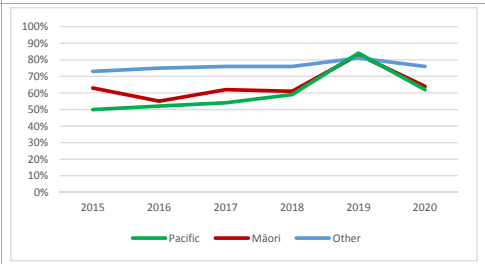
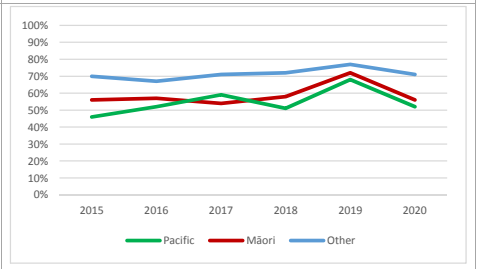
Sub-regional initiatives (2DHB)

- 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 (LMC) within the first trimester of pregnancy.	Early engagement with an LMC enables opportunity for screening, education and referral, and begins the primary maternity continuity of care relationship between a woman and her LMC.	≥75%			In 2020/21 CCDHB has invested in a new Māori and Pacific midwifery collective in Porirua, which we expect will continue to improve access to antenatal care in Porirua and across the DHB catchment. In 2020/21 we will commence our 2DHB Maternal Health System Plan, which will deliver models of care that improve access and engagement in early antenatal care and education.
Rate of Ambulatory Sensitive Hospitalisations (ASH) for children aged 0-4 years (per 100,000 people).	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% (≤7,162) HVDHB: ≤17,021			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. ASH rates across the 2DHB fell during the first COVID-19 lockdown and have begun to increase at the start of 2021/22.

% of Pacific babies living in smokefree households at 6 weeks.	This measure is important because it aims to reduce the rate of infant exposure to tobacco smoke by focusing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to - from pregnancy, to birth, to the home environment within which they will initially be raised.	CCDHB: 51% HVDHB: 49%			Actions to improve babies living in smokefree homes are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. From April 2021, the CCDHB Hapū Ora service will be able to offer nicotine replacement therapy directly to their clients as an additional support tool. HVDHB continues to progress work promoting the relationship between the Hapū Māmā smoking cessation service and maternal and child services provided in secondary care.
Rate of hospitalisations potentially related to housing conditions per 1,000 population for children under 15 years.	Housing related hospitalisations are related to the quality of housing. This indicator highlights variation between different population groups. Rates can be reduced by ensuring that homes are safe, warm and dry.	CCDHB: ≤7.2 HVDHB: ≤11.9			Actions to improve performance are related to ASH rates, particularly for Pacific children. These are outlined in our System Level Measures Improvement Plan for 2020/21 and 2021/22. We continue to actively monitor performance in this area and identify actions to improve performance. The declining rates are driven by decreased respiratory illness in 2020.
% of Pacific infants fully or exclusively breastfed at three months.	The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of lifelong 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.	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 one 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

% of Pacific children fully vaccinated at two years.		≥95%			completing the full schedule of vaccines but do 'catch up'. We are focused on developing a pro-equity commissioning approach adopting the learnings of our COVID-19 vaccine programme. What we know from our COVID-19 vaccine programme is that commissioning vaccination, with our priority populations (Māori, Pacific & Disability), in addition to the mainstream General Practice system can be more successful. This approach may not be cost neutral but will be developed as the equity gains may be worth a small investment.
% of Pacific children fully vaccinated at five years.		≥95%			
% of Pacific children accessing Well Child Tamariki Ora (WCTO) services and completing Core Checks (all checks by one year).	The early years of life set the foundation for lifelong health and wellbeing. The WCTO programme is a package of universal health services offered free to all New Zealand families/whānau for children from birth to five years. The programme includes 12 Core Checks.	≥90%			COVID-19 restrictions had a significant impact on the ability to deliver Core Checks and services have worked hard to catch up on missed Core Checks. HVDHB has recently reviewed its investment in its WCTO providers (Te Rūnanganui o Te Atiawa and Pacific Health Service 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 Check Programme (B4SC).	The purpose of the B4SC 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-19 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 years) 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 years).	≤5%			As a result of the COVID-19 lockdowns we lost 20% capacity in 2020 and (to date) 10% capacity in 2021. This means it is harder to catch up children who missed their appointments and maintain service for children already booked or due. The impacts of this lost capacity on caries is cumulative. For example, preventative work that wasn't done in 2020 may result in more caries in both 2020 and 2021. 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 five years.		CCDHB: ≥69% HVDHB: ≥85%			
% of Pacific children caries free at 12 years.		TBC			

Pacific Young People

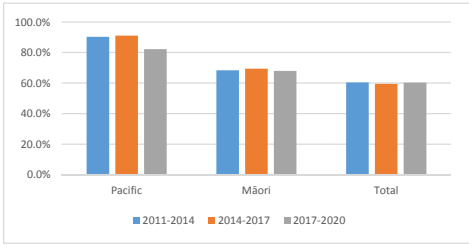
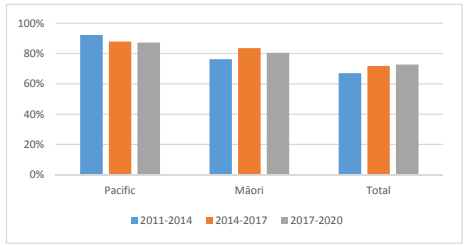
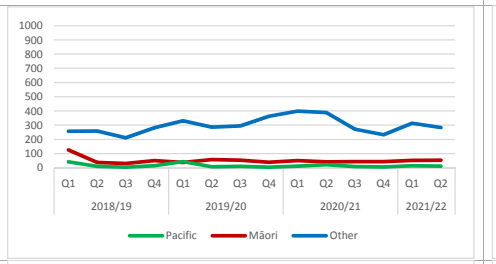
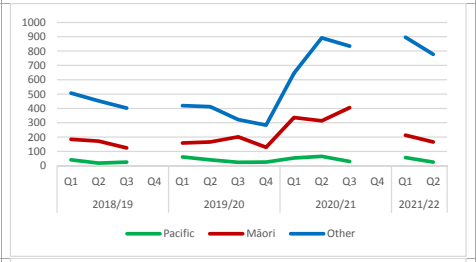
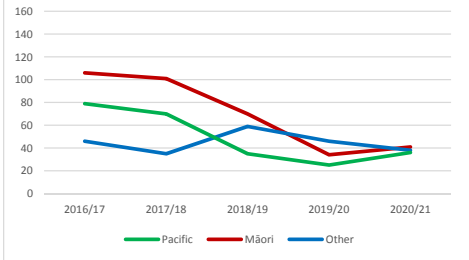
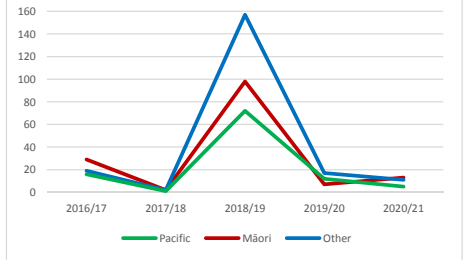
Pacific young people have timely access to services and programmes that enables them to grow into healthy adults and lead productive lives.

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 the Government's priority to make New Zealand the best place in the world to be a child and ensures the health system achieves health equity for Māori, Pacific and other underserved groups.	TBC			CCDHB and HVDHB are implementing improvements to identify and manage obesity earlier in a young person's 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 choices; and closer coordination with primary care, including delivery of immunisations.
Number of eligible Pacific young people's accessing community youth primary mental health services.	This measure focuses on improving and strengthening youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve: early identification of mental health and/or addiction issues; better access to timely and appropriate treatment and follow up; equitable access for Māori, Pacific and low decile youth populations.	TBC			The procurement for the Porirua YOSS was an incredibly successful process which disrupted traditional commissioning of services and looked to rangatahi from Porirua to be the decision makers with the DHB playing a supporting role. We look forward to working with Ora Toa and Partners Porirua to improve outcomes for Pacific youth. Integration of health services is critical and we will work to ensure youth services can meet all the care requirements of Pacific people and connect with existing services such as the Piki Pathway. There will be significant work done to bring youth functions together across the 2DHBs.
Number of Pacific students seen by School Based Health Services – routine health assessment.		TBC			

Pacific adults and ageing well

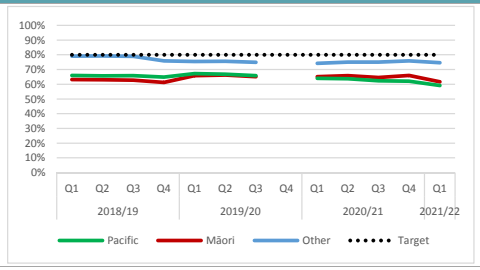
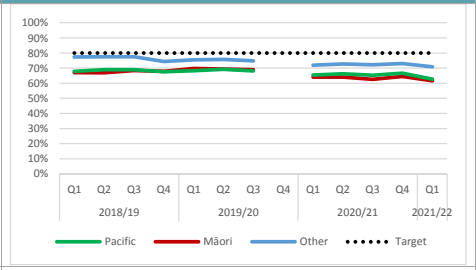
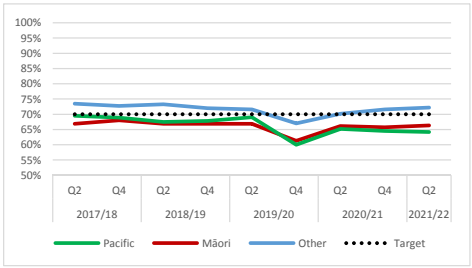
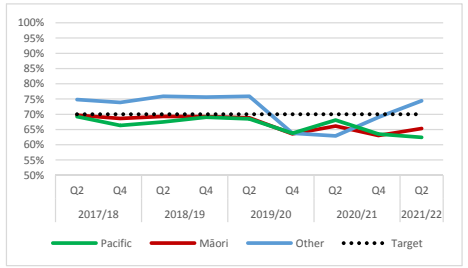
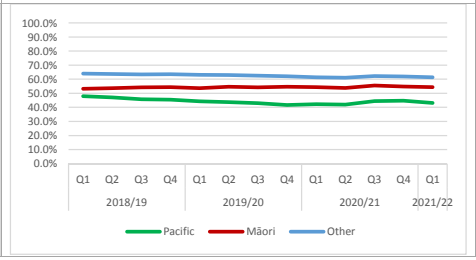
Pacific adults and elderly are actively engaged in their health care, live productive, active, culturally secure and quality long lives.

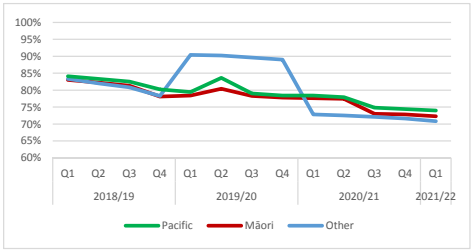
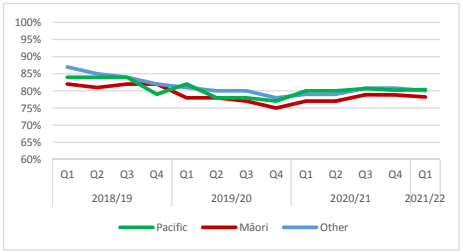
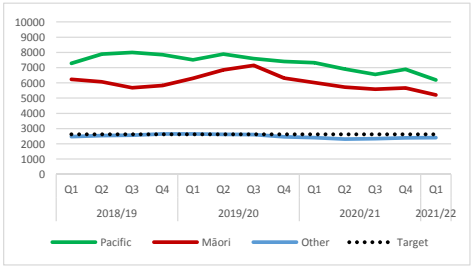
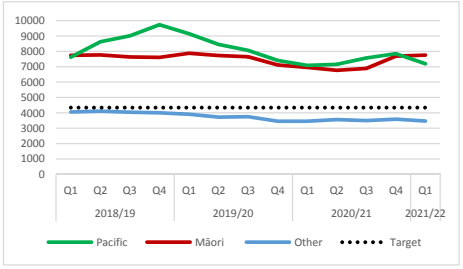
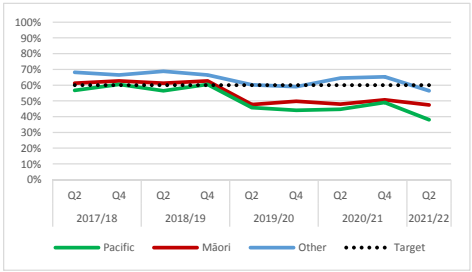
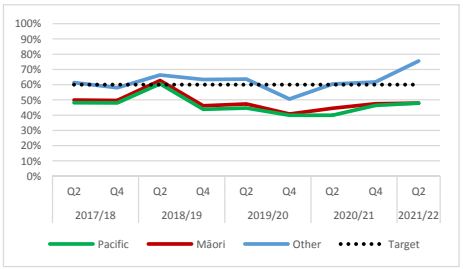
Areas of focus

- Work in partnership with key stakeholders to increase and encourage participation in screening programs (cervical, bowel, breast and other cancers) AND cessation support (smoking and drugs).
- Increased timely access to medications and pharmaceuticals by decreasing the number of prescriptions unfilled due to cost.

Sub-regional initiatives (2DHB)

- Developing and committing to an Equitable Commissioning Policy.
- Pacific workforce plan and recruitment strategy.
- Cultural competency training package.
- Community Localities, Neighbourhoods work.
- Regional Screening Services.
- Mental Health Projects.

Indicators	Rationale	Targets	CCDHB Performance	HVDHB Performance	Comments
% of eligible Pacific women (25-69 years) completing a cervical screen.	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 help 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 patients' appointments.
% of eligible Pacific women (50-69 years) completing a breast screen.		≥70%			
% of eligible Pacific population (60+ years) completing a bowel screen test.			Indicator to be developed to provide ethnicity data.		TBC

% 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 data.	Indicator to be developed to provide ethnicity data.	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 risk factor 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 services producing the best and most equitable health outcomes.				Across the 2DHBs we are strengthening nurse-led clinics and nurse capacity, including increases in the CVD risk assessment nursing hours to deliver checks every quarter. Opportunistic screening is undertaken outside of general practice, for example at the Bunnings Trade Breakfast where our PHOs checked workers blood pressures (this activity further identified and advised people to follow up with their GP due to high blood pressure results).
Ambulatory Sensitive Hospitalisation rate for Pacific adults aged 45-64 years (per 100,000 people).	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 activities to address equity gaps, with a particular focus on Pacific and young people who live with diabetes for longer and experience complications earlier.

Board Information – Public

16 February 2022

2DHB Quality & Safety – Clinical Governance and the Centre of Clinical Excellence

Action Required

The Boards note:

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

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

Strategic Alignment	2DHB Quality & Safety Framework
Presented by	2DHB Executive Director of Clinical Excellence – Dr Sarah Jackson
Purpose	Update the Board in relation to extending the scope from Clinical Governance to Clinical Excellence and the goals and aspirations for the Centre of Clinical Excellence.
Contributors	N/A

Executive Summary

1. On 1 December 2021 the Hutt Valley DHB's Quality, Service Improvement and Innovation (QSII) and Capital and Coast DHB's Quality, Improvement and Patient Safety (QIPS) departments were combined to form the Centre of Clinical Excellence (CoCE). This paper provides an overview of Clinical Governance, the reasons for extending the scope from Clinical Governance to Clinical Excellence and the goals and aspirations for the Centre of Clinical Excellence.

Strategic Considerations

Service	All 2DHB services are committed to delivering safe, quality care to patients and whānau, and ensuring staff safety.
People	Increase understanding of patient safety, quality improvement patient / whānau experience and recognising opportunities for learning.
Financial	Poor patient outcomes and harm can have a direct financial impact on the performance of our DHBs.
Governance	We will strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities.

Engagement/Consultation

N/A

Identified Risks

N/A

Attachment/s

1. Appendix 1 – COCE Vision Purpose & Values
2. Appendix 2 – Four Pillars of Clinical Excellence
3. Appendix 3 – Clinical Excellence Priorities

What is Clinical Governance?

2. Clinical Governance was first introduced in the United Kingdom in the late 1990s in response to major failures in the standard and delivery of patient care. It was seen as a key vehicle for developing a shared commitment to high-quality care. At this time, a definition for Clinical Governance emerged as:

> 'a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, creating an environment in which excellence in clinical care will flourish.'[1]

3. Definitions have continued to evolve over time, with a stronger emphasis on clinical governance being an integrated component of organisational governance and consumers being at the centre of continuous improvement.

> '*Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health, governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services*.'[2]

4. It is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.1 It requires a shared commitment from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward. It is more than a structure, although this is required to support clinical governance (and should be reviewed every three years). It should permeate every aspect of care in a DHB and all staff (clinical and non-clinical) should feel able to contribute to patient safety and quality improvement.

5. An effective clinical governance framework has four components. These are:

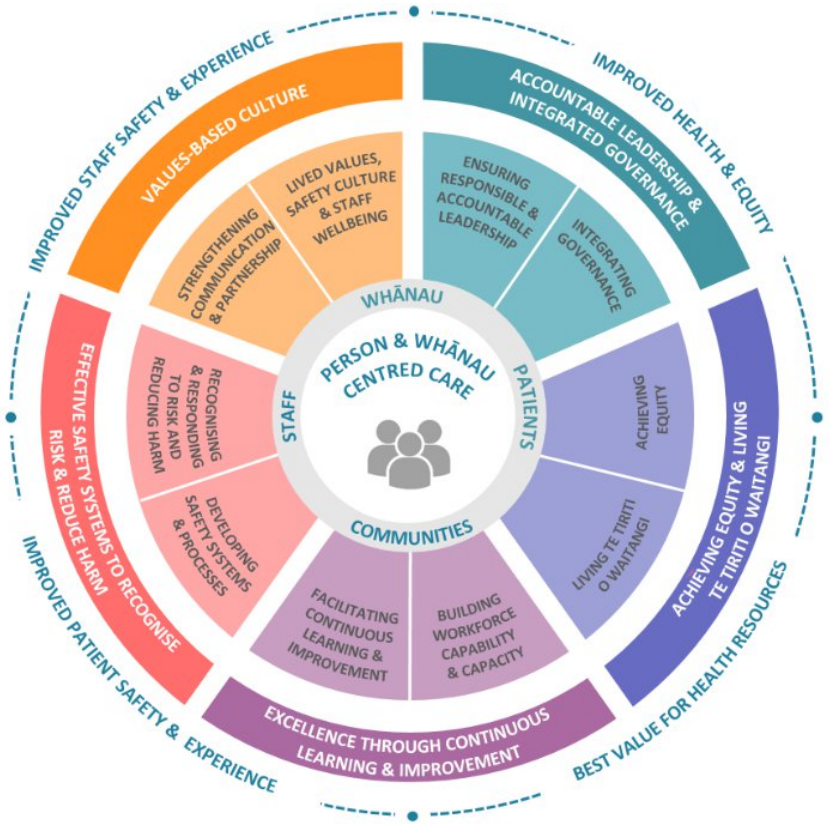
   - consumer engagement and participation
   - clinical effectiveness
   - quality improvement and patient safety
   - engaged effective workforce

6. The existing CCDHB Clinical Governance Model was developed in 2018 to clarify the structure and the reporting of quality and safety performance. This was to ensure that front line staff, clinical and

[1] Scally, Donaldson, et al 1998
[2] Australian National Safety & Quality Health Service Standards Second Edition 2017

non-clinical managers, the Executive and Board have the information to act to improve the quality of care delivered.[3]

7. The Clinical Governance Model is one of the strategic documents that sit below the 2DHB Quality & Safety Framework (The Framework), which was approved by the Board in February 2020. The Framework directly responds to the 2DHB CEO's vision of an overarching framework that will drive programmes of quality and safety, reduce harm, drive clinical excellence, and reflect the interdependencies between staff and patient safety.



8. The Framework has six domains that set the strategic direction for quality and safety:

<u>Person & Whānau Centred Care</u>

9. To provide care that is respectful and responsive to individual and whānau needs and will value and partner in designing and delivering care.

<u>Accountable Leadership & Integrated Governance</u>

10. To strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across the health and disability system.

<u>Achieving Equity & Living Te Tiriti o Waitangi</u>

11. To work to achieve equity. We recognise the status of Māori as tangata whenua and the obligations that arise from Te Tiriti o Waitangi.

[3] Review of Clinical Governance at Capital & Coast DHB – Dr Mary Seddon, Seddon Healthcare Quality Ltd

Excellence Through Continuous Learning & Improvement

12. To develop our people, our systems and our processes, by continuously learning and improving in order to support excellence.

Effective Safety Systems to recognise Risk & Reduce Harm

13. To proactively use data and information to recognise and manage risk and reduce harm, to create a safe and evidence based system which supports excellent experience and outcomes.

Values-Based Culture

14. To uphold our values in everything we do; the way we act, engage and make decisions.

Centre of Clinical Excellence

What is a Centre of Clinical Excellence?

15. In 2020 the 2DHB CEO proposed that a Centre of Clinical Excellence should be formed combining the functions of QIPS and QSII. This would result in clinical governance being expanded to clinical excellence, a change from a focus on structure and systems to the continual pursuit of excellence resulting from innovation, continuous improvement and empowering patients and their whānau.

16. Centres of excellence are a relatively new concept in health. A centre of excellence is a team of people within an organisation who provide thought leadership and direction in a specific area to drive improvement. There are some core functions that a centre of excellence should have:

- Well defined purpose
- Expertise in specific subject
- Provision of leadership and direction in this area of expertise
- Provision of learning and oversight in this area of expertise
- Establish and promote best practises
- Are a place for accumulating and creating knowledge

17. Clinical excellence is difficult to define and aspirational due to its dynamic and multi-dimensional nature. It should be regarded as a journey, not a destination. A centre of clinical excellence should continually pursue excellence by:

- Leading a quality and safety culture
- Empowering and supporting teams to improve care by innovation and continual learning
- Supporting and facilitating dissemination of best practise
- Identifying, monitoring and promoting improvements in quality of care
- Providing education and training
- Empowering consumers and their whanau

Developing the Centre of Clinical Excellence

18. In 2021, as the CoCE was being created, the leadership team worked to develop a purpose and vision. Information, ideas and concepts were gathered at a hui in May 2021 with both HVDHB and CCDHB teams. Being clear about the function of the centre of clinical excellence and understanding the changes required to provide excellent, equitable healthcare for all was crucial in developing the CoCE's purpose and vision (Appendix 1). From this purpose the four pillars of the CoCE were identified, being pro-equity, partnership, innovation and transformation (Appendix 2). Embedding the 2DHB pro-equity approach is vital, as is moving to be an organisation which has an open, transparent, supportive culture, is committed to learning, where patients' interests are paramount

and all healthcare professionals treat each other with respect and find joy in work. Healthcare needs to be transformed, not improved.

19. Along with the purpose and vision, CoCE's values have also been developed and are based on the HVDHB and CCDHB values (appendix 1). This work was done by the leadership team of the CoCE to ensure that the interpretation of the values would be meaningful for the whole team.

20. After an extensive change process, with consultation with both teams and the wider organisation, the CoCE was launched on 1 December 2021.

Centre of Clinical Excellence -Aims

21. The CoCE aims to provide leadership in improvement and innovation, patient safety and quality, patient experience, clinical governance and research, and will partner with all (patients, whānau, staff and external agencies) to support culture change and transformation of the quality of care across the 2DHBs.

22. The centre will also implement the 2DHB Quality & Safety Framework. It is crucial we become a learning organisation where innovation and quality improvement is embedded in the practice of all staff. Leadership is influential in shaping a culture of high quality, safe and compassionate patient care and so the centre will need to work closely with Organisational Development to develop leaders in all areas and levels of the organisation. Innovation should be a core part of all roles and all data on quality and safety needs to be available to everyone involved in all services.

23. In creating a Centre of Clinical Excellence, there are a number of other benefits to be realised, including:

    - Embedding Te Tiriti o Waitangi principles by walking alongside Māori, to help provide culturally safe care where Māori aspirations are met
    - Continued development of a strong safety culture where learnings are shared and harm minimised
    - Creating an environment where people are encouraged to think differently, where innovation is encouraged and celebrated
    - Increasing collaboration and communication across the 2DHBs
    - Supporting leadership development in partnership with 2DHB People and Capability

Priorities

24. Priorities for the first six months of 2022 have been established (Appendix 3). A strategy for 2022-2025 is being developed and will be presented to the Board once completed. As well as having a pro-equity approach, there are key functions that each team will be focusing work around:

    <u>Improvement and Innovation</u>

    - Building a culture of continuous improvement and innovation and capability across the 2DHBs.
    - Embedding improvement training so that frontline staff have the tools to continually improve care.

Patient Safety and Quality

- Development of a learning and dissemination strategy to ensure that recommendations are implemented and learnings disseminated.
- Strengthening our approach to adverse event reviews to ensure standardised systems and processes are used across the 2DHBs.

Governance

- Development of a performance and reporting framework to ensure that data is utilised to inform improvement
- Having an integrated 2DHB Clinical Governance approach

Research

- Strengthening our commitment to health delivery research opportunities, particularly those that aim for equitable health outcomes

Consumer Engagement

- Driving patient and whānau centred care in all aspects of service provision using a co-design approach

Next Steps

25. Phase two of the change process is underway. This includes a review of the CoCE's medical leadership and a plan to transfer a core function of a CoCE, Clinical Training, from Capability Development. This will enable a communication strategy to be developed to ensure that staff are able to speak up for safety, are having open conversations and ensure that patients are asked 'what matters to you'.

26. As a centre of clinical excellence is a new concept to both DHBs there will be a formal internal launch to socialise the centre at the end of February, co-ordinated by the Communications team. This will be supported by a number of communication outlets, e.g. daily dose, health matters and presentations at leadership meetings to raise visibility the centre. Once phase two is completed an external launch of CoCE will occur with support from the Communications team.

27. The development of a Centre of Clinical Excellence at 2DHB will provide an opportunity to support transformation of healthcare in the Wellington region and also inform changes at a regional level. The support of the Board, CEO and ELT is vital in enabling the centre to support patients and their whānau, healthcare staff and the wider community in transforming care to one which is equitable and excellent.