PUBLIC

AGENDA

Held on Wednesday 1 September 2021
Time: 9.30am
Location: Zoom
Zoom Meeting ID: 876 5068 1844

2DHB CONCURRENT BOARD MEETING

	Item	Action	Presenter	Time	Min	Pg
1	**PROCEDURAL BUSINESS**			**9.30**		
1.1	Karakia		All members			2
1.2	Apologies	**NOTE**	Chair			
1.3	Public Participation Petitions – Te Awakairangi Birthing Centre	**NOTE**	Chair			3
1.4	Continuous Disclosure 1.4.1 Board Interest Register 1.4.2 ELT Interest Register	**NOTE**	Chair			4 8
1.5	Minutes of Previous Concurrent Meeting	**APPROVE**	Chair			10
1.6	Matters Arising	**NOTE**	Chair			22
1.7	Chair's Report and Correspondence	**NOTE**	Chair			
1.8	Chief Executive's Report	**NOTE**	Chief Executive			23
1.9	Board Work Plan 2021/2022	**NOTE**	Chair			42
2	**DHB Performance and Accountability**			**10.00**		
2.1	HVDHB Financial and Operational Performance Report – June 2021 3.1.1 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			46 49
2.2	CCDHB Financial and Operational Performance Report – June 2021 3.1.2 Report	**NOTE**	Chief Financial Officer Director Provider Services Director Strategy, Planning and Performance			95 98
3	**STRATEGY**			**10.15**		
3.1	Pro-Equity Commissioning Policy and Communications and Engagement Strategy for Pro-equity 3.1.1 Attachment 1 3.1.2 Attachment 2	**NOTE**	Director Strategy, Planning and Performance			140 144 156
4	**DECISION**			**10.45**		
4.1	Sale and Supply of Alcohol Act 2012 and Smokefree Aotearoa 2025 Goal 4.1.1 Attachment 1 4.1.2 Attachment 2	**APPROVE**	Chair Chief Executive			157 159 176
4.2	3DHB Sustainability Strategy 4.1.1 Attachment 1 4.1.2 Attachment 2 4.1.3 Attachment 3 - **Resource Centre**	**APPROVE**	Chief Financial Officer			190 193 203
	OTHER			**11.00**		
5.2	General Business	**NOTE**				
5.3	Resolution to Exclude the Public	**APROVE**				206

Next concurrent Board meeting:
Date: Wednesday 6 October 2021, **Location:** Boardroom, Level 11 Grace Neill Block, Welligton Hospital, **Time:** 9am

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!

Board Information

1 September 2021

Petitions – Te Awakairangi Birthing Centre	

Action Required

The HVDHB Board agrees:

a) to receive the petition and thank Hutt Families for Midwives for the petition

The HVDHB Board notes:

a) the petition received by HVDHB on 23 August 2021 in relation to Te Awakairangi Birthing Centre

b) the list of e-signatures and the associated document titled 'Evidence paper to support a publicly funded Birthing Centre in the Hutt Valley', which are available to Board members in the Diligent Resource Centre for the meeting dated 1 September 2021.

Presented by	Board Secretary, Sally Dossor
Purpose	For the Board to receive the petition by Hutt Families for Midwives in relation to Te Awakairangi Birthing Centre.

Executive Summary

1. On 22 August 2021, the HVDHB received a petition in relation to Te Awakairangi Birthing Centre in Lower Hutt. The petition (now closed) was opened by Hutt Families for Midwives through the Change.org website and can be located online at: https://www.change.org/p/minister-of-health-save-the-te-awakairangi-birthing-centre. A total of 6,029 e-signatures were received on the petition.
2. Hutt Families for Midwives are an advocacy group and describe themselves as 'a group of families in the Hutt taking action to see how we can save our birthing centre' (refer to https://www.facebook.com/huttfamiliesformidwives/ and https://birthhub.weebly.com/save-our-birth-centre.html).
3. The petition seeks the following:

   As Ministers, Associate Ministers, DHB Chief Executive and DHB Board members, we are asking you to urgently provide funding to save the Birthing Centre from closing.

4. The list of e-signatures and the associated document titled 'Evidence paper to support a publicly funded Birthing Centre in the Hutt Valley' are available to Board members in the **Diligent Resource Centre** for the meeting dated 1 September 2021, and available to members of the public upon request to the Board Secretary (boardsecretary@ccdhb.org.nz).
5. Chris Bishop MP has also opened a petition called 'Save our birthing centre' that (at the time the Board papers were published) remains open, and therefore has not been presented to HVDHB. The petition is located here: https://chrisbishop.national.org.nz/saveourbirthingcentre.

Attachments

N/A

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

26/08/2021

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

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

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

CAPITAL & COAST AND HUTT VALLEY DISTRICT HEALTH BOARDS

Interest Register

EXECUTIVE LEADERSHIP TEAM

3 AUGUST 2021

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

Wednesday, 25 August 2021

Chris Kerr *Chief Nursing Officer 2DHB*	• Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager • Adjunct Teaching Fellow, School of Nursing, Midwifery and • Health Practice, Victoria University of Wellington
Karla Bergquist *3DHB Executive Director MHAIDS*	• Former Executive Director, Emerge Aotearoa Ltd • Former Executive Director, Mind and Body Consultants *(organisations that CCDHB and HVDHB contract with)*
Sally Dossor *Director of the Chief Executive Office & Board Secretary*	• Partner is a Director of Magretiek, BioStrategy and Comrad
Paul Oxnam *Executive Clinical Director MHAIDS*	• Member, NZ College of Clinical Psychologists
Rachel Gully *Director People, Culture & Capability 2DHB*	• NIL
Sue Gordon *Transformation Director*	• Board Member, Netball New Zealand

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HUTT VALLEY DHB / Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**MINUTES** Held on Wednesday 4 August 2021 Location: Wellington Regional Hospital, Level 11 Boardroom, Grace Neil Block Zoom: 876 5068 1844 Time: 9:00am
2DHB CONCURRENT BOARD MEETING	**PUBLIC**

PRESENT

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

APOLOGIES

Yvette Grace
Keri Brown
Ken Laban

IN ATTENDANCE

Hutt Valley and Capital & Coast DHB

Rosalie Percival	Acting Chief Executive Chief Financial Officer
Arawhetu Gray	Director Māori Health
Karla Bergquist	Executive Director Mental Health, Addictions and Intellectual Disability Service
Paul Oxnam	Executive Clinical Director Mental Health, Addictions and Intellectual Disability Services
Sarah Jackson	Director of Clinical Excellence
Joy Farley	Director Provider Services
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

Procedural note:

The Chair re-ordered the agenda to bring item 2.1 (Te Upoko O Te Ika Māori Council (TUIMC)) forward to follow agenda item 1.2.

PUBLIC

1 PROCEDURAL BUSINESS

1.1 KARAKIA

The Board opened the meeting with a karakia.

The Chair welcomed and introduced the new members of the Executive Leadership Team:

- Sue Gordon, Director Transformation
- Rachel Gully, Director People and Culture
- Paul Oxnam, Executive Clinical Director MHAIDS
- Matthew Parr, Acting Chief Executive

1.2 APOLOGIES

As noted above.

2 TE UPOKO O TE IKA-A-MAUI MĀORI COUNCIL (TUI MC)

2.1 TE UPOKO O TE IKA A MAUI MĀORI COUNCIL (TUI MC) – TERMS OF REFERENCE

Members of TUIMC: Jack Rikihana (Chair), Liz Mellish and Mark Te One, presented.

The Boards note:

a) the establishment of Te Upoko o te Ika-a-Maui Māori Council (TUI MC)

b) the Agreement and Terms of Reference for TUI MC

Notes:

- The Chair of TUI MC gave an overview of the history of Māori Partnership Boards and the establishment of Te Upoko o te Ika-a-Maui Māori Council (TUI MC)
- TUI MC discussed issues that mana whenua face in Wellington and the Hutt Valley. Māori have been severely impacted by delivery of health care services over time and effects of this are still ongoing. This requires systemic change across the 2DHBs.
- Acknowledged this important occasion signalling coming together. The signing of the Terms of Reference document represent promises, ambitions, respect and trust between TUI MC and the Boards.
- The Chair of TUI MC presented the taonga to the Chair of the Boards
- The Chair of the Boards thanked TUI MC for their presentation and support and the Boards look forward to partnering with TUI MC to improve health outcomes for Māori in our community.

1 PROCEDURAL BUSINESS *(CONTINUED)*

1.3 PUBLIC PARTICIPATION

Nil.

1.4 CONTINUED DISCLOSURE

1.4.1 COMBINED BOARD INTEREST REGISTER

1.4.2 COMBINED EXECUTIVE LEADERSHIP TEAM INTEREST REGISTER

PUBLIC

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 7 July 2021 (public).

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

1.6 MATTERS ARISING FROM PREVIOUS CONCURRENT MEETINGS

- **21-P03**: Note that Arawhetu Gray gave an update on data sovereignty at the July Board concurrent meeting. The Chair noted that it is an ongoing process at the regional and national level and is being worked through with Māori partners.

1.7 CHAIR'S REPORT AND CORRESPONDENCE

The Chair noted:

- that the Boards have entered a Memorandum of Understanding with two mana whenua partners – Ngāti Toa and Te Ātiawa noting this is a significant step forward to ensuring we work closely with mana whenua partners across the region. 'Te Rangapū Ahi Kā Roa Relationship with the District Health Boards of the Wellington Region' is an agreement between Te Rūnanganui o Āti Awa ki te Upoko o te Ika a Maui Inc, Te Rūnanga o Ngāti Toa Rangatira, and the two DHBs.
- DHB Chairs and CEs continue to meet and a focus is on what all DHBs need to be doing to support Health New Zealand and the Māori Health Authority. There is strong commitment to supporting the transition.
- It is the intention for Māori (Iwi, hapu, Māori communities and providers) in each region to establish how they partner with Health New Zealand and the Māori Health Authority.
- DHB Chairs are continuing to meet with the Minister, which is one means to ensure shared awareness of system pressure, challenges and opportunities.

1.8 CHIEF EXECUTIVE'S REPORT

*The paper was taken as **read** and the Acting Chief Executive was available for questions.*

Notes

- RSV levels are beginning to decline after recent spike.
- New Greater Wellington Regional Council bus service (the Wellington Hospital express from the Railway Station) is being promoted as part of promoting the travel action plan.

1.9 BOARD WORK PLAN 2021

The Board **noted** the work plan for the rest of 2021.

3 DHB PERFORMANCE AND ACCOUNTABILITY

3.1 HVDHB FEBRUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTREPORTS

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

PUBLIC

The HVDHB Board noted:

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

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

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

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

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

	Moved	**Seconded**	
HVDHB	Prue Lamason	John Ryall	**CARRIED**

3.2 CCDHB JANUARY 2021 FINANCIAL AND OPERATIONAL PERFORMANCE REPORTS

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

The Capital & Coast DHB Board noted:

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

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

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

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

	Moved	**Seconded**	
CCDHB	Brendan Boyle	Chris Kalderimis	**NOTED**

Notes:

- It was noted that once extraordinary items are taken out, both DHBs are tracking to budget.
- An explanation was asked for regarding the letter of comfort, which the CFO clarified and noted the rationale is available to members in the FRAC papers.
- An update was asked for on the HVDHB maternity upgrade, and it was noted that regular progress is reported to MCPAC.

4 STRATEGY

4.1 STRATEGIC PRIORITIES UPDATE

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

The Boards note:

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

i. Governance

ii. Programme and Project Development

iii. Performance Monitoring

iv. Communications and Engagement

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

Notes:

- Focus continues on priority areas:
    - 2DHB Hospital network and clinical configuration work – while funding from Government is needed, it gives a positive way forward to relieve some of the pressure that we are under.
- Key work continues in the commissioning and the community area.
- Workforce is a key enabler.
- The Boards asked if the data is available for each of the three equity groups and a request was made for the future localities updates to include an update on the ongoing initiatives for Wainuiomata.

5 REPORTING

5.1 MAORI HEALTH UPDATE – QUARTER 4

*The paper was taken as **read** and the Director, Māori Health was available for questions.*

The Boards noted:

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

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

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

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

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

	Moved	**Seconded**	
CCDHB	'Ana Coffey	Chris Kalderimis	**CARRIED**
HVDHB	Naomi Shaw	Ria Earp	**CARRIED**

Notes:

- The team will be working with TUI MC to ensure they have what they need to work with the Māori Health Authority (MHA) and Health New Zealand (HNZ), in preparation for 1 July 2022.
    - The Māori health team is now established and with increased resource and capability – real focus will be brought to implementing the Te Pae Amorangi and Taurite Ora. It remains a small team (17FTE) across our workforce of 8000 so it requires focus and collaboration.
    - The work programme for the team has changed slightly in light of HNZ/MHA announcement. The team will ensure that the work programme allows for "business as usual"

implementation of Te Pae Amorangi and Taurite Ora, but also in preparing 2DHBs for the changeover to HNZ and MHA on 1 July 2022.

- Continuing with a number of initiatives to get Māori into our health workforce, and in particular to grow our Māori leaders. One priority areas is to get our ethnicity data correct.
- Proof of concept testing services, such as Whare ki te Whare, have been established to try to address and improve Did Not Attend (DNA) rates.
- We have been working with tangata whaikaha (Māori with disabilities) on what is needed across the 3DHBs to make a difference in outcomes for them.
- Work is ongoing in relation to the Māori and Pacific midwifery collective in Porirua - Te Ao Marama Tapui. This programme, follows the same principle as the Covid programme, trusted faces and trusted places, has been very successful and the service will be used as a prototype.

5.2 PACIFIC HEALTH & WELLBEING STRATEGIC PLAN 2020-2025 UPDATE: A FOCUS ON THE 2DHB PACIFIC HEALTH WORKFORCE

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

The Boards noted:

(a) the Pacific Directorate are focussed on addressing the six priority areas defined in the Pacific Health & Wellbeing Strategic Plan 2020 – 2025. This paper provides an update on the approach to developing the 2DHB Pacific Health Workforce.

(b) development of a Pacific workforce is linked to the ability of the DHB's to address Pacific health disparities.

(c) there are a number of initiatives that need to be implemented to recruit, retain, and develop the Pacific Health Workforce.

Notes:

- Workforce is one of the six key pillars to the strategy and staff are putting in significant effort in this space.
- There are three focus areas in workforce improvement – recruitment, retention and promotion.
- Work is being done in association with Allied Health to ensure that pathways are created for service support staff to progress to other roles.
- Conversations on how to attract Pacific people into midwifery – understanding that professional requirements can be barriers and work is being done on how the training environments can be more receptive to learning and cultural needs of Pacific people.
- Workforce development and capability is a focus as we prepare for the new health system structure.

	Moved	**Seconded**	
CCDHB	'Ana Coffey	Roger Blakeley	**CARRIED**
HVDHB	Prue Lamason	Ria Earp	**CARRIED**

PUBLIC

6 UPDATES

6.1 DSAC UPDATE FROM MEETING DATED 21 JULY 2021

The Chair of DSAC gave a verbal update and was available for questions.

The Boards approved:

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

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

The Boards noted:

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

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

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

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

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

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

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

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

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

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

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

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

Item 3.5 – Mental Health and Addiction Commissioning Forum

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

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

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

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

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

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

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

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

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

Item 4.2 – 3DHB MHAIDS Service Performance Update

(a) the attached data report from MHAIDS.

Notes:

- The Chair of DSAC noted the positive feedback from members of the Sub-Regional Disability Group regarding access to management in the 2DHB.
- The Chair of DSAC commended staff on the 3DHB Suicide Prevention Postvention Annual Action Plan 2021/2022 and noted it was important that lived experiences have formed part of the action plan. There is still work to do in the suicide prevention space that understands and meets the needs of our Disability Community.
- Prue Lamason noted previous concerns raised in relation to the loss of disability car parking in the CBD with the implementation of Let's Get Wellington Moving (LGWM) initiative. Prue has raised these concerns with the Chair of LGWM who would ensure that those concerns were brought to the attention of the wider LGWM Board. Staff will inform SRDAG of this.

	Moved	**Seconded**	
CCDHB	'Ana Coffey	Roger Blakeley	**CARRIED**
HVDHB	Prue Lamason	Ria Earp	**CARRIED**

6.2 HSC UPDATE FROM MEETING DATED 28 JULY 2021

The Boards noted:

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

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

Item 2.2 Kāpiti Community Health Network update

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

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

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

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

Item 3.1: Health Outcomes for Kāpiti Residents

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

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

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

Item 3.2: Localities and Community Networks – Our Approach

(a) our approach to localities and community networks

Item 4.1: Regional Public Health Report

(a) this regular update from Regional Public Health

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

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

(a) the summary from two key reports:

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

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

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

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

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

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

(f) overall results for CCDHB and HVDHB demonstrates:

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

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

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

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

Notes:

- The Chair of HSC noted the positive work of the Kāpiti Community Health Network and highlighted successes and the positive shift in the community regarding the progress that has been made.
- Discussed capacity issues in primary care that need to be addressed, noting particularly the shortage of PHOs and progress and options being trialled regarding specialist care in localities.
- Highlighted discussion on vaping and associated harms and whether there are opportunities for DHBs to collectively advocate for change.

	Moved	**Seconded**	
CCDHB	'Ana Coffey	Roger Blakeley	**CARRIED**
HVDHB	Prue Lamason	Ria Earp	**CARRIED**

Josh Briggs left the meeting at 11.05am.

6.3 COVID VACCINE UPDATE

The General Manager – COVID response presented.

The Board **noted** the presentation on the Covid vaccination programme to date.

Covid Vaccintation Programme Update.

Notes:

- Vaccine delivery is on track
- Various initiatives have been established to promoted vaccinations including one for disability. Pacific events have been well received.
- Tristram Ingham tabled a report on vaccination rates for disabled people

Action: Staff to respond to the report tabled by Tristram Ingham and provide information on what financial support is available for people getting vaccines.

PUBLIC

7 OTHER

7.1 2022 BOARD AND COMMITTEE DATES AND BOARD WORK PLAN

*The paper was taken as **read**.*

The Boards approved:

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

The Boards note:

a) the meeting schedule is to June 2022 only, due to the timing of the health system reform
b) the HVDHB and CCDHB Board meetings will be held concurrently
c) the HVDHB and CCDHB Finance, Risk and Audit Committee (FRAC) meetings will be held concurrently
d) the location of all meetings will alternate between the Hutt Hospital and the Wellington Regional Hospital
e) the meeting dates and approach for the Heath System Committee (HSC) and Disability Support Advisory Committee (DSAC) involves:
    i. one scheduled meeting for 16 March 2022 (HSC morning and DSAC afternoon)
    ii. one placeholder scheduled for 8 June 2022 noting that the Chair will make a decision (in consultation with the Committee Chairs) on whether the meeting is required, once there is greater clarity on the work programme required for 2022 and the transition to Health NZ.
f) the draft 2022 Board Work Plan in attachment 2 which will be updated as progress on the strategic priorities is made and the health system reform progresses.

	Moved	**Seconded**	
HVDHB	Prue Lamason	Naomi Shaw	**CARRIED**
CCDHB	Roger Blakeley	‘Ana Coffey	**CARRIED**

7.2 GENERAL BUSINESS

Nil.

7.3 RESOLUTION TO EXCLUDE THE PUBLIC

	Moved	**Seconded**	
HVDHB	Wayne Guppy	Richard Stein	**CARRIED**
CCDHB	Chris Kalderimis	‘Ana Coffey	**CARRIED**

Meeting concluded at 11.47am.

8 NEXT MEETING

Date: 1 September 2021, **Location:** Ratonga Rua o Porirua, **Time:** 9:30am

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

DATED this day of 2021

PUBLIC

David Smol
BOARD CHAIR

MATTERS ARISING LOG AS AT 26/08/2021

Action Number	Date of meeting	Assigned	Status	Date Completed	Meeting	Agenda Item #	Agenda Item title	Description of Action to be taken	Status
21-P03	7-Apr-21	Chief Digital Officer	In progress		Board - Public	3.2	Māori Health Strategy Reporting	Māori data sovereignty paper to be shared with Board when it is appropriate.	The issue is still a work in progress with all regional Directors Maori, Iwi, and the Ministry of Health continuing discussions. Refer update oral update at 7 July 2021 Board meeting at item 6.3 of the minutes.
21-P07	2-Jun-21	Director Provider Services Director Strategy, Planning and Performance	In progress		Board - Public	4.1	HSC Update	Management to continue to raise lowering of the age for screening for Māori and Pacific with the Ministry and provide keep Board members informed of any progress.	Oral update from management to be provided as appropriate.
21-P08	4-Aug-21	Director Strategy, Planning and Performance	In progress		Board - Public	6.3	COVID Vaccine Update	Staff to respond to the report tabled by Tristram Ingham and provide information on what financial support is available for people getting vaccines.	Email response in relation to the report was provided on 8 August 2021. The access to transport and other support costs to attend a vaccine is part of the screening process when people are booking. There has been no system for claiming of costs and if the person does not identify a need, these costs will not be met. This matter is now being considered by Minister Sepuloni and Disability Support Services, with regards to access to support and ability to claim for costs incurred. At this stage we have no further information.

Chief Executive's Report

Prepared by: Fionnagh Dougan, Chief Executive

1 Introduction

This report covers the period from 23 July 2021 to 23 August 2021.

2 COVID-19 Update

2.1 Current cases

Number of cases:
Number of days without cases, HVDHB: 277
Number of days without cases, CCDHB: 0

2.2 Managed Isolation Facilities

Number of COVID-19 cases in managed isolation: 11
Number of guests (**as 22/08**): 11

- Bay Plaza: 0
- Grand Mercure: (11 in quarantine)

2.3 Testing statistics (to end 22/08/2021)

	2DHB	HVDHB	CCDHB
Tests performed to date	227,692	56,932	170,760
People tested to date	137,259	36,209	101,050
Testing coverage	30%	25%	32%
Tests performed 18/08 – 23/08	14,577	3,110	11,467

2.4 Testing statistics by ethnicity (to end 22/08/2021)

	2DHB		HVDHB		CCDHB	
	Māori	Pacific	Māori	Pacific	Māori	Pacific
Tests performed to date	25,970	17,807	8,941	5,352	17,029	12,455
People tested to date	16,211	10,914	5,750	3,308	10,461	7,606
Testing coverage	33%	34%	29%	30%	37%	36%
Tests performed last week (17/07-23/07)	1,541	1,143	461	290	1,080	853

2.5 Vaccinations (to end 22/08/2021)

	2DHB	HVDHB	CCDHB
Total immunisations	225,469	73,329	152,140
Dose 1 total	155,503	47,118	108,385
Completed total	70,308	26,667	44,290
Group 1 people served	5,099	695	4,463
Group 2 people served	28,971	9,497	19,869
Group 3 people served	74,055	28,043	46,127
Group 4 people served	47,697	9,253	38,527

2DHB group	Coverage
Māori	35%
Pacific	42%
Asian	46%
Other	38%

3 Communications and Engagement

3.1 External engagement with partners and stakeholders

Focus for the past month has been ongoing proactive engagement, outreach and events for the COVID-19 vaccination programme, with the 2DHBs and partners hosting a range of festival days. The 2DHB Directors of Māori Health and Pacific Health attended a visit from the Prime Minister to Ora Toa's vaccination clinic in Porirua. Following the community COVID-19 cases announced on 17 August and the change to alert level 4, engagement increased with cross-sector agencies, and health and community leaders to enable increased testing and vaccination across the region.

The 2DHBs signed 'Te Rangapū Ahi Kā Roa Relationship with the District Health Boards of the Wellington Region', an agreement between Te Rūnanganui o Āti Awa ki te Upoko o te Ika a Maui Inc, Te Rūnanga o Ngāti Toa Rangatira, and the two DHBs. This agreement recognises the two parties to Te Tiriti o Waitangi – iwi/hapū Māori, represented by mana whenua, and the Crown represented by the two DHBs.

Members of the executive team and the Wellington Hospitals Foundation hosted the Governor General for a tour of the Te Wao Nui hospital. Executive leaders also hosted the Labour Party's Health, Wellbeing, and Social Services caucus committee for a presentation on the child health service and a tour of the new hospital, and supported our Pacfic partners during the caucus' visit to the Pacific vaccination clinic in Porirua.

3.2 External communications and engagement – press releases and pitches

DHB	Subject	Outlet / Channel
2DHB	2DHB orchestra	PR / websites / social media

2DHB	Ramping up of COVID-19 vaccinations	PR / websites / social media including festival days for the disabled community
2DHB	Industrial action	Website / social media

3.3 Health promotion campaigns

COVID-19 vaccination programme

The 2DHBs have now reached a significant milestone of over 200,000 vaccine doses in the Wellington region.

We continue to support the Ministry of Health's nationwide rollout with local and regional communication via digital channels, media, events, and targeted engagement for Māori, Pacific people, and the disabled community.

The vaccination programme to 16 August is delivering at 101% against plan, with additional primary care providers brought on and ongoing community outreach during August and September, ahead of mass vaccination events planned in October and early November.

We now have a total of 36 clinics in the Wellington region - a mix of GP, Pharmacy, community vaccination centres, and outreach/pop up sites. The alert level 4 lockdown put a pause on COVID-19 vaccinations on 17 August but sites reopened the following day with level 4 protocols in place. Further sites and events are now being considered.

Age bands opened up

The 40+ age band opened on 18 August, on 25 August the 30+ age band opens, and from 1 September all remaining eligible ages will open. Cabinet has now approved the vaccine for use for with 12-15 year olds (when booked with parents/guardians in eligible age groups).

Supporting our equity populations

Ongoing work continues with the vaccination programme's equity leads to provide supporting communications and engagement, including outreach and events, for Māori, Pacific, and disabled communities.

Māori-led clinics provide a kaupapa Māori approach to vaccinating, incorporating an all-of-whānau approach under the 'trusted faces in trusted places' model.

Māori health partners and providers are operating two marae-based clinics located at Wainuiomata Marae in Lower Hutt and Maraeroa Marae in Porirua, as well as a Māori-led clinic at Waiwhetū in Lower Hutt. The Porirua Community Vaccination Centre is run by Ora Toa, a Māori PHO, and Māori provider Hora Te Pai has partnered with Tū Ora PHO to set up the Kāpiti-based Community Vaccination Centre.

A further 17 outreach projects are currently being coordinated across the region to reach targeted groups and, as at 16 August, we have provided at least one dose of the vaccine to more than 25% of all Māori in the region.

The Pacific Health team working alongside Pacific providers and PHOs are organising Pacific Festival Days – with block-booking for Pacific people. As at 16 August, 35% of Pacific people in our region have received at least one dose of the vaccine. We will continue to hold festival days for the remainder of the year, working with Pacific providers, PHOs, churches and community groups. A further 20 additional Pacific festival events are planned, with 7 confirmed.

Accessible events

The 2DHB Disability team has rolled out tailored events at vaccination clinics for disabled people and those with impairments or long-term conditions throughout August, and a further 14 events are booked in September. We also continue our outreach programme, including phoning people in the disability community to invite them to be vaccinated.

Overall 42 events are scheduled, plus a further four Autism-specific clinics with Autism NZ at their purpose-designed building in Petone.

At these events, additional supports and accommodations are provided to make vaccination as accessible and safe as possible. This includes NZSL interpreters for Deaf and hard-of-hearing community events, low-sensory options (dimmer lighting and no music) for Autistic people, and other modifications as needed. These events can continue with Alert Level 4 protocols.

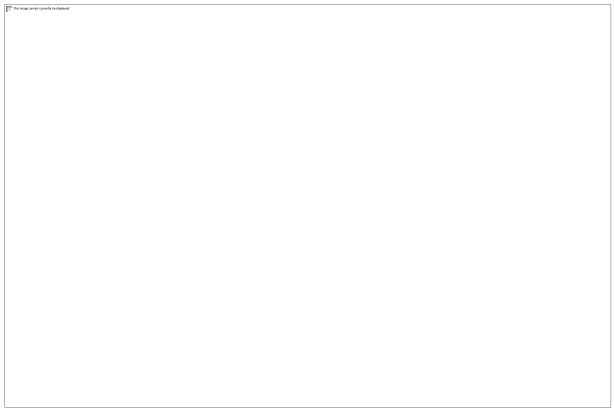
Appointments are longer than the standard vaccine appointment, to allow each person to feel comfortable in the environment, with only around 50 people vaccinated per day.

Prime Minster visits Porirua Community Centre

Prime Minister Jacinda Ardern and local MP, Barbara Edmonds MP visited Ora Toa PHO Porirua Community Vaccination Centre on 12 Augusta. The Ora Toa team who are doing an outstanding job of providing a warm and friendly environment for COVID-19 vaccinations.

Working in partnership with Māori health providers like Ora Toa is a key part of our 'trusted faces in trusted places' vaccination programme approach.

The photo features Helmut Modlik (CE Te Rūnanga o Toa Rangatira), Te Iringa Davies (General Manager, Health Services), Grace Davies (Clinic Coordinator), Prime Minister Jacinda Ardern, Faith Woodcock (Ora Toa COVID-19 Response Lead) and Barbara Edmonds Mana MP.



Booking system

Book My Vaccine, an online self-booking tool built by the Ministry of Health, and Whakarongorau, the national call centre, has now become the main tool for booking appointments at all our vaccination centres. Medical practices who are vaccinating their enrolled populations may continue to use their own booking systems.

Vaccinate Greater Wellington website

In cooperation with Wairarapa DHB, the 2DHBs run the Vaccinate Greater Wellington website and weekly pānui.

The website is the hub for information about the local vaccination rollout including age groups we are vaccinating and how people can book, with news stories, video content and other information about the vaccination rollout in the region.

Our weekly pānui is read by thousands of people each week. People can subscribe to this newsletter online.

Bowel screening

The 2DHBs bowel screening nurse and two programme managers from Hutt Valley and Capital & Coast DHBs joined a variety of healthcare workers including programme managers, kaitakawaenga, health promoters, and equity leads at a bowel screening equity forum to share learnings on improving equity for Māori, Pacific peoples and those residing in high deprivation areas.

Hutt Valley DHB went live with screening in 2017 and Capital & Coast went live with in April this year, and we are now working closely as 2DHBs to raise awareness of the programme.

All 6 DHBs across the central region have a localised approach to outreach models and health promotion. It is apparent that a 'one size fits all' solution doesn't work, but instead taking into account factors such as culture, language, geographical and disabilities to tailor their work for the best outcomes in participation. CCDHB has created a unique outreach model for community engagement which will work closely with the participants' GP practices.

Bowel screening has had a presence at a number of Pacific vaccination festivals, handing out leaflets and pens and raising awareness about the importance of the programme with Pacific peoples.

Caroline Mareko from Whanau Manaaki kindergartens and Vanessa Masoe from Porirua City engaged with Pacific community members of all ages around the importance of bowel screening.

Changes to the sale of vaping products

On 11 August 2021, new restrictions on the sale of vaping products came into force as part of the Smokefree Environments and Regulated Products Act. The legislation aims to protect the health of young people by reducing influences that may encourage vaping or smoking. Regional Public Health (RPH) welcome these new restrictions, which limit the range of products some retailers can sell and helps to protect the health of young people and rangatahi.

RPH will help support these changes which reduce access to vaping products, and we support the use of vaping as a tool to help people quit smoking. As we head towards Smokefree 2025, we will continue to advocate for further restrictions that reduce access to vaping products. This is particularly important as we see an increase in the number of young people vaping.

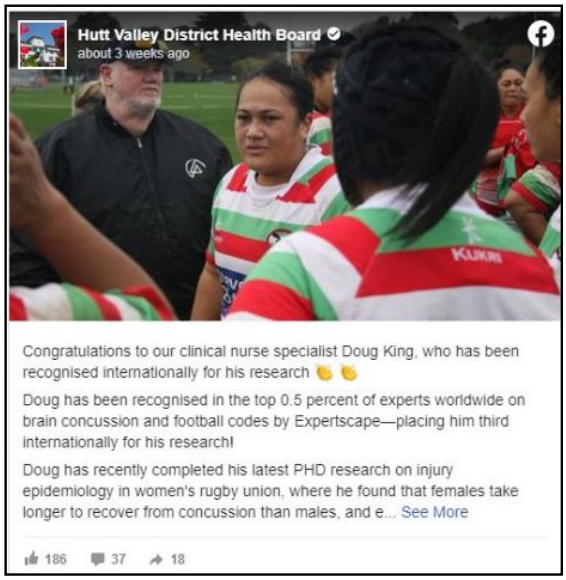
3.4 Social media views and stories

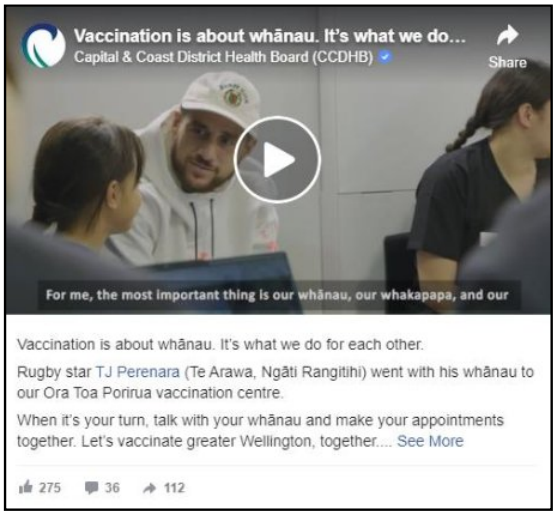
3.4.1 Top social media posts

CCDHB impressions	HVDHB impressions	RPH impressions
Facebook: 519,323 Twitter: 100,748 LinkedIn: 23,978	Facebook: 318,737 Hutt Maternity Facebook: 12,455 Twitter: 19,037 Instagram: 7,107 LinkedIn: 13,406	Facebook: 29,897


Regional Public Health
about a week ago
Changes to the sale of vaping products
RPH welcomes new restrictions on the sale of vaping products that come into force this week which help to protect the health of young people. General retailers (for example dairies, supermarkets) can now only sell vaping products that are mint, menthol or tobacco flavour. Specialist vaping stores may still continue to sell a variety of fruit and dessert flavoured vaping products.
We support these changes which reduce access to vaping products and we support vaping as tool t... See More
49 13 17


Capital & Coast District Health Board (CCDHB)
about a month ago
In Group 3?
Phone 0800 28 29 26 to book your COVID-19 vaccination
www.VaccinateGreaterWellington.nz
If you are in Group 3 and haven't booked your COVID-19 vaccination yet, you can now phone 0800 28 29 26 to book your appointments. The line is open 8am – 8pm, 7 days per week.
You will be able to choose the most convenient location from twelve vaccination centres across our region. Vaccinations are by appointment only, no walk-in spots are available.
Special events are also being organised for Pacific people to be vaccinated together. Visit the Vaccinate Greater Wellington we... See More
447 137 206


Hutt Valley District Health Board
about 3 weeks ago
Congratulations to our clinical nurse specialist Doug King, who has been recognised internationally for his research
Doug has been recognised in the top 0.5 percent of experts worldwide on brain concussion and football codes by Expertscape—placing him third internationally for his research!
Doug has recently completed his latest PHD research on injury epidemiology in women's rugby union, where he found that females take longer to recover from concussion than males, and e... See More
186 37 18


Vaccination is about whānau. It's what we do...
Capital & Coast District Health Board (CCDHB)
Share
For me, the most important thing is our whānau, our whakapapa, and our
Vaccination is about whānau. It's what we do for each other.
Rugby star TJ Perenara (Te Arawa, Ngāti Rangitihi) went with his whānau to our Ora Toa Porirua vaccination centre.
When it's your turn, talk with your whānau and make your appointments together. Let's vaccinate greater Wellington, together.... See More
275 36 112

3.5 Website page views and stories

CCDHB	HVDHB	RPH	MHAIDS
133,332 page views	40,174 page views	57,439 page views	11,932 page views

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

Top five webpages CCDHB

- Staff login
- COVID-19 CBACs
- Careers with CCDHB
- Wellington Regional Hospital
- Connect Me and Webmail
- COVID-19 changes to our services

Top five webpages HVDHB

- Staff login
- COVID-19 CBACs
- Contact Us
- Hutt Hospital campus map
- Careers with HVDHB

Top five webpages RPH

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

Top five webpages MHAIDS

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

3.5.1 Website stories and releases

DHB staff come together for orchestral performances

Musicians and singers from Hutt Valley and Capital & Coast DHBs came together last year to play music as Manawa Ora – the 2DHB orchestra. Now they are putting on concerts in DHB hospitals across the region over the winter months.

Dr Manjula Ricciardi was instrumental in the formation of the orchestra in early 2020 after seeing how much musical performances were enjoyed by patients, visitors, and staff alike.

“Music is a simple way to connect people – patients, whānau and staff appreciate the music and are grateful for a moment of joy,” she said.

“It feels like we’re welcoming people to a place where we want them to feel safe.”

With the increasing sharing of staff and services between the two DHBs, it felt natural that the orchestra include staff from both DHBs. Staff juggle on-call rosters and hospital shifts to rehearse together.

“It takes commitment from everyone to make it this far – but everyone wanted to perform well and be there at the concerts. It’s wonderful to see so many musicians and singers from different roles and backgrounds coming together.”

A debut concert last Christmas is now being followed up with performances over the winter months. The first concert, a Matariki celebration, took place in the atrium of Wellington Regional Hospital in late May. “Matariki has great cultural significance in New Zealand, and we felt that a concert was a great way to celebrate Māori New Year,” says Manjula.

Around 42 musicians and singers performed, with a hospital choir featuring soprano soloist Jess Segal “taking our performance to the next level.”

After having to cancel two more Matariki performances due to the recent COVID-19 alert level change, the orchestra has now scheduled another winter concert at Kenepuru Community Hospital in August.

Manawa Ora is supported by Wellington Hospitals Foundation, while its name was gifted by 2DHB director of Māori Health, Arawhetu Gray. “Arawhetu felt that Manawa Ora was the right name as it encompasses a sense of joy, hope, and acknowledgement that music can lighten the heart.”

Dr Ailsa Wilson's journey into medicine

Born and raised in Tokoroa, known as the sixteenth star of the Cook Islands due to its large Cook Island community, Dr Ailsa Wilson initially pursued studies in performance piano and sports science, before becoming inspired by a career in medicine through the Pacific and Māori medical students she was living with at the time.

"I was inspired by their passion and drive to improve Māori and Pacific health, and seeing the effect that they could have on the health outcomes of their own people," she says.

Now based in Hutt Hospital, she is one of three senior trainees on the orthopaedic surgical training scheme and deals with a range of patients, from those who present with traumatic injuries to those who have arthritis and require hip or knee joint replacements. As a registrar she accompanies patients through their healthcare journey from making decisions on treating their injury or problem, performing surgery on these patients, and following them up at clinics.

"Surgery gives me instant gratification, patients come in with a problem and it's up to us to fix them," says Ailsa. "The best thing about my job is not one thing, but the whole the process, I am very lucky to be doing a job that I love."

She also is very proud to say she is of both Māori and Cook Island descent. "When I have a Māori or Pacific patient, I often get the feeling that I'm walking in to see one of my family members. You instantly see patients faces brighten up when they know you are from the same village, island, iwi, or hapu as you. That really touches me – knowing that kind of rapport could lead to a better experience and outcome for our patients. As a Māori and Pacific Island doctor, I am fully aware of the health inequities that exist, and constantly advocate for our patients in any way I can to get them the best care they need."

She would love to see more Māori and Pacific People join the medical profession – but she is already inspiring others, starting with her younger sister, who is now a house officer and was recently accepted onto the rural training programme. "She copied me with a lot of things growing up, so she

decided to copy me in medicine as well," jokes. Ailsa, who has also now begun mentoring Pacific and Māori students.

Of Cook Islands Language Week, she says it's about more than the language. "It's about learning from our metuas or elders and embracing our culture, our history, where we come from, and encouraging our young ones to learn this too."

Capital's vaccination programme scaling up significantly

The Hutt Valley and Capital & Coast DHB region is continuing to rapidly scale up its COVID-19 vaccination programme to make it as easy as possible for more people to be vaccinated in the way that best suits them.

This includes offering a range of vaccination options, including Community Vaccination Centres, Māori providers, general practice, community pharmacy, and pop-up events for Pacific and Disabled communities.

In the past fortnight 21 new clinics have opened across the region through general practice and pharmacy, taking the total number of active clinics to 34. In the coming weeks more clinics will open, including some open to all eligible people and others at general practices for enrolled patients only.

"We know our population will have different preferences for how they want to be vaccinated, so that's exactly what we're providing," said 2DHB director Strategy, Planning & Performance Rachel Haggerty.

"Our programme is a partnership with primary care and our Māori providers, who are leading the 14 Community Vaccination Centres across our region that are open to anyone eligible for vaccination, as well as supporting medical practices who are vaccinating their enrolled populations.

"More than 23 percent of all Māori aged 15-plus in our region have received at least one dose of the vaccine to date. This work has been led by five Māori providers focusing on all-of-whānau vaccination, supported by a commitment to health equity by the DHB and PHOs.

"Our Pacific communities told us they want to be vaccinated together in the places they feel comfortable, so that's what we're doing. Our church-based vaccination festivals have helped 29 percent of Pacific people aged 15-plus in our region to be vaccinated already.

"This week we also began holding Accessible Events for Disabled communities at our vaccination centres, including low-sensory options and sessions with NZSL interpreters. Our material is available in Easy Read and large print formats and we are creating NZSL videos so Deaf and hard-of-hearing people can make informed decisions."

The full list of vaccination centres is available on the Vaccinate Greater Wellington website – www.VaccinateGreaterWellington.nz – and anyone eligible can book by visiting www.BookMyVaccine.nz or phoning 0800 28 29 26.

"With this scaling up of delivery in our region, everyone will be on track to receive two doses of the COVID-19 vaccine before the end of this year."

3.6 Internal Engagement and Communication

3.6.1 Intranet page views and stories

CCDHB	HVDHB
227,193 page views	106,390 page views

3.6.2 New Health Matters magazine and staff posters

We released a refreshed edition of our regular Health Matters magazine during August as well as a range of posters for staff to highlight key work programmes.

3.6.3 Top intranet stories

Reaffirming our commitment to mana whenua

The Hutt Valley and Capital & Coast DHBs reaffirmed their commitment to working in partnership with mana whenua to improve the health and wellbeing of tamariki, rangatahi, tāngata, kaumātua, and whānau across the rohe.

'Te Rangapū Ahi Kā Roa Relationship with the District Health Boards of the Wellington Region' is an agreement between Te Rūnanganui o Āti Awa ki te Upoko o te Ika a Maui Inc, Te Rūnanga o Ngāti Toa Rangatira, and the two DHBs.

"This agreement recognises the two parties to Te Tiriti o Waitangi – iwi/hapū Māori, in this case represented by mana whenua, and the Crown as represented by the two DHBs," said 2DHB director of Māori Health Arawhetu Gray.

"It recognises the mana motuhake and kaitiaki role that mana whenua have in protecting and nurturing their people, language, customs, culture, and environment."

Te Rūnanga o Toa Rangatira chief executive Helmut Modlik described the updated strategic agreement as a refreshed commitment between the Crown and mana whenua to uphold Te Tiriti o Waitangi.

"Our intention is to exert our rangatiratanga and increasingly row our own waka – directly delivering services to enhance the wellbeing of our people," he said.

"Ngāti Toa Rangatira and Te Āti Awa expect our kāwanatanga partners to do their part in achieving that outcome, and this signing is the first step on this renewed journey."

Te Rūnanganui o Te Āti Awa ki te Upoko o Te Ika a Maui chief executive Wirangi Luke tautoko Mr Modlik's whakaaro.

"From a regional approach we are all looking forward to working closely together, it has been a long time coming," he said.

Not all smooth sailing for nurses

When the fishing vessel Viking Bay carrying 20 crew realised it had a potential COVID-19 case on board, it was immediately quarantined in Wellington. Sixteen of the 20 crew were moved into a managed isolation and quarantine facility and now, fully recovered, they are back to semi-normal life on board the ship.

Managed Isolation and Quarantine Facility Charge Nurse Manager Leaha North says it shows the solid teamwork and specialised skills of those involved in protecting our borders and keeping Aotearoa safe.

"It wasn't all smooth sailing, because we faced a lot of unknowns and unanticipated challenges, but the experience and unity of our teamwork shone through to ensure the safety of the crew and the wider team."

Registered Nurses from the Managed Quarantine Facility and infection prevention control met the crew from the Viking Bay vessel when it arrived at Queens Wharf and tested 18 of the crew. Following the testing, 16 of the 20 crew on the Viking Bay were transferred to the Grand Mercure managed isolation and quarantine facility.

Leaha says the nursing team went over and above their duty of care and have cared for the crew professionally and compassionately.

"The crew spoke Spanish and Indonesian with very little or no English which required interpreters, translations and a lot of patience on both sides dealing with the challenges of language. But we eventually managed well with the support of interpreters, nurses' intuition and hand signals.

Regional Public Health carried out the all-important daily health checks for those who remained on board, and arranged for the deep clean of the vessel.

Alongside the health teams, the work was well supported by the wider Managed Isolation and Quarantine Facility cross-sector teams – NZ Defence Force (logistics, coordination), MBIE (communications coordination), Ministry of Health (lead for communications, policy and decisions), Customs (security at Queens Wharf), Wellington City Council (liaison regarding other events on in the area), Grand Mercure (fed and housed Viking crew), NZ Police (security for transport and safety), interpreting services, and the generous donation of care packages to the crew from the Indonesian Embassy.

Leaha says caring for the crew and managing so many positive cases in the hotel at one time was a wider team effort.

"We managed all this alongside the regular returnee cohorts and the unexpected border averters (those people arriving on flights from Australia who were not eligible for quarantine free travel for various reasons) who also came into the facilities during this time. Everyone stepped up to the challenge."

The ship has now sailed with everyone safe on board.

Te Upoko o te Ika Māori Council

A future vision for our DHBs centred around improved equity and health outcomes for Māori will be advanced following the formation of a new partnership board.

Te Upoko o te Ika Māori Council's goal is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within our health boards and wider community.

The council is made up of two representatives from each of the following: Te Runanganui o Te Atiawa; Taranaki Whānui ki te Upoko o te Ika (PNBST); Ngāti Toa Rangatira; Te Atiawa ki Whakarongotai; Taurahere Iwi; Wellington Tenths Trust – Te Atiawa/Taranaki; and Palmerston North Māori Reserve – Te Atiawa.

Chairman Jack Rikihana and other members signed an Agreement and Terms of Reference at a Hutt Valley DHB and Capital & Coast DHB board meeting on 4 August.

Mr Rikihana said the next year holds strong potential locally at our DHBs and across Aotearoa to bring about much-needed change to the way we support healthy whānau.

“Our council is looking forward to working with the Māori Health Authority to drive rangatiratanga for Māori in our health system and ensuring Māori are deeply involved in its design.”

2DHB Director Māori Health Arawhetu Gray said establishing the new Council will help provide a firm foundation to build a more equitable future.

COVID-19: Moving to alert level 4

Prime Minister Jacinda Ardern has this evening announced that New Zealand will move to COVID-19 alert level 4 at from 11.59pm tonight (Tuesday 17 August), for a period of three days.

Essential workers

Unless advised by your manager, all staff are considered essential workers and should continue to come to work as normal. If you have visited a location of interest during the relevant period, or are unwell, please stay at home and contact Occupational Health on RES-COVID19Enquiries@ccdhb.org.nz or 0800 33 88 22. If you believe you may be a vulnerable worker or require a risk assessment, please email COVID19Enquiries@ccdhb.org.nz.

Masks and distancing

Prime Minister Jacinda Ardern has advised anyone leaving their home to wear a mask. DHB-issued masks are required for ALL staff in the workplace. We will provide advice if there are any other changes to the type of mask required in clinical settings.

Please also remember to practice safe distancing and maintain a two-metre distance from your colleagues – this includes at our onsite cafes.

Hand hygiene is a key priority so please ensure you are practicing this at work and at home.

Visiting

Our level 4 visitor restrictions are in place. This means we will not be permitting any visitors under alert level 4 unless there are exceptional circumstances, and we will also have screening at our entrances. Information about visiting is publicly available on our websites: www.huttvalleydhb.org.nz/visitors/covid-19-information-for-visitors/ and www.ccdhb.org.nz/our-services/covid-19-changes-to-our-services/.

Door screening

Please remember to always display your DHB ID when accessing DHB premises, otherwise you will be required to undergo COVID-19 screening before you will be allowed to enter. Screening is a key part of keeping our hospitals, patients, and staff safe. Please be kind and courteous to the people who are performing this valuable screening work at our entrances.

Please also remember not to swipe other people through our entrances, or to allow people to follow you through after you have swiped in. Our services will be reduced during this time and we will work through our hospital response plans to ensure our infection prevention and control guidelines are in place.

If you can volunteer for screening on our doors, please contact:

- Capital & Coast DHB: Martin.taylor@ccdhb.org.nz
- Hutt Valley DHB: Tina.ririnui@huttvalleydhb.org.nz

Media

The move to alert level 4 has generated media interest around our hospitals and services. Please remember that all interactions with media must align with Hutt Valley DHB's Media and External Communications Policy and Capital & Coast DHB's External Communications Policy, and any media enquiries are to be directed to the 2DHB Communications and Engagement Directorate – news@ccdhb.org.nz or news@huttvalleydhb.org.nz.

Accessing Your Desktop, Zoom and Email from Home

If you have been asked to work from home, you can access your DHB desktop through our online Citrix gateway, details on how to access this can be found on our DHB internet sites. Just click the Staff Login button, or use the following links

https://www.ccdhb.org.nz/working-with-us/staff-login/

http://www.huttvalleydhb.org.nz/health-professionals/staff-and-provider-login/

All users will need to enable multi-factor authentication, this is when you use your phone to confirm your access. It is as easy as accepting a text message, answering a call, using an app to approve access. Attached is a document for setting up MFA.

ICT Service Desk – Covid Related Requests

If you have need to contact the ICT Service Desk for a ticket relating to the DHB's Covid-19 response, then please use the link on the ICT help desk portal for this. This will ensure the ticket is prioritised by the service desk for attention.

Please note that the Service Desk can only offer a reduced service at the moment, so please log all tickets using out Customer Portal and contact Service Desk again if your need is urgent.

Thank you all for your support and professionalism at this time. Please visit the 2DHB COVID-19 hub for information and resources on the latest alert level changes and guidelines. This will be updated regularly.

2DHB BOARD WORK PLAN 2021/2022 – AS AT 1 SEPT 2021

	Wed 6 Oct 2021	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
	WLG Hospital	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital	Hutt Hospital	WLG Hospital
Service Spotlight	**ENT**	**Rheumatology**	**Cardiology**	**TBC**	**TBC**	**TBC**	**TBC**
Quality and Safety/Health and Safety							
2DHB Quality and Safety	2DHB Quality and Safety Report and focus area (Improvement)	2DHB Quality and Safety Report Gap analysis on the Health and Disability Standards Update on the corrective actions from the surveillance audits	2DHB Quality and Safety Report	2DHB Quality and Safety (and selected focus area)	2DHB Quality and Safety Report	2DHB Quality and Safety Report	2DHB Quality and Safety Report (and selected focus area)
MHAIDS Quality and Safety	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report	MHAIDS Quality and Safety Report
2DHB Health and Safety	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	2DHB Health and Safety Report	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 August 2021	Report for September 2021 (from FRAC)	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022
Financial and Operational Performance CCDHB	Report for August 2021	Report for September 2021 (from FRAC)	Report for October 2021 (from FRAC)	Report for November and December 2021	Report for January (from FRAC) and February 2022	Report for March (from FRAC) and April 2022	Report for May 2022

	Wed 6 Oct 2021	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Scheduled reporting							
People and Culture Report	People and Culture Report		People and Culture Report		People, Capability and Culture Report		People, Capability and Culture Report
3DHB Digital Report		Q1 Report		Q2 Report		Q3 Report	
Māori Stratey (Te Pae Amorangi and Taurite Ora)		Q1 Report		Q2 Report		Q3 Report	
Pacific Health and Wellbeing Strategic Plan		Q1 Report and selected focus area		Q2 Report and selected focus area (To be advised)		Q3 Report and selected focus area (To be advised)	
Strategic Priorities							
Pro-Equity							
Strategic Priorities Overview	Reporting on implementation and engagement on next steps. *The papers marked * are on the HSC work plan for 29 September 2021 and 24 November 2021 – and will be reported to the Boards via HSC.*						
Our Hospitals	*Planned Care		*Maternity and Women's Health				
			*2DHB Hospital Network				
Commissioning and Community	*Integrated Primary Care and Acute Demand		*Complex Care and Frailty				
			*Inter-sectoral Priorities				
Mental Health and Addiction Services	*Community Mental Health and Addictions Networks		*Kaupapa Māori and MHA development				
Enablers							

	Wed 6 Oct 2021	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Committees							
FRAC items for Board Approval		FRAC items for Board Approval from meeting dated 27/10/21	FRAC items for Board Approval from meeting dated 26/11/21		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
HSC update and items for Board Approval	HSC update and items for approval from meeting dated 29/09/21		HSC update and items for approval from meeting dated 24/11/21		HSC update and items for approval from meeting dated 16/03/22		
DSAC update and items for Board Approval	DSAC update and items for approval from meeting dated 29/09/21		DSAC update and items for approval from meeting dated 24/11/21		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 from meeting dated 28/09/21	MCPAC update from meeting dated 27/10/21	MCPAC update from meeting dated 26/11/21		HSC update and items for approval from meeting dated 16/03/22		
Engagement							
Te Upoko o te Ika Māori Council (TUI MC)	Boards meet with TUI MC		Boards meet with TUI MC		Boards meet with TUI MC		Boards meet with TUI MC
Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group			Sub-Regional Disability Advisory Group	
Annual Planning and Reporting							
Budgets/Annual Plan	Planning process for 2022/2023 – subject to confirmation of process required for HNZ			Planning process for 2022/2023 – subject to confirmation of process required for HNZ			
Annual Report		Annual Report 2020/2021		N/A			
Other items							
Environmental Sustainability Strategy					Environmental Sustainability Strategy update		
Procedural and Board process issues			Delegations for Summer Break				

	Wed 6 Oct 2021	Wed 3 Nov 2021	Wed 1 Dec 2021	Wed 16 Feb 2022	Wed 30 Mar 2022	Fri 13 May 2022	Wed 22 Jun 2022
Action log items							
Workshops/Training/Site Visit at conclusion of Board meeting (where time allows)							
Workshop	Risk Workshop - TBC						
Site Visit	Te Wao Nui/Children's Hospital – **TBC**		Te Wao Nui/Children's Hospital – **TBC**				

Board Information – Public

1 September 2021

HVDHB Financial and Operational Performance Report – June 2021

Action Required

The HVDHB Board notes:

(a) the DHB had a $3.1m surplus for the month of June 2021, being $4.4m favourable to budget;

(b) the DHB year to date had a deficit of ($12.2m), being ($1.6m) unfavourable to budget;

(c) the DHB year to date deficit excluding $2.7m Holidays Act provision was a deficit of ($9.5m), being $1.1m favourable to budget, which includes a $6.5m impairment of the RHIP;

(d) the Funder result for June was $6.4m favourable, Governance $0.2m favourable and Provider ($2.2m) unfavourable to budget;

(e) total Case Weighted Discharge (CWD) Activity was 9% ahead of plan.

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

Executive Summary

The COVID-19 response costs for the 20/21 financial year have been fully funded by the Ministry of health, additional revenue was received in June. The Ministry have asked DHBs to separately report ongoing provisions for the liability due to Holidays Act remediation from the base budget as this has not been funded.

Excluding the Holidays Act provision the DHB's result for the twelve months to 30 June 2021 is a ($9.5m) deficit, versus a budget deficit of ($10.6m).

The monthly provision for increasing Holidays Act liability is $227k and year to date the impact on the result is $2.7m

For the twelve months to 30 June 2021 the overall DHB year to date result, including COVID-19 and Holidays Act costs is a ($12.2m) deficit compared to a budget deficit of ($10.6m), this also include a write down of the RHIP of $6.5m.

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

Capital Expenditure was $68m year to date with $26.1m remaining including projects that are delayed and funding will be transferred to next financial year.

The DHB has a positive cash balance at month-end of $22.9 million with an equity injection for deficit support received in October 2020 of $35m. Overall the DHB cash balance is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is now expected in 2021/22 to line up with forecast expenditure.

Hospital: Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients and at year end we are at our planned care target with continuing work in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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.
- Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level.

Funder COVID-19 Vaccine programme has been progressing well and in line with MoH targets. Other key areas of performance with a focus on core services and achieving equity:

- A national shortage of midwives impacts women's ability to engage early with LMC care. HVDHB has contracted a breastfeeding education specialist to build a community of support for Māori, Pacific, Indian and disabled women on their breastfeeding journey.
- We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to diagnostics (CT & MRI) and access to elective general surgery, orthopaedic surgery and gynaecology surgery.
- We are working to improve patient flow by reviewing the journey from inpatient units into stepdown facilities to create a smooth transition into lower levels of care.

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 196 below plan with additional costs in outsourced personnel for roles employed by CCDHB for MHAIDs and IT.
Financial	Planned deficit for HVDHB $10.6 million with no COVID-19 or Holidays Act provision impacts included.
Governance	The FRAC committee is accountable for scrutinising the financial and operational performance on behalf of the board, and reporting back to the board on issues as identified by the committee.

Engagement/Consultation

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

Identified Risks

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

Attachments

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

Monthly Financial and Operational Performance Report

For period ending
30 June 2021 (unaudited)

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

- The COVID-19 response costs for the 20/21 financial year have been fully funded by the Ministry of health, additional revenue was received in June. The Ministry have asked DHBs to separately report ongoing provisions for the liability due to Holidays Act remediation from the base budget as this has not been funded.
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- Key underspends are in the funder demand driven costs including Aged Residential Care (ARC) and Other Health of Older People (Other HoP), Pharmaceuticals. Mental health contacts are also underspend due to timing of contracts.
- Capital Expenditure was $68m year to date with $26.1m remaining including projects that are delayed and funding will be transferred to next financial year.
- The DHB has a positive cash balance at month-end of $22.9 million with an equity injection for deficit support received in October 2020 of $35m. Overall the DHB cash balance is better than was budgeted due to delayed capital spend. We are expecting an equity injection for capital in relation to two capital projects approved for MoH funding (TWA replacement and the Maternity upgrade projects). The equity injection is now expected in 2021/22 to line up with forecast expenditure.

Executive Summary (continued)

- **Hospital:** Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients and at year end we are at our planned care target with continuing work in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
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- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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.
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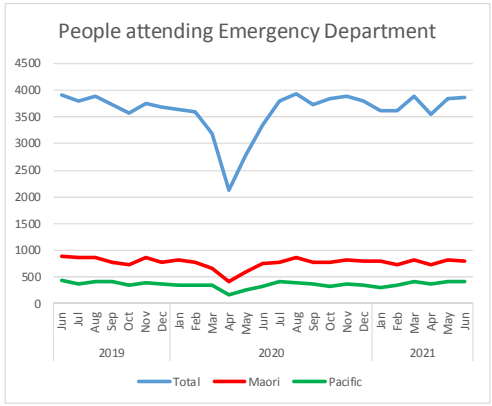
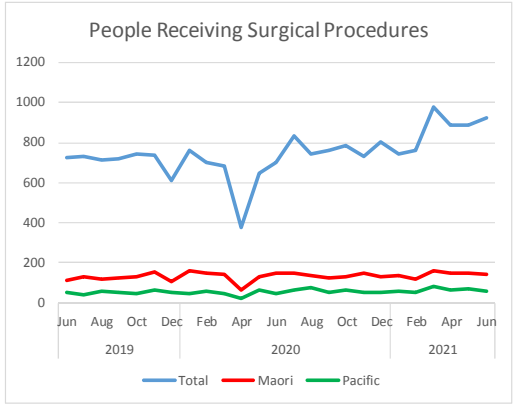
- **Funder** COVID-19 Vaccine programme has been progressing well and in line with MoH targets. Other key areas of performance with a focus on core services and achieving equity:
- A national shortage of midwives impacts women's ability to engage early with LMC care. HVDHB has contracted a breastfeeding education specialist to build a community of support for Māori, Pacific, Indian and disabled women on their breastfeeding journey.
- We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to diagnostics (CT & MRI) and access to elective general surgery, orthopaedic surgery and gynaecology surgery.
- We are working to improve patient flow by reviewing the journey from inpatient units into stepdown facilities to create a smooth transition into lower levels of care.

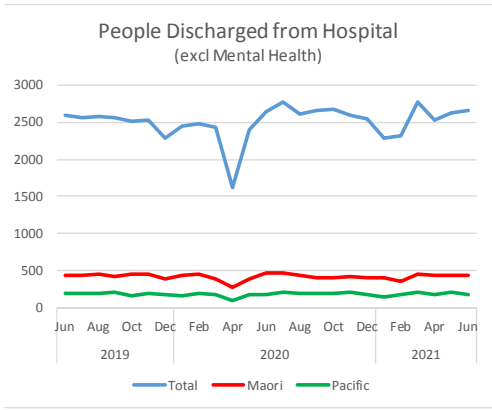
Performance Overview: Activity Context (People Served)

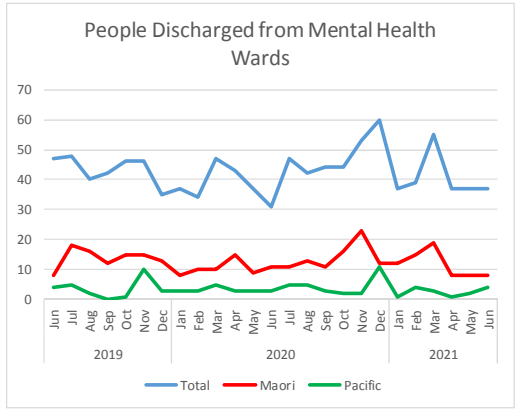
The numbers below count individuals once and are based on Hutt Valley DHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19. Services continue to take necessary precautions. March was busy in all services but April was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

People attending ED	**3,867**	802 Maori, 414 Pacific
People receiving Surgical Procedures	**926**	142 Maori, 61 Pacific
People discharged from Hospital (excl Mental Health)	**2,654**	431 Maori, 183 Pacific
People discharged from Mental Health wards	**37**	8 Maori, 4 Pacific



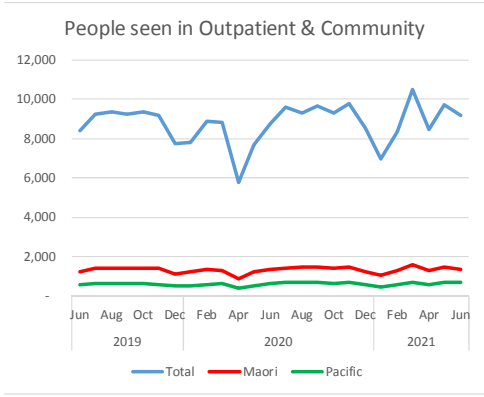


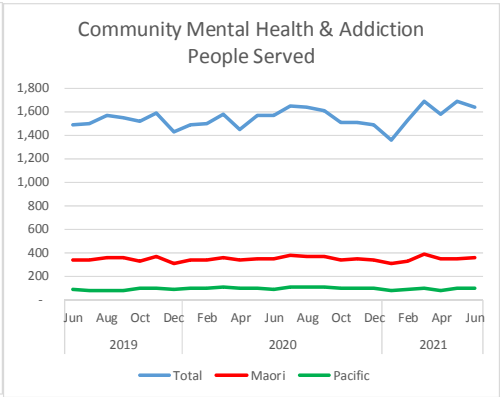


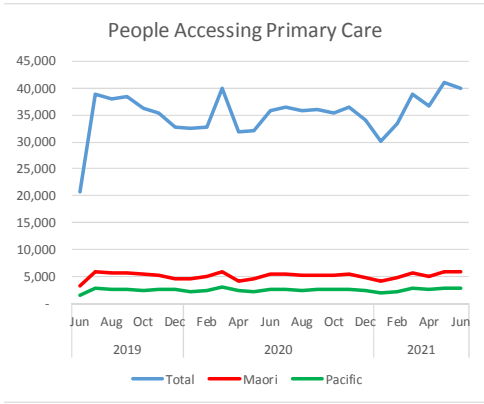


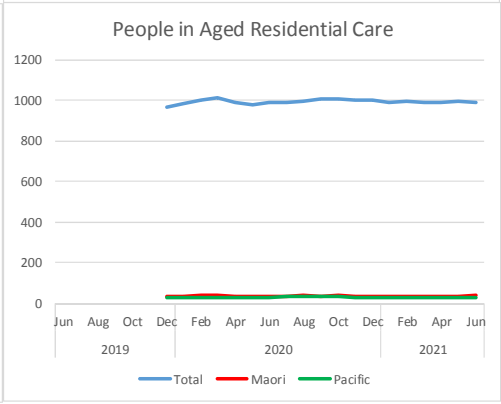
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**9,209**	1,375 Maori, 680 Pacific
Mental Health and Addiction Contacts	**1,642**	358 Maori, 101 Pacific
Primary Care Contacts	**39,918**	5,812 Maori, 2,770 Pacific
People in Aged Residential Care	**990**	37 Maori, 28 Pacific









Financial Overview – June 2021

YTD Operating Position	YTD Provider Position	YTD Funder Position	YTD Capital Exp
$12.2m deficit	$25.4m deficit	$11.9m surplus	$8.0m
Against the budgeted deficit of $10.6m.	Against the budget deficit of $10.9m.	Against the budget deficit of $0.01m.	

YTD Activity vs Plan (CWDs)	YTD Paid FTE	Annual Leave Accrual
9% ahead	1,862	$21.9m
329 CWDs ahead PVS plan for June. IDFs were 68 CWD below budget for the month	YTD 196 FTE below annual budget of 2,058 FTE. Note: The MHAIDS & ITS restructures and change of employer contributed 148 FTE to this variance	This is an increase of $0.8m on prior period.

Hospital Performance Overview – June 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%	904	625	80%
13% below the ED target of 95%, Similar to March 2020, but well below June 20 90% impacted by Covid-19.	Against a target of zero long waits a monthly decrease of 116.	Against a target of zero long waits a monthly decrease of 183	We were below the 62 day target this month. The 31 day target was achieved at 90%

YTD Activity vs Plan (CWD)	YTD Standard FTE	Serious Safety Events
9% ahead	1,851	2
329 CWDs ahead PVS plan for June. IDFs were 68 CWD below budget for the month	186 below YTD budget of 2,037 FTE. Month FTE was 205 under budget an upwards movement from May of 13.4 FTE.	An expectation is for nil SSEs at any point.

Section 2

FUNDER PERFORMANCE

Executive Summary – Funder

- Overall the funder has a positive variance of $6.4m for the month and $11.9m year to date, with revenue for IDFs being ahead of budget by $1.2m due to wash-ups from last year and increased volumes for the current year. In addition COVID-19 revenue, which is offset by costs also means we are ahead of revenue by a total of $6.9m YTD.
- Aged residential care costs are $185k favourable for the month and $1.6m year to date. Other Health of Older People costs are favourable $224k for the month and $2.3m YTD. Pharmaceutical costs are under $3.7m for the month and $1.7m year to date reflecting the recognition of the Pharmac rebates fro the year.
- Mental Health costs are unfavourable ($69k) for the month but favourable $1,147k YTD, reflecting timing of contracts which will be rectified with the acute care continuum.
- Additional funding for Mental Health and Child & Youth services of $4.3m has been received and has been contracted to NGO Providers, including primary mental health.
- Community, MIQ and Vaccine rollout COVID-19 response costs ($29m) mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by the Ministry.
- The COVID Vaccine programme has been progressing well and in line with MoH targets. There is considerable pressure over the next month as the general practises come on board. There is a risk we will be behind targets for the next four weeks. Strategies are being developed to close this gap using temporary vaccination sites.
- 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:
  - A national shortage of midwives impacts women's ability to engage early with LMC care. HVDHB has contracted a breastfeeding education specialist to build a community of support for Māori, Pacific, Indian and disabled women on their breastfeeding journey. The programme will consist of (1) Breastfeeding education/promotion; and (2) Training breastfeeding kaiāwhina . Work has re-started to get HVDHB's electronic newborn notification system up and running. The system will eliminate the need for faxing and other manual processes currently used as part of the newborn enrolment process.
  - We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to diagnostics (CT & MRI) and access to elective general surgery, orthopaedic surgery and gynaecology surgery. HVDHB has chosen to focus our $2.3 million service delivery funding in areas of greatest need, and are focused on areas of historically long waitlists and performance.
  - We are working to improve patient flow by reviewing the journey from inpatient units into stepdown facilities to create a smooth transition into lower levels of care. By providing a streamlined transition into lower levels of care, there is an opportunity to reduce length of stay. We are implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.

Funder Financial Statement – June 2021

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

Month					$000s	Year to Date				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance
					Revenue					
37,924	37,970	(46)	34,735	3,189	Base Funding	455,083	455,637	(554)	416,816	38,267
3,835	2,341	1,495	4,114	(278)	Other MOH Revenue	34,030	28,090	5,941	38,006	(3,976)
40	36	5	140	(99)	Other Revenue	733	427	306	619	114
9,458	9,229	230	9,306	152	IDF Inflows	111,945	110,742	1,203	102,280	9,665
51,257	**49,575**	**1,683**	**48,295**	**2,963**	**Total Revenue**	**601,791**	**594,895**	**6,895**	**557,721**	**44,070**
					Expenditure					
381	416	35	383	2	DHB Governance & Administration	4,652	4,987	335	4,597	(55)
20,957	21,048	92	21,443	486	DHB Provider Arm	252,732	252,577	(155)	241,131	(11,601)
					External Provider Payments					
(317)	3,376	3,693	5,478	5,795	Pharmaceuticals	37,162	38,866	1,704	37,365	203
4,357	4,369	12	4,283	(74)	Laboratory	52,577	52,424	(152)	50,903	(1,673)
2,425	2,541	116	2,509	84	Capitation	31,021	30,495	(525)	29,563	(1,458)
1,143	1,196	52	1,123	(20)	ARC-Rest Home Level	13,871	14,543	672	11,877	(1,994)
1,725	1,858	133	1,650	(75)	ARC-Hospital Level	21,724	22,604	880	19,154	(2,571)
2,505	2,730	224	2,557	51	Other HoP	30,333	32,654	2,321	26,281	(4,052)
0	0	0	832	832	Pay Equity	2	0	(2)	9,084	9,082
1,158	1,089	(69)	950	(208)	Mental Health	11,898	13,045	1,147	9,580	(2,317)
378	0	(378)	902	524	COVID-19	4,740	0	(4,740)	4,183	(558)
1,503	1,930	427	1,754	251	Other External Provider Payments	20,327	22,901	2,575	20,595	268
8,808	9,151	342	10,680	1,872	IDF Outflows	108,813	109,807	994	101,298	(7,514)
45,023	**49,702**	**4,680**	**54,544**	**9,521**	**Total Expenditure**	**589,851**	**594,905**	**5,053**	**565,610**	**(24,241)**
6,234	**(128)**	**6,362**	**(6,250)**	**12,484**	**Net Result**	**11,939**	**(9)**	**11,949**	**(7,889)**	**19,829**

There may be rounding differences in this report

Funder Financials – Revenue

Revenue:

- Revenue is made up of base funding, other MOH revenue, other revenue and inter district flows. The table shows the variance for other MOH revenue.
- Base Funding is unfavourable ($46k) to budget for the month and ($554k) year to date, reflecting the various changes for Capital Charge impacting both Income and expenditure for the DHB.
- Other MoH revenue is favourable $1,495k for June and $5,941k year to date, including COVID-19 funding and Planned Care.
- IDF inflows are $230k favourable for the month driven by current year wash-ups and favourable $1,203k year to date.

Other MOH Revenue Variance	MTH $000's	YTD $000's
In- Between Travel (prior years)	(0)	(441)
In- Between Travel (2020/21)	11	131
Capitation Funding	(161)	245
Planned Care	769	1,642
Admin & clerical Pay Equity	-	319
COVID-19 Funding	1,042	5,356
COVID-19 Funding - RPH	(127)	(1,527)
Crown funding agreements		
B4 School Check Funding	1	29
Hospice - Cost Pressure funding	12	142
Additional Immunisation funding	72	72
PHO NZNO MECA funding	12	12
More Heart and diabetes checks	(5)	(91)
Additional School Based MH Services	(10)	(118)
Maternity Quality and Safety Programme	(89)	29
Rheumatic Fever Prevention Services	(0)	(72)
Well Child/Tamariki Ora Services	6	73
Other CFA contracts	39	(139)
Year to date Variance $000's	**1,495**	**5,941**

Expenditure:

Governance and Administration is favourable $35k for June. Provider Arm payments variance includes; IDF Wash-up Payments to the Provider and Capital Charge rate reduction.

External Provider Payments:

Pharmaceutical costs are favourable $3,693k for June and unfavourable $1,704k YTD, reflecting the recognition of the Pharmac Rebates in June. We have received $1,763k for increased pharmaceutical costs due to COVID-19.

Capitation expenses are $116k favourable for the month, partially offset by changes to revenue.

Aged residential care costs are $188k favourable for the month.

Other Health of Older People costs are favourable by $224k for the month and favourable $2,319k YTD.

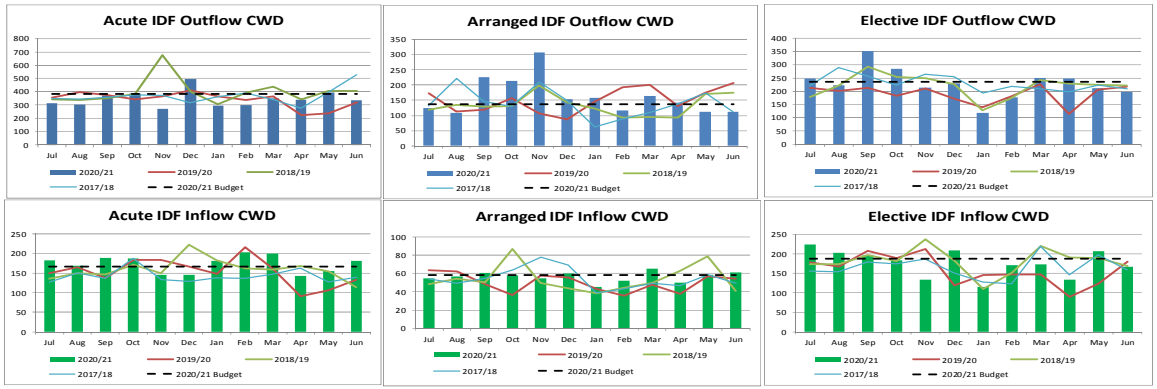
Mental Health costs are unfavourable ($69k) for the month, favourable $1,147k YTD, reflecting timing of contracts.

COVID-19 Payments were ($378k) for the month and ($4,740) YTD.

Other external provider costs are favourable to budget $478k for the month.

IDF Outflows are favourable $342k, due to Current Year Wash-up payments for volumes and PCT's.

Inter District Flows (IDF)



IDF Wash-ups and Service Changes June 2021		
IDF Outflows $000s	Variance to budget	
	Month	YTD
Base	(0)	(2)
CCDHB - Advance Care Planning	18	(38)
CCDHB - Mental Health (MHACS)	(143)	(143)
Wash-ups		
2020/21 Outflows - inpatient	414	0
2020/21 Outflows - outpatient	508	908
2020/21 Outflows - PCT	817	1,498
2020/21 Outflows ATR	302	302
2020/21 PHO	(121)	(347)
2020/21 FFS	-	14
2020/21 Community Pharmacy	(1,452)	(1,452)
2019/20 Wash-ups	-	254
Rounding (timing) differences	-	-
IDF Outflow variance	**342**	**994**

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

IDF inflow (revenue):

- Based on the data available, overall IDF inflows are over budget YTD by $1,203k, mainly due to favourable wash-ups for the year. Inflows for other services under budget ($750k) and inpatient ($377k) under budget. Inpatient inflows are under budget mainly in Plastics, Medical and Cardiology.

IDF Outflow (expense):

- Based on the data available, overall IDF outflows are under budget by $994k year to date mainly due to PCT's and outpatient wash-ups. Inpatient outflows being over budget by ($117k), mainly in Neonates, elective Cardiology and Vascular Surgery at Capital Coast.

Commissioning: Families & Wellbeing

What is this measure?

Mothers

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

Why is this important?

- Early engagement with an LMC provides an opportunity for screening, education and referral, and begins the primary-maternity continuity of care relationship.
- The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of life long physical and psychological benefits for babies.
- Newborn enrolment ensures access to affordable and essential health care as early as possible, such as childhood immunisation, community oral health and Well Child Tamariki Ora services.

How are we performing?

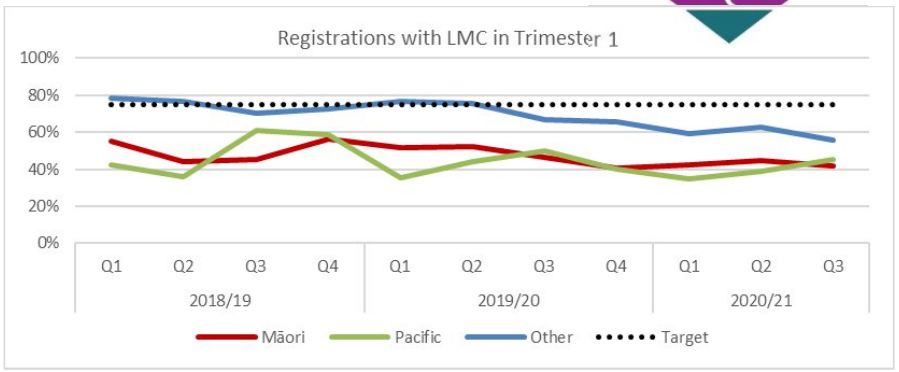
- Performance is below the 75% target for pregnant women registered with a LMC within the 1st trimester of pregnancy for Māori (42%) and Pacific (45%). Non-Māori, non-Pacific is above target at 56%.
- Performance is below the 80% target for infants exclusively or fully breast fed at two weeks for Māori (51%), Pacific (47%) and non-Māori, non-Pacific (62%).
- Performance is below the 85% target for newborns enrolled in a PHO by three months for Pacific (78%). Performance is above target for Māori (85%) and non-Māori, non-Pacific (95%).

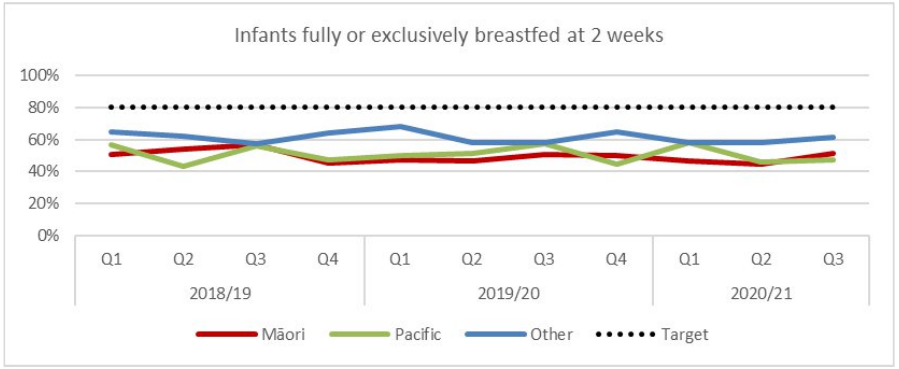
What is driving performance?

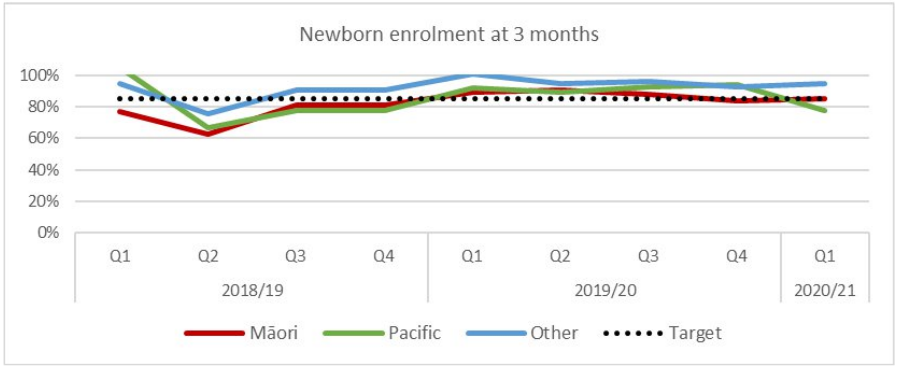
- A national shortage of midwives impacts women's ability to engage early with LMC care
- HVDHB has contracted a breastfeeding education specialist to build a community of support for Māori, Pacific, Indian and disabled women on their breastfeeding journey. The programme will consist of (1) Breastfeeding education/promotion; and (2) Training breastfeeding kaiāwhina
- Work has re-started to get HVDHB's electronic newborn notification system up and running. The system will eliminate the need for faxing and other manual processes currently used as part of the newborn enrolment process.

Management comment

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







Commissioning: Primary & Complex Care

What is this measure?

End of life

- % of clients assessed by InterRAI with an Enduring Power of Attorney (EPOA) in place
- % of clients assessed by InterRAI having funded Advanced Care Plan (ACP) consultation

Why is this important?

- An EPOA appoints someone to make decisions about an individual's personal care and welfare on their behalf.
- Advance Care Planning is a voluntary process of discussion and shared planning for future health care. The process assists the individual to identify their personal beliefs and values, and incorporates them into plans for future health care. This may indicate who the EPOA is. The 2DHB ACP aligns with the HQSC's national ACP overarching vision to "Empower New Zealanders to participate in planning their future care." This has a particular focus on removing inequities in healthcare and outcomes for Māori.

How are we performing?

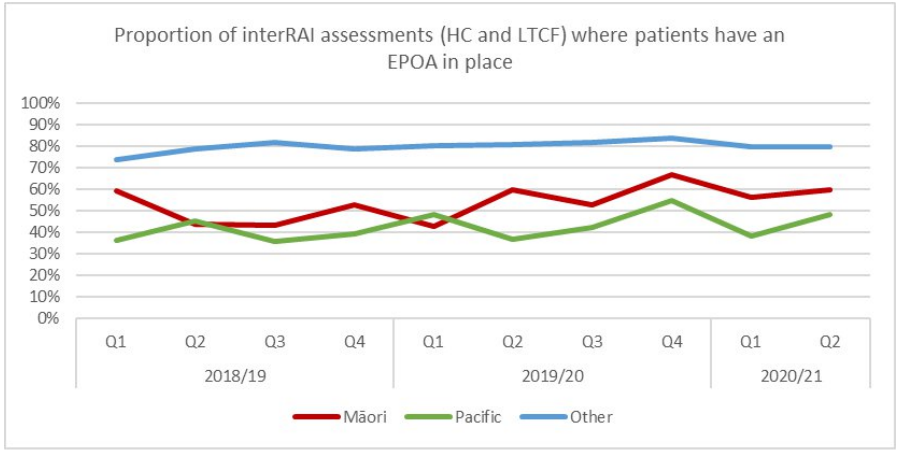
- There are no national or local targets for these performance measures.
- The proportion of people who have an EPOA in place for Māori is 60% and for Pacific is 48%. Performance for Non-Māori, non-Pacific is at 80%.
- The proportion of people who have an ACP in place for Māori is 0% and for Pacific is 2%. Performance for Non-Māori, non-Pacific is at 5%.

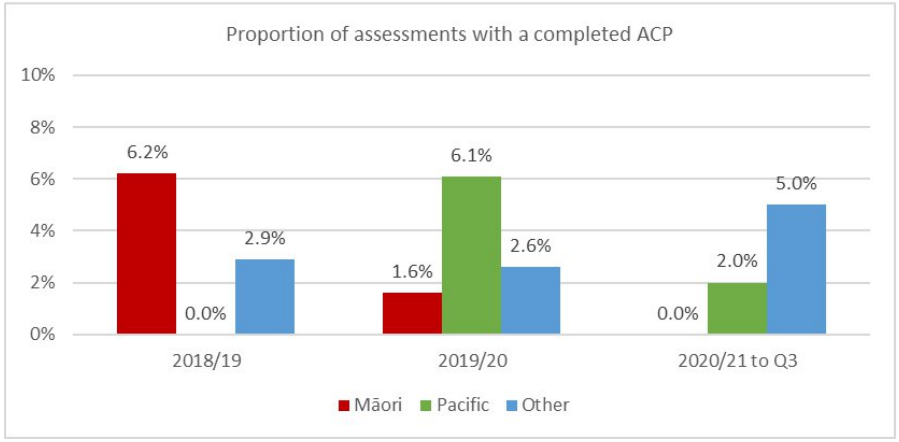
What is driving performance?

- HVDHB is not funded for ACP referrals in the community. We know that investment in our NGOs to support the implementation of ACPs works. NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities.

Management Comment

- The 3DHB ACP coordinator continues engage with key providers of care and community forums across HVDHB to support patients and whanau to complete their ACPS.





Commissioning: Hospital & Speciality Services

What is this measure?

Planned Care

- Did not attend (DNA) rate for first specialist appointment (FSA)
- 95% of patients with accepted referrals for CT scans will receive their scan and results within 6 weeks
- 0% of patients given a commitment to treatment, but not yet treated within the required timeframe (ESPI 5)

Why is this important?

Equity: patients receive care that safely meets their needs, regardless of where they live and who they are.
Access: patients can access the care they need in the right place, with the right health provider.
Quality: Services are appropriate, safe, effective, efficient, respectful and support improved health.
Timeliness: patients receive care at the most appropriate time to support improved health.
Experience: You and your whānau work in partnership with healthcare providers to make informed choices and get care that responds to your needs, rights and preferences.

How are we performing?

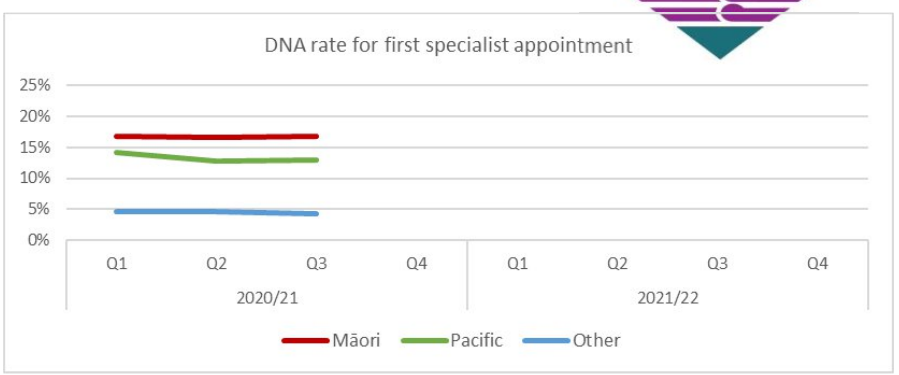
- The proportion of people who did not attend their FSA is 17% for Māori and 13% for Pacific. Performance for Non-Māori, non-Pacific is at 4%.
- Performance is below the 95% target for patients receiving their CT scan in 6 weeks or less. Performance in May 2021 was 91% and has increased from 67% in May 2020.
- The proportion of people given a commitment to treatment, but not yet treated within the required timeframe for Māori is 44% and for Pacific people is 40%. Performance for non-Māori, non-Pacific was 38%.

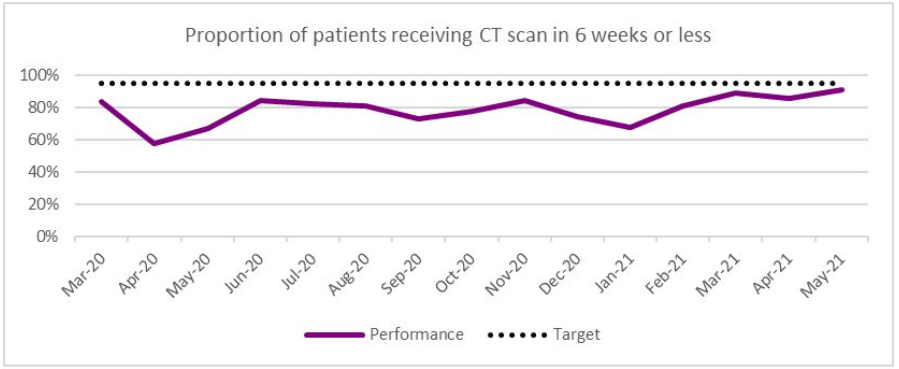
What is driving performance?

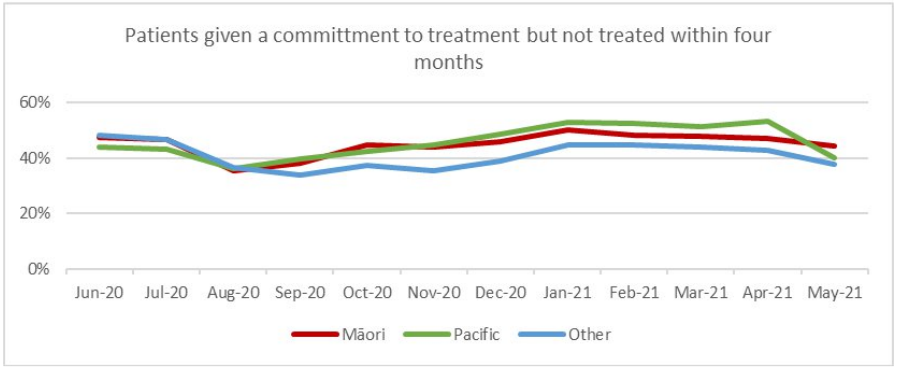
- There is significantly more activity than planned for this financial year and most of it is acute. The majority of the acute activity is surgical and this is impacting planned care provision.

Management Comment

- We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to diagnostics (CT & MRI) and access to elective general surgery, orthopaedic surgery and gynaecology surgery. HVDHB has chosen to focus our $2.3 million service delivery funding in areas of greatest need, and are focused on areas of historically long waitlists and performance.







Commissioning: Mental Health & Addictions

What is this measure?

- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients discharged from TWOM with a Length of Stay of more than 14 days
- Number of people aged 0-19 years referred to AOD services

Why is this important?

- Reducing wait times corresponds to earlier treatment in the progression of illness and links to better outcomes. Timeliness is a key quality indicator
- The demand for acute inpatient services continues to grow. Length of stay has an impact on ward occupancy and therefore the capacity to respond to demand.
- Currently, there is no community based AOD service designed for youth, we are seeing a large proportion of youth presenting at EDs for AOD-related reasons, highlighting unmet need.

How are we performing?

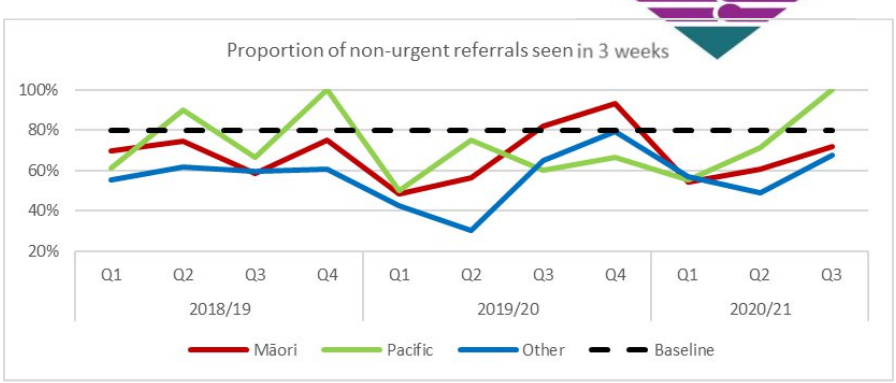
- Performance is below the 80% target for non-urgent referrals seen within 3 weeks for Māori (72%), and Non-Māori, non-Pacific (68%). Performance for Pacific was Pacific.
- There has been an overall decrease in the number of people discharged from TWA with a Length of Stay of more than 14 days. In the year to date, there have been 34 Māori, and 14 Pacific patients.
- In the year to date, 46 Māori youth have been referred to AOD services; 8 Pacific you have been referred.

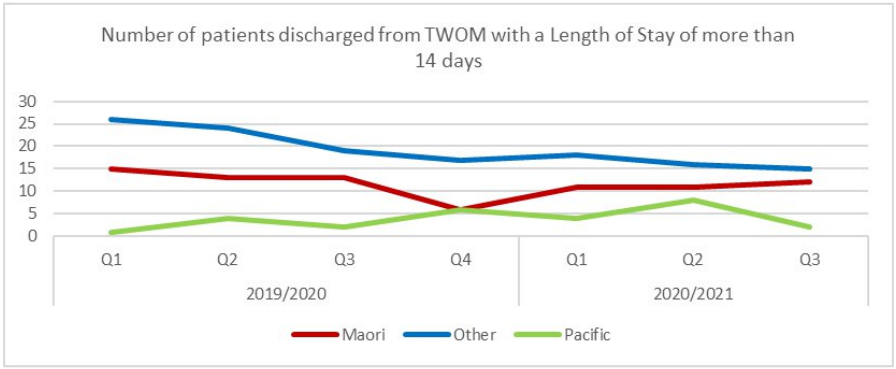
What is driving performance?

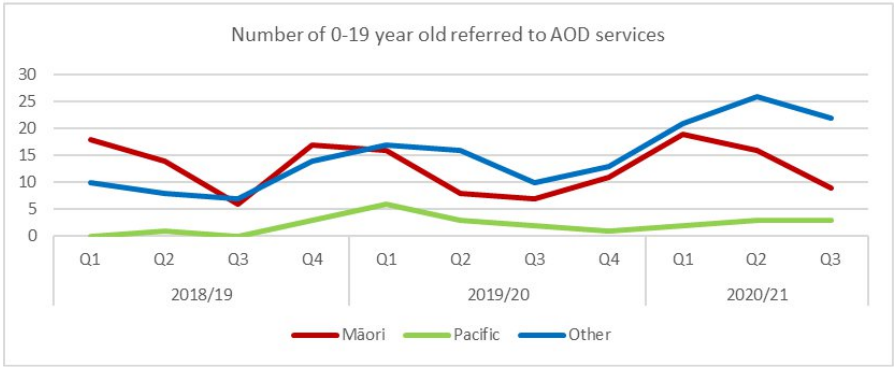
- MHAIDS are developing smart systems as a key enabler of effective service delivery, including the Te Haika upgrade.
- The 3DHB Acute Care Continuum project is developing increased access to Crisis Respite services as an alternative to acute inpatient care or earlier discharge pathways.
- The 3DHB Model of Care for Addictions is being implemented. This will support improved health outcomes and improve our ability to achieve equity for our priority populations. Establishment of a new investment in primary and community mental health service will offer improved access to youth and adult clients.

Management comment

- We are working to improve patient flow by reviewing the journey from inpatient units into stepdown facilities to create a smooth transition into lower levels of care. By providing a streamlined transition into lower levels of care, there is an opportunity to reduce length of stay.
- We are implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.







2DHB COVID-19 Response

What is this measure?

- COVID-19 vaccination roll-out

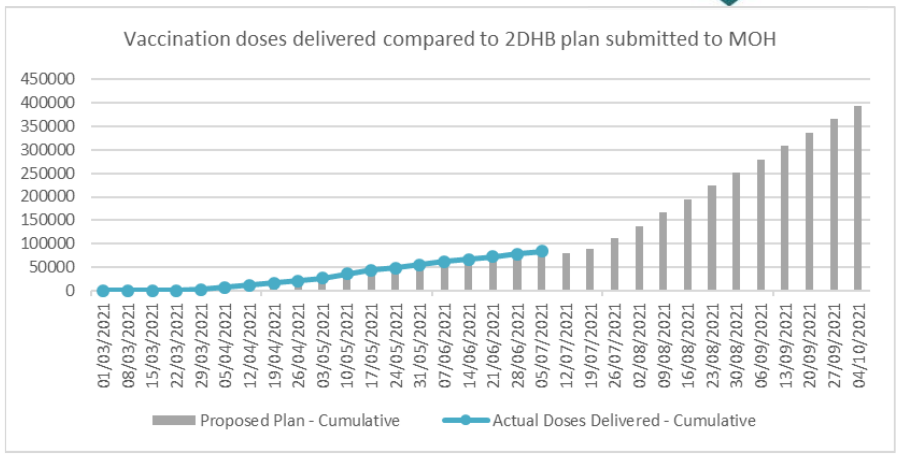
Why is this important?

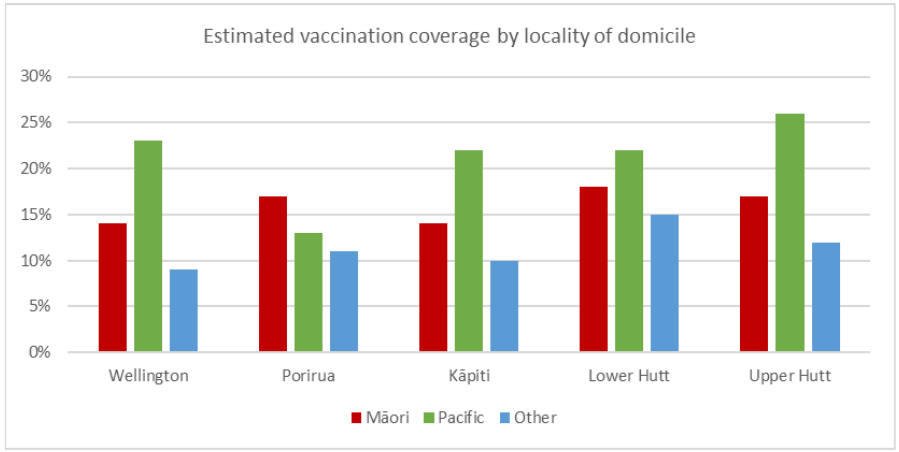
- The COVID-19 vaccine rollout aims to protect Aotearoa by ensuring that everyone over 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

How are we performing?

- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area
- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings
- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

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





Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 04/07/2021
Data current at: 05/07/2021 @11:00am

Section 3

Hospital Performance

Executive Summary – Hospital Performance

- Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action. ED and specialities have worked together to consider alternative pathways of care rather than an inpatient stay; Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.
- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes however we are making slow progress against our long wait patients and at year end we are at our planned care target with continuing work in place to achieve the Recovery wait list trajectories. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.
- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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.
- Medical and Nursing service costs remain unfavourable to budget driving the overall provider result. The impact of more complex patients/increasing one to one care, treatment related costs particularly treatment disposables and implants are high again this month taking us well ahead of plan in line with the increased acute demand for surgery. Nursing Mitigations in place include active recruitment for the required FTE to reduce overtime, casual/allocation use, completion of the CCDM roll out and continual review use of minders/cohort watches to keep the level to a reasonable safe level. Leave planning is in place for the holiday period.

Hospital Throughput

Month					Hutt Valley DHB Hospital Throughput YTD Jun-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							
1,191	1,071	(120)	1,057	(134)	Surgical	13,880	12,950	(930)	12,128	(1,752)	12,950	12,797
1,939	1,668	(271)	1,861	(78)	Medical	22,570	19,737	(2,833)	21,024	(1,546)	19,737	19,506
445	435	(10)	499	54	Other	5,769	5,374	(395)	5,484	(285)	5,374	5,474
3,575	**3,174**	**(401)**	**3,417**	**(158)**	**Total**	**42,219**	**38,061**	**(4,158)**	**38,636**	**(3,583)**	**38,061**	**37,777**
					CWD							
1,259	1,148	(111)	1,074	(185)	Surgical	14,779	13,889	(889)	13,073	(1,706)	13,889	12,852
1,073	854	(219)	952	(122)	Medical	11,961	10,719	(1,242)	11,264	(697)	10,719	11,991
507	459	(49)	522	14	Other	6,727	5,811	(917)	6,589	(138)	5,811	4,698
2,840	**2,461**	**(379)**	**2,548**	**(292)**	**Total**	**33,467**	**30,419**	**(3,048)**	**30,926**	**(2,541)**	**30,419**	**29,540**
					Other							
4,331	4,166	(165)	3,720	(611)	Total ED Attendances	50,206	48,696	(1,510)	46,058	(4,148)	48,696	47,491
952	1,003	51	922	(30)	ED Admissions	12,086	11,386	(700)	11,217	(869)	11,386	11,847
846	738	(108)	733	(113)	Theatre Visits	9,587	9,370	(217)	8,514	(1,073)	9,370	9,271
145	112	(33)	136	(9)	Non- theatre Proc	1,631	1,500	(131)	1,548	(83)	1,500	1,891
7,674	7,030	(644)	7,232	(442)	Bed Days	89,609	82,873	(6,736)	85,177	(4,432)	82,873	85,515
4.80	4.50	(0.30)	4.32	(0.48)	ALOS Inpatient	4.55	4.50	(0.04)	4.51	(0.04)	4.50	4.29
2.18	2.18	(0.00)	1.96	(0.22)	ALOS Total	2.08	2.18	0.10	2.18	0.11	2.18	2.20
8.08%	8.02%	-0.07%	7.31%	-0.77%	Acute Readmission	7.80%	8.02%	0.21%	7.84%	0.04%	7.31%	7.36%

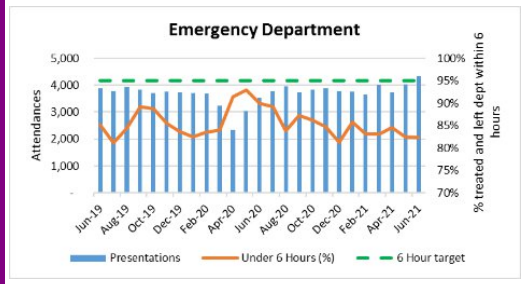
For the month, Surgical and Medical discharges and caseweights (CWD) were higher than budget and the same time last year (COVID-19 lockdown period). Year to date, CWD for Surgical services are over budget mainly due to higher General Surgery, Orthopaedics and Gynaecology volumes. Medical year to date, discharges and CWD are higher than budget, mainly due to an increase Gastroenterology and Rheumatology compared to the last two years offset by lower volumes for Paediatrics. General medicine acute CWD and ED admissions (treated over 3 hours) have also increased compared to the last two years. Other services are higher than budget due to more discharges under Maternity. Total ED visits were higher than budget for the month but the number of patients who were admitted from ED was lower than budget. Over the year, ED visits were higher mainly in October, November and February compared to the same time in the last two years. Theatre visits and Non-theatre procedures were higher than budget for the month, and higher than budget year to date. Bed days were significantly higher than budget for the month and higher year to date. Inpatient ALOS in June was longer than budget and the same time last year. The acute readmission rate was close to budget for the month but higher than the same time last year.

Operational Performance Scorecard – 13 mths

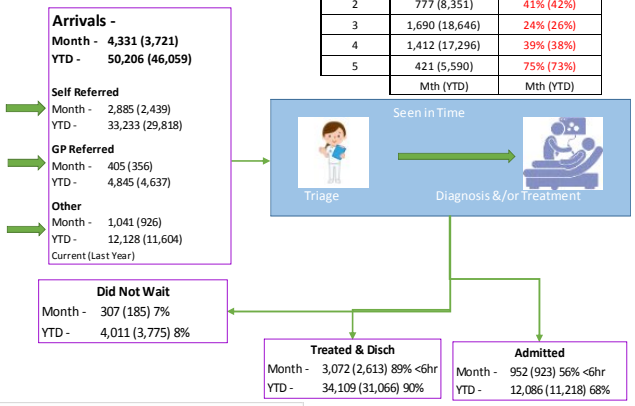
Domain	Indicator (MoH KPIs highlighted yellow)	2019/20 Target	13 Months Performance Trend													Last 4 Weeks			
			Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	14/06/21	21/06/21	28/06/21	5/07/21
Safe	Serious Safety Events[1]	Zero	2	3	3	1	2	3	0	1	3	3	3	0	2				
	SABSI Cases [2]	Zero	0	1	0	1	2	1	1	1	0	1	0	0	1				
	C. difficile infected diarrhoea cases	Zero	0	3	4	1	1	4	0	1	0	1	2	1	1				
	Hand Hygiene compliance (quarterly)	≥ 80%	87%	82%			79%			79%			TBC						
	Seclusion Hours- average per event (MH Inpatient ward TWA)[3]		13.8	27.7	36.7	11.4	13.3	1.4	43.6	7.6	22.4	39.8	13.6	21.0	21.4				
Patient and Family Centred	Complaints Resolved within 35 calendar days[4]	≥90%																	
	Patient reported experience measure[5] (quarterly)	≥80%	N/a	N/a			N/a			N/a			N/a						
Timely	Emergency Presentations	49,056	3,721	4,039	4,281	3,997	4,273	4,328	4,259	4,059	4,026	4,315	3,982	4,315	4,331	1,031	968	1,137	1,144
	Shorter Stays in ED (SSiED) % within 6hrs	≥95%	89.9%	89.2%	84.0%	87.2%	86.3%	84.8%	81.3%	85.8%	83.1%	83.1%	84.6%	82.6%	81.5%	82.7%	86.4%	75.5%	75.9%
	SSiED % within 6hrs - non admitted	≥95%	94.7%	93.3%	90.7%	91.5%	91.0%	89.8%	86.9%	90.7%	89.9%	89.5%	89.7%	89.6%	89.2%	91.1%	92.2%	84.8%	83.1%
	SSiED % within 6hrs - admitted	≥95%	76.1%	78.6%	64.5%	75.1%	73.2%	71.8%	66.3%	72.0%	62.8%	65.3%	70.3%	61.3%	56.8%	55.0%	66.5%	46.7%	51.9%
	Total Elective Surgery Long Waits -ESPI 5	Zero Long Waits	1,130	1,082	913	915	992	1,002	1,115	1,251	1,328	1,238	1,177	1,020	904	941	925	897	875
	No. Theater surgeries cancelled (OP 1-8)		98	140	148	154	142	128	138	87	139	198	124	127	186	31	37	19	
	Total Elective & Acute Operations in MainTheatres 1-8[6]		733	868	792	805	824	775	744	664	712	898	816	843	846	226	182	100	
	Specialist Outpatient Long Waits- ESPI 2	Zero Long Waits	1,240	1,096	798	674	723	704	758	1,016	1,124	1,093	1,015	808	625	728	687	660	664
	Outpatient Failure to Attend %	≤6.3%	8.3%	6.8%	6.3%	5.4%	5.6%	6.0%	6.2%	7.7%	5.6%	5.5%	6.2%	6.4%	6.6%	5.3%	6.8%	7.9%	5.9%
	Full Year Forecast surplus / (deficit) $m - Provider (1) (2)	($2.03)	($14.20)	($10.61)	($10.61)	($15.38)	($12.54)	($14.33)	($14.64)	($14.29)	($16.06)	($19.72)	($20.40)	($25.09)	TBC				
	Full Year Forecast surplus / (deficit) $m - DHB (1) (2)	($8.14)	($21.45)	($10.65)	($10.65)	($13.37)	($12.31)	($12.87)	($14.54)	($14.33)	($14.24)	($14.25)	($14.01)	($16.93)	TBC				
	% Theatre utilisation (Elective Sessions only)[7]	≤90%	87.6%	85.7%	87.9%	90.4%	86.2%	88.1%	87.2%	86.4%	87.2%	87.8%	88.4%	87.8%	87.3%	87.5%	89.6%	85.7%	
	Overnight Patients - Average Length of Stay (days)	≤4.3	4.44	4.39	4.76	4.52	4.26	4.72	4.79	4.50	4.37	4.89	4.35	4.64	4.84	4.30	4.57	5.04	4.34
	Long Stay Patients Not Yet Discharged (>14 days)	≤5	14	16	21	17	15	21	24	21	34	20	23	29	22	25	27	27	26
	Overnight Beds (General Occupancy) - Average Occupied	≤130	136	141	151	144	130	138	144	130	149	146	143	148	152	155	154	152	152
	Overnight Beds (General Occupancy) - % Funded Beds Occupied	≤85%	84.2%	86.8%	93.1%	88.8%	80.4%	85.1%	93.4%	84.7%	96.5%	94.8%	92.9%	96.2%	98.5%	100.8%	99.7%	95.6%	93.9%
	All Beds - ave. beds occupied[8]	≤250	241	244	254	249	231	240	240	229	253	253	243	255	256	256	260	264	266
	% sick Leave v standard	≤3.5%	3.1%	4.3%	4.2%	4.0%	3.4%	3.4%	3.1%	2.0%	2.5%	3.5%	3.1%	3.2%	3.8%				
	% Nursing agency v employee (10)	≤1.49%	2.0%	1.6%	1.2%	2.2%	26.2%	12.7%	12.7%	12.8%	12.4%	13.0%	11.8%	0.4%	TBC				
	% overtime v standard (medical) (10)	≤9.22%	9.2%	6.7%	7.8%	8.1%	9.2%	10.7%	6.9%	11.9%	9.6%	7.9%	8.3%	10.1%	TBC				
	% overtime v standard (nursing)	≤5.47%	12.3%	10.8%	13.6%	12.3%	12.3%	14.4%	11.6%	23.7%	14.2%	11.2%	15.7%	13.2%	TBC				

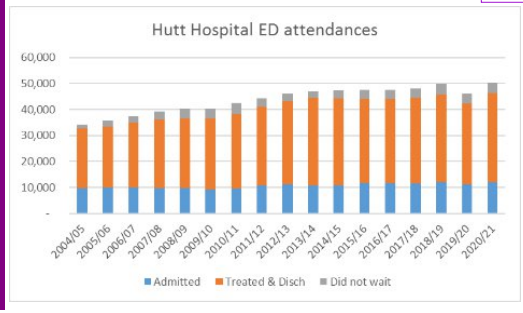
Refer to later pages for more details on HVDHB performance. Highlighted where an identified target in 20/21.

Shorter Stays in Emergency Department (ED)



Category	Volume	% Seen in time
1	31 (323)	100% (100%)
2	777 (8,351)	41% (42%)
3	1,690 (18,646)	24% (26%)
4	1,412 (17,296)	39% (38%)
5	421 (5,590)	75% (73%)
	Mth (YTD)	Mth (YTD)





- **What is this Measure**
  - The percentage of patients admitted, discharged and transferred from an Emergency Department within 6 hours.
- **Why is it important**
  - This indicator measures flow through the whole system it is impacted by the number planned of people arriving at ED, how fast ED treats them, availability of beds in the hospital and community service availability.
- **How are we performing**
  - The month of June has seen an overall increase in ED presentations when compared with June 2020. This combined with a sustained increase in presentations of a higher acuity and a hospital bed state running over 90% capacity has pressurised our ability to treat and move on patients from the ED within 6 hours.
- **What is driving Performance**
  - A 5% increase in children under the age of 6 presenting for care this month is a noticeable comparison to June 2020 data.
  - Despite the increased pressures of acuity and increased presentation numbers, this has prompted the ED and specialities to consider alternative pathways of care rather than an inpatient stay. June 2021 sees a 3% reduction in admission rate compared with June 2020.
- **Management Comment**
  - The pressures in June see the principles of our Winter Plan in action. Inpatient areas are flexing up in bed numbers in order to better match the needs of our community who are presenting for care. This is the whole of system approach working together to enable shorter stays in ED.

Planned Care Funding & Service delivery

Figure one: Planned care funding sources

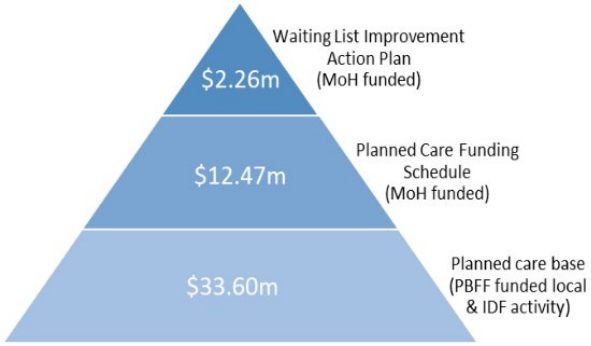
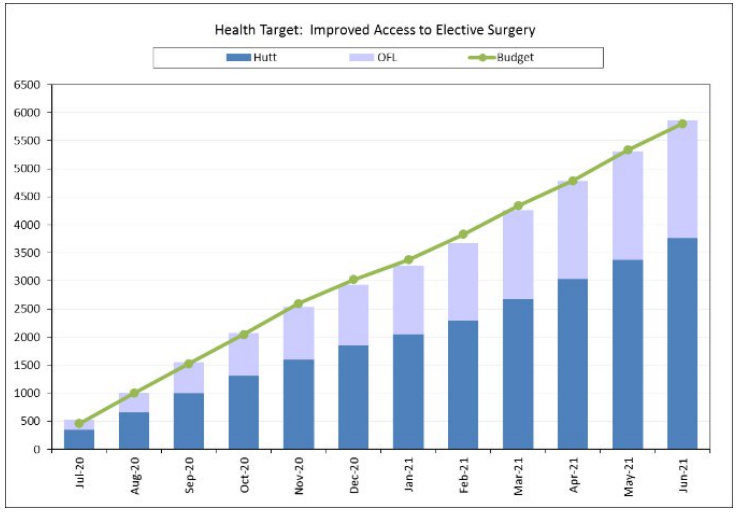
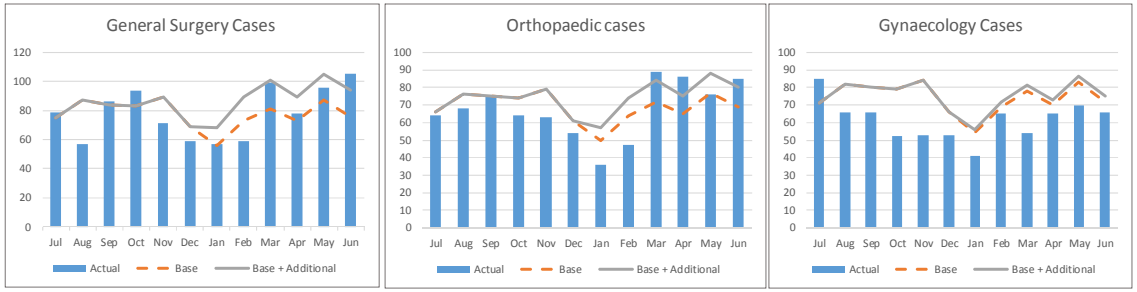


Figure two: Discharge trajectory for Planned care base and Planned care funding schedule – 101%

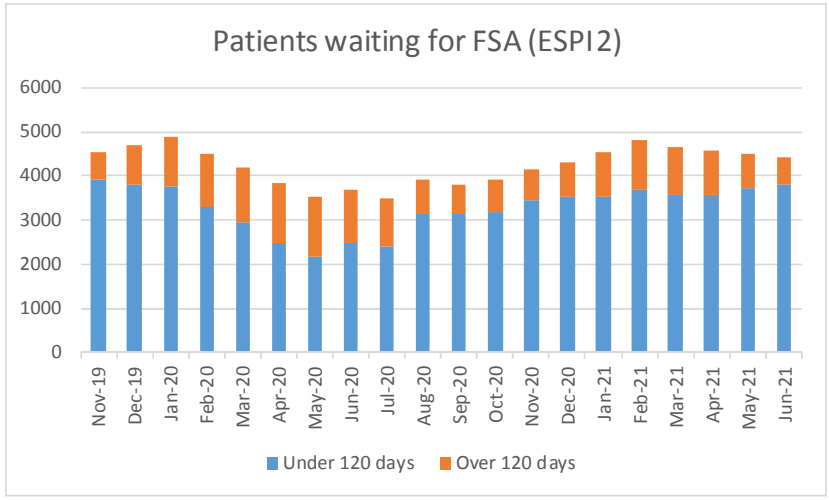


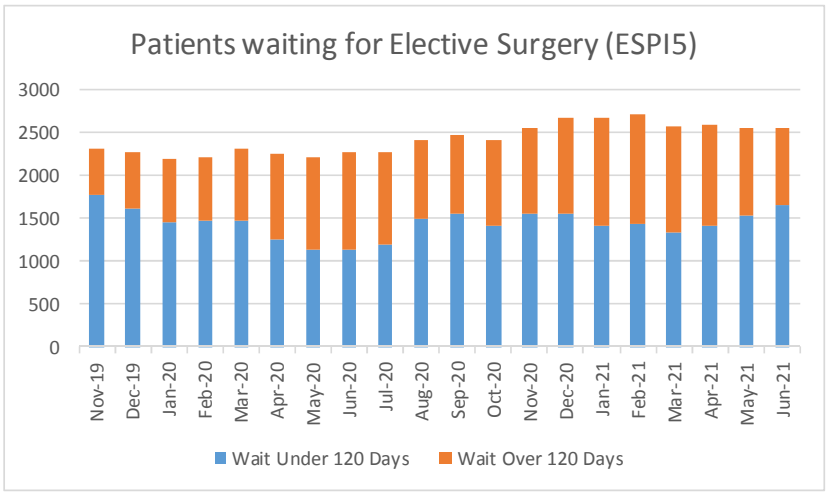
- **What is this measure?**
  - The delivery of an agreed number of inpatient surgical discharges and minor procedures to the Hutt Valley Population
  - The are three funding sources as per figure one – this is important as each has measures and deliverables required to access the funding which is paid after delivery .
- **How are we performing?**
  - Discharges are 58 ahead plan for the Planned care base and Planned Care Funding Schedule (figure one) – this equates to 101% as per figure 2.
  - June results were an improvement from May however acute demand and NZNO Industrial action did result in some cancellations.
  - The increase in acute surgical presentations displaces planned surgeries as the theatres and beds are required for acute cases. Two of our most pronounced examples are in General Surgery and Orthopaedics as described earlier
  - Data submissions for IAP have not yet closed however we have an indicative position of receiving $900k
- **What is driving performance?**
  - Saturday elective operating sessions continue to assist with general surgery waitlist recovery.
  - The sub-regional skin cancer pathway with CCDHB was agreed in May and service provision expected to commence in July 2021. This will relieve the pressure on the Plastic Surgery Service.

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

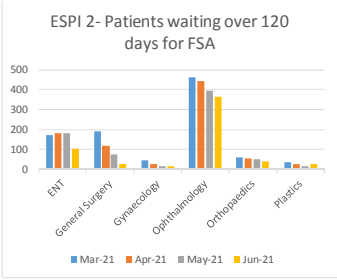


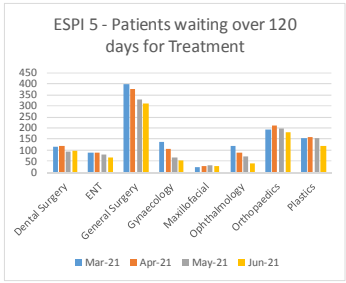
Planned Care – waiting times-

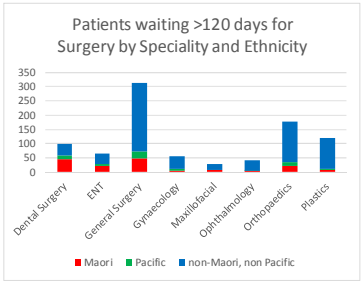




- **What is this measure?**
  - The delivery of Specialist assessments or Treatment within 120 days
- **Why is it important?**
  - It is important to ensure patients receive care at the most appropriate time to support improved health.
- **How are we performing?**
  - The total waiting for an FSA decreased by 2.3% (102) this month. The number waiting over 120 days fell by 23% (183)
  - The number waiting for elective surgery fell by 1 to 2,551 and the number waiting over 120 days fell by 116 to 904
  - However the numbers of patients waiting longer than 120 days for both assessment and treatment remains high.

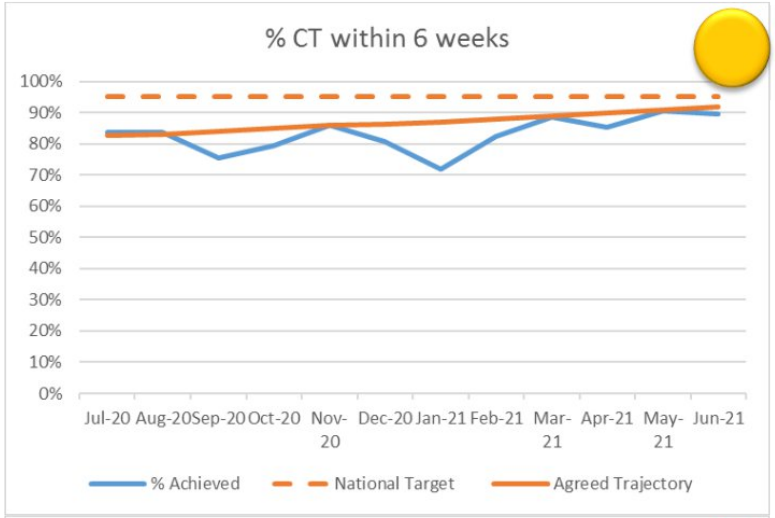


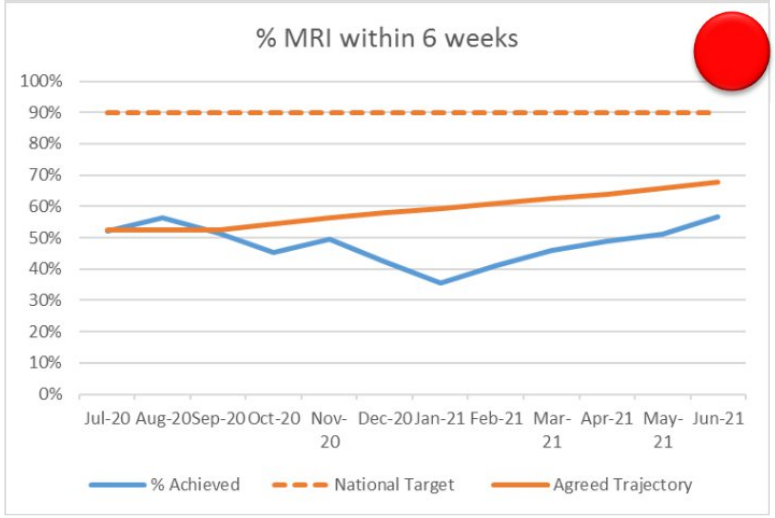




- **What is driving performance?**
  - Principally managing inflows to our waiting list and balancing against outflows is not yet robust,
  - Registered Nursing staffing in the value chain for OR production does not meet patient demand however we are moving to correct this .
  - Cancellations due to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

CT & MRI wait times

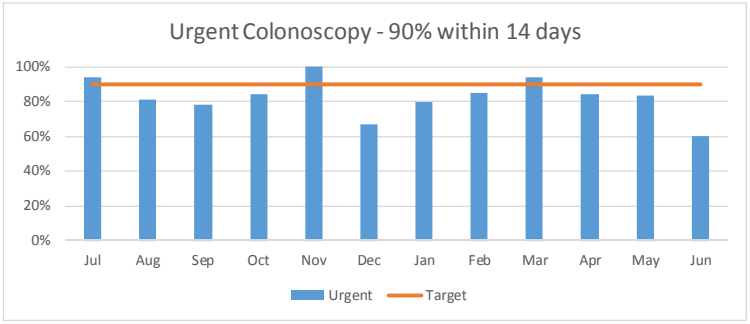




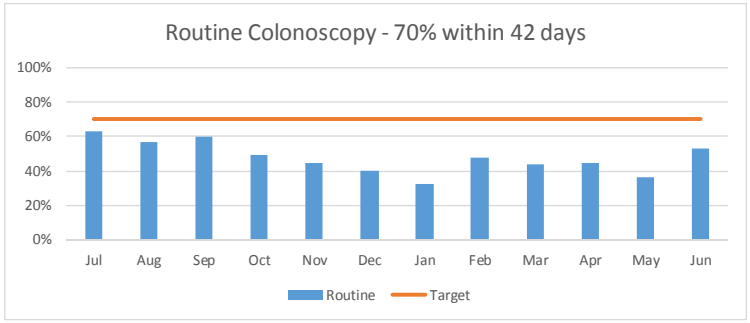
- **What is this measure?**
  - The delivery of computerised tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans in a timely fashion to non-acute patients (within 42 days of referral).
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - The % of patients receiving their MRI within 6 weeks is improving.
  - CT wait times remain close to target.
- **What is driving performance?**
  - CT is at 90% scanned and reported within 6 weeks.
  - MRI performance continues to improve just above the newly agreed (with MOH) trajectory with 52.7% scanned and reported within 6 weeks.

- **Management comment**
  - Actions currently underway:
    - A further two contract reporters for 2 days per week have commenced
    - Managed daily outsourcing of reporting to Pacific Radiology to support in-house Radiologists.
    - Voluntary overtime weekend MRI day lists – approximately 4 days per month
    - Weekend CT day list - approximately 4 days per month
    - MOH Planned Care funding being used to outsource 30 MRIs per month

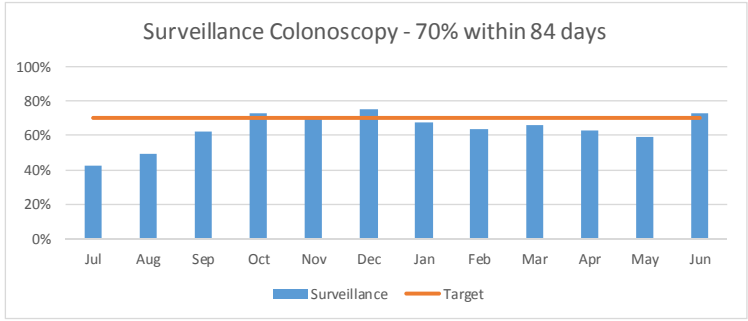
Colonoscopy Wait Times



Urgent
87% YTD



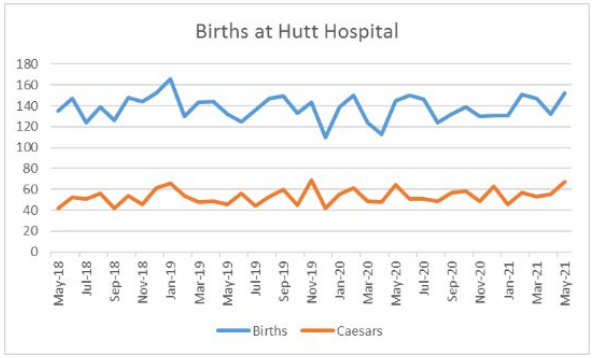
Routine
49% YTD

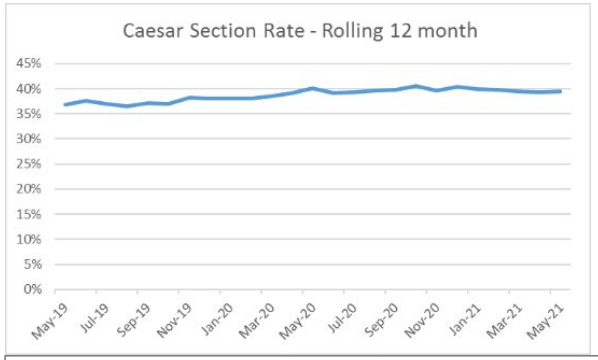


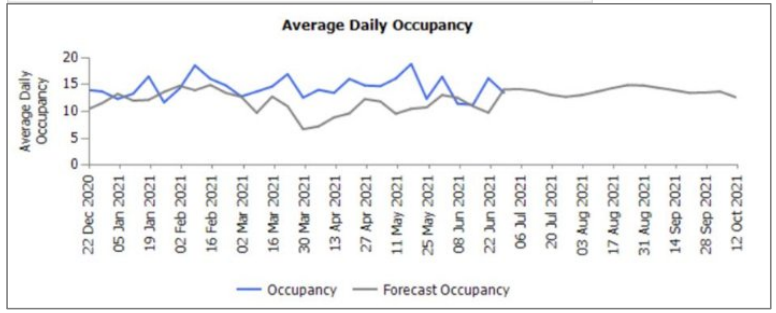
Surveil
62% YTD

- **What is this measure?**
  - The delivery of Colonoscopy, urgent within 14 days, routine 42 days and surveillance within 84 days of being due.
- **Why is it important?**
  - Delayed diagnostic results can negatively affect health outcomes.
- **How are we performing?**
  - We have met the target for Surveillance and are close to target for Urgent colonoscopies. However we continue to struggle with routine
  - One patient is outside of the target for Urgent (Maori). They were deferred as are not medically fit. Four Maori are overdue (routine category) however they are all being actively pursued to enable a booking asap although contact is proving challenging for some.
  - There are no pacific overdue for any category
- **What is driving performance?**
  - The growing surveillance waitlist continues to put additional pressure on the service along with overall increase in referrals.
  - There is concerted effort occurring to ensure that there are no Maori or Pacific patients overdue for any category however this has been a challenge in June with 3 pacific and 5 Maori overdue all subsequently booked in for July.
  - All patients that are waiting outside maximum timeframes are booked in for July and August.
- **Management comment**
  - A new performance and monitoring plan has been developed as is being used in the service.
  - The service is now projecting full recovery by November 2021 with it being in a stable position from then.

Maternity

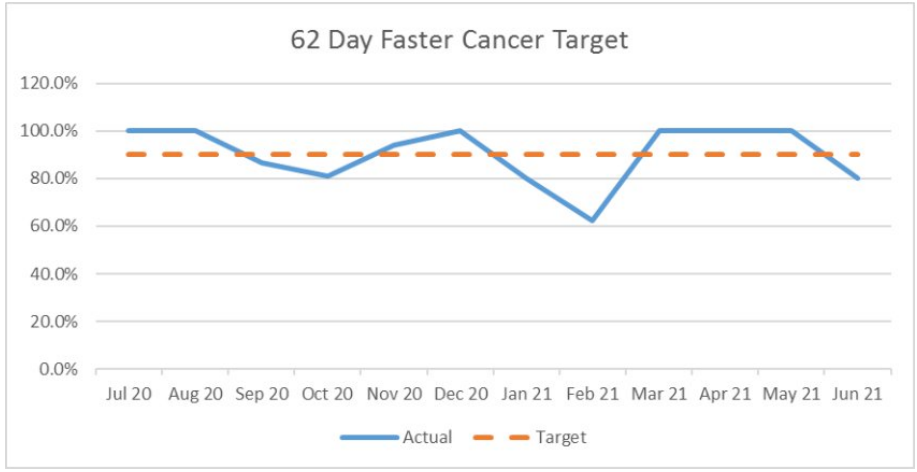


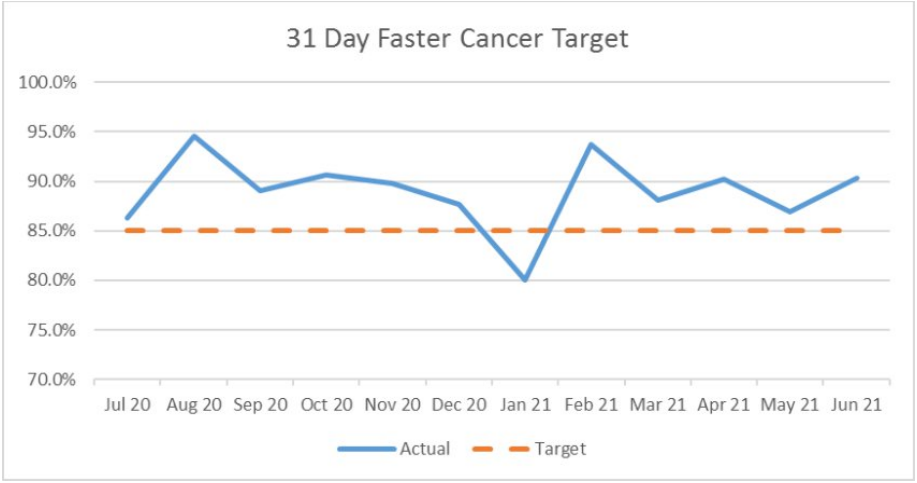




- **What is the issue?**
  - In 2019 a number of clinical and community concerns around Hutt hospital's maternity services were identified.
- **Why is it important?**
  - An external review of the service and HDC investigations showed a number of areas where improvements needed to be made.
- **How are we performing?**
  - Hutt Valley DHB is making positive progress on the birthing optimisation project and audit of caesarean cases. This audit covers the period from April-June 2021 and focuses on the criteria for caesarean sections and pathways for optimal birth. Findings from the audit will be reviewed and analysed over the coming month.
- **Management comment**
  - The Minister of Health confirmed in January 2021 approval to invest $9.47 million capital funding to upgrade the Maternity Assessment Unit, Maternity Ward and Special Care Baby Unit (SCBU). Phase One of building work (CMT space) is complete. Phase Two (MAU) is in final design - concept and building consent stage.
  - A 2DHB International Midwifery campaign is underway.
  - Registered midwife, senior nurse, and registered nurse vacancies across Hutt Valley DHB maternity services currently sit at 14.43FTE.
  - A small number of RNs have been employed to support the care provided in maternity.
  - A comprehensive orientation and education package has been developed to support nurses working in maternity and recruitment for clinical coaching positions is underway.

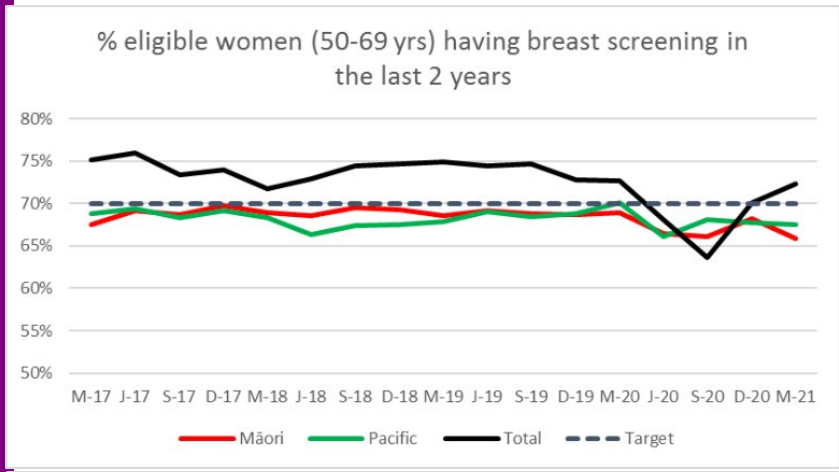
Faster Cancer Treatment

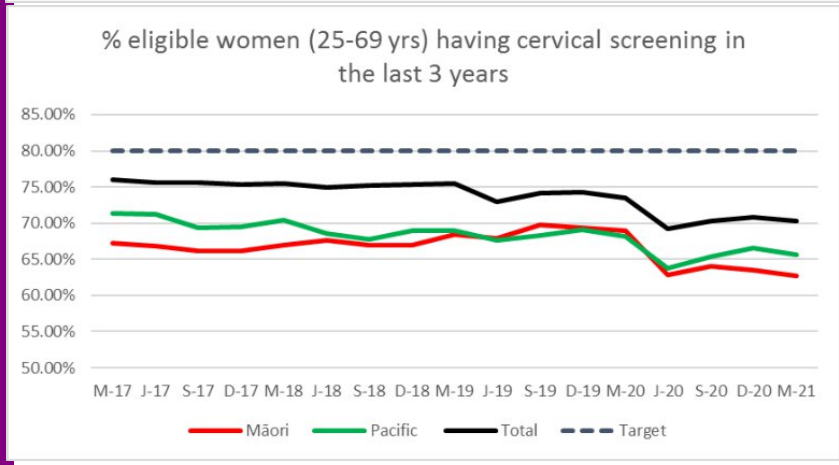




- **What is the issue?**
  - 62 day target: 90% of patients should receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
  - 31 day indicator: The maximum length of time a patient should have 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?**
  - 80% of patients met the HVDHB 62 day pathway for June. (2 out of 10 patients breached due to capacity related issues). 90% for the 31 day target pathway was achieved.
- **What is driving performance?**
  - The first component of assessment from referral is well achieved and the latter part of treatment is the area needing focus.
- **Management Comment**
  - Individual breaches are viewed through MDT across both DHBs.

Screening





- **What is the issue?**
  - 80% of Women aged 25-69 have completed cervical screening in the previous three years
  - 70% of Women aged 50-69 have completed breast screening in the previous two years
- **Why is it important?**
  - By improving breast and cervical screening coverage DHBs will assist in delivery of the Government's priority to support healthier, safer and more connected communities and our health system outcome that we live longer in good health
- **How are we performing?**
  - COVID lockdowns have resulted in a backlog of 6000 women that are overdue for BreastScreening in the 20/21 year. There has been longstanding recruitment issues for both Medical Imaging Technologists (MIT) and Radiologists.
- **What is driving performance?**
  - In June the service continues to provide Saturday sessions for the full month and screening capacity has met projected target. Saturdays and evening clinics continue to be run on a volunteer basis while Medical Imaging Technologist (MIT) recruitment has been pursued.
  - Provision of 'Free Cervical Screening' after hour evening clinics and Saturday clinics targeted at wāhine Māori, Pacific and Asian women has aided increased Cervical coverage.
  - Māori, Pacific and Asian (cervical) women continue to be prioritised for screening in both Cervical and Breast Screening.
- **Management Comment**
  - MIT Recruitment continues with a contract for a casual MIT signed this month.
  - Voluntary Saturday screening continues with five clinics at Kenepuru site including a priority clinic. Extended screening weekday hours at the Hutt Valley Breast Centre as staffing allows started this month with eight clinics allowing an additional 16 women to be screened.
  - Submissions for the admin team consultation decision, moving to a 6 day rostered and rotating service was extended to the end of June, with a decision due July.

Section 4

Financial Performance & Sustainability

Summary of Financial Performance for June 2021 (unaudited)

Month					$000s	Year to Date								
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year	Variance	
					Revenue									
41,759	40,313	1,446	38,849	2,910	Devolved MoH Revenue	489,113	483,750	5,363	454,822	34,291	483,750	454,822	32,568	
2,812	1,742	1,071	2,579	233	Non Devolved MoH Revenue	21,680	20,049	1,631	19,272	2,407	20,049	19,272	1,320	
628	632	(4)	(360)	988	ACC Revenue	7,129	7,219	(90)	6,457	672	7,219	6,457	677	
659	522	137	234	425	Other Revenue	7,483	6,309	1,174	6,074	1,409	6,309	6,074	1,072	
9,458	9,229	230	9,313	146	IDF Inflow	111,945	110,742	1,203	102,288	9,657	110,742	102,288	9,364	
1,160	303	856	495	665	Inter DHB Provider Revenue	13,197	3,637	9,560	4,507	8,690	3,637	4,507	8,441	
56,476	**52,740**	**3,736**	**51,110**	**5,366**	**Total Revenue**	**650,547**	**631,707**	**18,840**	**593,420**	**57,127**	**631,707**	**593,420**	**53,442**	1
					Expenditure									
					Employee Expenses									
5,640	5,365	(276)	4,973	(667)	Medical Employees	62,678	63,310	632	60,010	(2,668)	63,310	60,010	(2,281)	
5,629	6,461	832	6,524	895	Nursing Employees	72,415	76,767	4,352	75,339	2,924	76,767	75,339	2,361	
2,261	2,952	691	2,822	561	Allied Health Employees	28,663	34,575	5,912	32,175	3,512	34,575	32,175	3,245	
804	725	(79)	765	(39)	Support Employees	9,579	8,394	(1,185)	8,676	(903)	8,394	8,676	(945)	
2,012	2,602	589	2,421	409	Management and Admin Employees	26,733	30,842	4,108	28,166	1,433	30,842	28,166	1,130	
16,346	**18,104**	**1,757**	**17,505**	**1,159**	**Total Employee Expenses**	**200,068**	**213,888**	**13,819**	**204,366**	**4,298**	**213,888**	**204,366**	**3,510**	2
					Outsourced Personnel Expenses									
724	247	(477)	488	(236)	Medical Personnel	5,973	2,965	(3,007)	3,763	(2,210)	2,965	3,763	(2,135)	
718	91	(627)	131	(587)	Nursing Personnel	6,407	1,093	(5,315)	2,002	(4,405)	1,093	2,002	(4,315)	
509	87	(422)	75	(434)	Allied Health Personnel	4,561	1,049	(3,511)	583	(3,978)	1,049	583	(3,995)	
55	20	(34)	55	0	Support Personnel	491	244	(247)	522	31	244	522	65	
963	164	(799)	135	(828)	Management and Admin Personnel	7,031	1,765	(5,267)	1,671	(5,360)	1,765	1,671	(5,069)	
2,969	**610**	**(2,359)**	**884**	**(2,085)**	**Total Outsourced Personnel Expenses**	**24,463**	**7,116**	**(17,347)**	**8,541**	**(15,922)**	**7,116**	**8,541**	**(15,449)**	2
1,445	697	(748)	1,120	(325)	Outsourced Other Expenses	13,157	8,363	(4,794)	9,845	(3,313)	8,363	9,845	(2,718)	3
4,029	2,417	(1,612)	604	(3,425)	Treatment Related Costs	33,080	28,666	(4,415)	27,169	(5,911)	28,666	27,169	(4,578)	4
3,044	1,575	(1,469)	19,488	16,444	Non Treatment Related Costs	36,000	18,465	(17,535)	37,215	1,216	18,465	37,215	1,698	5
8,808	9,151	342	10,680	1,872	IDF Outflow	108,813	109,807	994	101,298	(7,514)	109,807	101,298	(6,223)	6
14,878	19,088	4,211	22,037	7,159	Other External Provider Costs	223,654	227,534	3,880	218,583	(5,072)	227,534	218,583	(9,232)	7
1,854	2,376	521	2,358	504	Interest, Depreciation & Capital Charge	23,537	28,517	4,980	25,186	1,649	28,517	25,186	1,400	8
53,374	**54,017**	**644**	**74,676**	**21,303**	**Total Expenditure**	**662,772**	**642,354**	**(20,418)**	**632,203**	**(30,569)**	**642,354**	**632,203**	**(31,592)**	
3,102	**(1,277)**	**4,380**	**(23,567)**	**26,669**	**Net Result**	**(12,226)**	**(10,647)**	**(1,578)**	**(38,784)**	**26,558**	**(10,647)**	**(38,784)**	**21,850**	
					Result by Output Class									
6,234	(128)	6,362	(6,250)	12,484	Funder	11,939	(9)	11,949	(7,889)	19,829	(9)	(7,889)	15,014	
217	22	195	89	128	Governance	1,261	310	951	634	627	310	634	397	
(3,349)	(1,171)	(2,178)	(17,406)	14,057	Provider	(25,425)	(10,948)	(14,477)	(31,528)	6,102	(10,948)	(31,528)	6,440	
3,102	**(1,277)**	**4,380**	**(23,567)**	**26,669**	**Net Result**	**(12,226)**	**(10,647)**	**(1,578)**	**(38,784)**	**26,558**	**(10,647)**	**(38,784)**	**21,850**	

There may be rounding differences in this report

Executive Summary – Financial Position

Financial performance year to date

- Total Revenue favourable $18,840k
- Personnel and outsourced Personnel unfavourable ($3,528k)
  - Medical unfavourable ($2,375k); Nursing unfavourable ($963k); Allied Health favourable $2,401k, Support Staff unfavourable ($1,432k); Management and Admin unfavourable ($1,158k); Annual leave Liability cost has increased by $335k since June 2020
- Outsourced other expenses unfavourable ($4,794k), includes MAHIDS ($1,812k), Outsourced radiology and inpatient services
- Treatment related Costs unfavourable ($4,415k)
- Non Treatment Related Costs unfavourable ($17,535k), includes Holiday Act provision, RHIP write-off provision, charge of MHAIDS Non-clinical costs offset by revenue.
- IDF Outflow favourable $994k
- Other External Provider Costs unfavourable $3,880k
- Interest depreciation and capital charge favourable $4,980k

Analysis of Operating Position – Revenue

- **Revenue:** Total revenue favourable $3,736k for the month
  - Devolved MOH revenue $1,446k favourable, driven by a reduction in funding for capital charge offset by PHO, planned Care and COVID-19 funding.
  - Non Devolved revenue $1,071k favourable driven largely Pacific Advisory Income $149k, Regional Bowel Screening $79k reflecting volumes and COVID-19 funding for the Public Health Unit $630k.
  - ACC Revenue ($4k) unfavourable.
  - Other revenue $137k favourable for the month driven by Patient Revenue, Food Sales, Donations and Bequests.
  - IDF inflows favourable $230k for the month, reflecting wash-up adjustments for the current year.
  - Inter DHB Revenue favourable $856k, reflecting the use of shared 2 & 3DHB services, including recoveries from CCDHB for Mental Health. There is a corresponding increase in expenditure.

COVID–19 Revenue and Costs

YTD Result -June 2021	Funder [1] (4)	Provider (excl. Regional Public Health)	Provider - Regional Public Health (RPH) [1][3]	Total
$000s	Actual	Actual	Actual	Actual
Revenue				
MoH Revenue Recognised - COVID19 [2]	5,658	157	1,527	7,342
Expenditure				
Employee Expenses				
Medical Employees		15	187	203
Nursing Employees		110	428	538
Allied Health Employees		22	497	520
Support Employees		50	0	50
Management and Admin Employees		70	121	191
Total Employee Expenses	**0**	**268**	**1,234**	**1,502**
Expenses				
Outsourced - Provider	0	0	0	0.0
External Providers - Funder [5]	5,400			5,400.2
Clinical Expenses - Provider	0	2	11	13.2
Non-clinical Expenses- Provider	0	237	165	402.1
Total Non Employee Expenses	**5,400**	**239**	**176**	**5,815.5**
Total Expenditure	**5,400**	**507**	**1,410**	**7,317**
Net Impact	**257**	**(350)**	**117**	**25**

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

(2) Includes funding via Whanganui DHB

(3) Excludes overhead charges

(4) Includes technology grant

(5) Includes Additional COVID-19 Community Pharmacy Payments

- The June year to date financial position includes $7.3m additional costs in relation to COVID-19.
- Revenue of $7.3m has been received to fund additional costs for community providers and Regional Public Health.
- The net impact year to date is $0.0m additional costs currently unfunded.

Analysis of Operating Position – Personnel

- **Total Personne**l including outsourced unfavourable ($602k) for the month
  - Medical personnel incl. outsourced unfavourable ($753k). Outsourced costs are ($477k) unfavourable due to MHAIDS ($485k). Medical Staff Internal are ($276k) unfavourable, the MHAIDS restructure $269k off set by Medical and Acute ($144k), Surgical and Woman's ($190k), Regional Public Health and other variances .
  - Nursing incl. outsourced $205k favourable. Employee costs are $832k favourable, driven by the 3DHB MHAIDS Restructure $591k, the adjustment to the Staff Entitlements Annuity $902k and other variances
  - Allied Health incl. outsourced $269k favourable, with outsourced unfavourable ($422k) and internal employees favourable $691k. Employee costs are driven by the 3DHB MHAIDS Restructure $448k, the balance is mostly due to vacancies.
  - Support incl. outsourced unfavourable ($114k), with Outsourced ($34k) unfavourable, and employee costs ($79k) unfavourable, driven by Sterile Support Assistants ($33k), Security ($20k), Orderlies ($44k) offset by other variances.
  - Management & Admin incl. outsourced unfavourable ($210k) internal staff favourable $589k, outsourced unfavourable ($799). This reflects the transition to 2DHB services for ITS and MHAIDS.
  - Sick leave for June was 3.8%, which is higher than this time last year.

FTE Analysis

Month					FTE Report	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance	Jun-21	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
					FTE							
280	287	8	305	26	Medical	279	287	8	294	15	287	294
743	828	85	855	112	Nursing	763	829	67	818	55	829	818
351	418	67	428	77	Allied Health	352	417	65	402	50	417	402
150	137	(13)	151	1	Support	147	137	(10)	143	(4)	137	143
317	388	71	382	65	Management & Administration	321	388	67	365	44	388	365
1,841	**2,058**	**217**	**2,121**	**280**	**Total FTE**	**1,862**	**2,058**	**196**	**2,023**	**161**	**2,058**	**2,023**
					$ per FTE							
20,174	18,671	(1,503)	16,283	(3,891)	Medical	224,419	220,444	(3,974)	203,883	(20,536)	216,896	215,094
7,575	7,804	229	7,633	57	Nursing	94,960	92,588	(2,371)	92,131	(2,828)	88,018	93,878
6,444	7,060	616	6,599	155	Allied Health	81,462	82,905	1,444	79,995	(1,467)	69,368	85,962
5,344	5,283	(61)	5,058	(286)	Support	65,065	61,188	(3,877)	60,519	(4,547)	70,136	58,552
6,349	6,708	359	6,341	(8)	Management & Administration	83,268	79,523	(3,745)	77,105	(6,163)	69,712	84,428
8,880	**8,795**	**(84)**	**8,254**	**(626)**	**Average Cost per FTE all Staff**	**107,447**	**103,911**	**(3,536)**	**101,024**	**(6,423)**	**97,580**	**105,731**

Medical under budget for the month by 8 FTE, driven by the MHAIDS restructure 13FTE:
Excluding MHAIDS the contribution to movements were; SMOs under budget by 2FTE, offset by RMO's & House Officers combined.

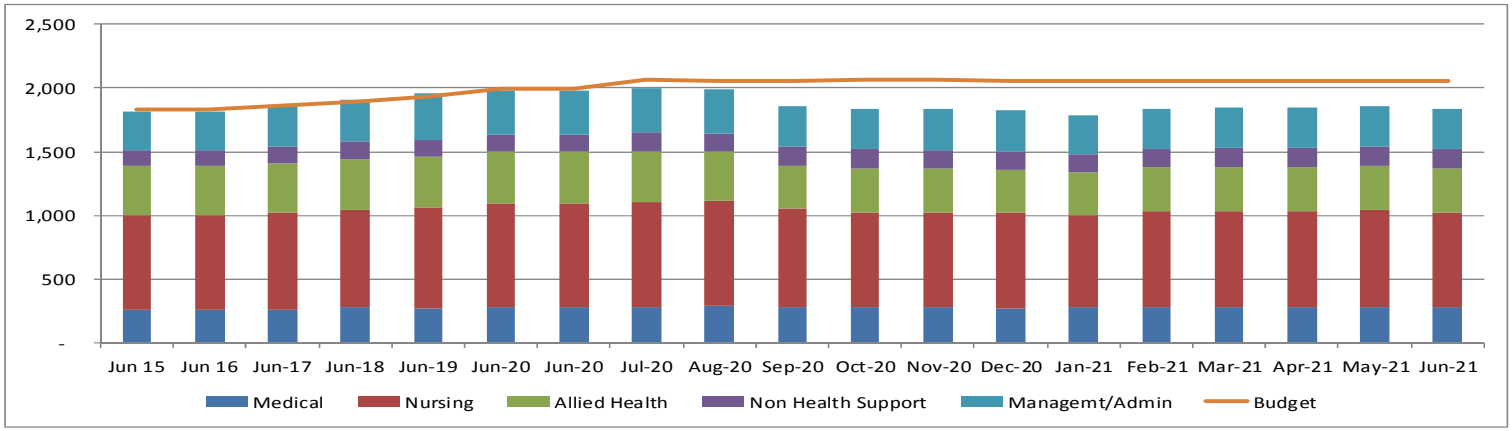
Nursing under by 85 FTE for the month, driven by MHAIDS restructure 75 FTE:
Excluding MHAIDS the contribution to movements were; Internal Bureau Nurses and HCA's are over budget (21) FTE mostly driven by General Surgery (3) FTE, General Medical (4) FTE, Maternity (3), ED (4FTE) and other variances. This is offset by Midwives 23 FTE. This reflects the transition to changes made under both CCDM recommendations and the Maternity Review.

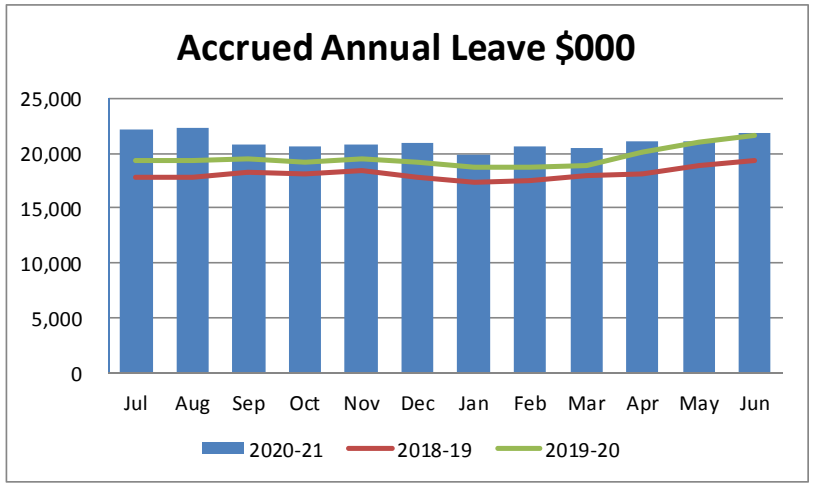
Allied FTEs are under by 67 FTEs for the month, driven by the MAHIDS restructure 62:
Excluding MHAIDS the contribution to movements were; Favourable variances in community support workers 3 FTE, Health promotion 4 FTE, Other Allied Health 3 FTE.

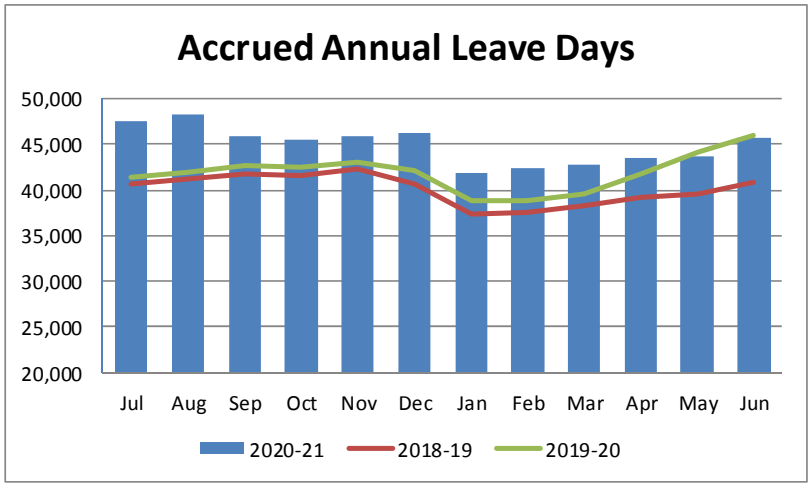
Support FTEs are (13) FTEs over budget driven by CSSD (3) FTE, Cleaning (2) FTE, Property services (1) FTE and Orderlies (6) FTE and other variances.

Management & Admin are under budget by 71 FTEs driven by the MHAIDS & ITS Restructures 40 FTE.
Excluding MHAIDS and ITS changes favourable variance of 31FTE, other variances include; Executive Office 5 FTE, Project Management 3 FTE, SPO 9 FTE, Quality 4 FTE, Chief operating officer 1 FTE, Surgical Women's & Children's 2 FTE, Regional Public Health 3 FTE and Regional Screening 5 FTE.

FTE Analysis







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

Analysis of Operating Position – Other Expenses

- **Other Operating Costs**
  - Outsourced other unfavourable ($748k) for the month, due to increase outsourcing of surgical, orthopaedics and radiology ($395k) and Public Health ($277k).
  - Treatment related costs ($1,612k) unfavourable for the month, Pharmaceuticals ($255k), Blood Supplies ($428k), Implants and Prostheses ($36k) and PPE ($104k), Health Promotions ($555k).
  - Non Treatment Related costs unfavourable ($1,469k), provision for Holidays Act Settlement ($227k) which is not budgeted as advised by MoH, Security ($70k), Consultancy ($145k), ITS expenses ($177k) , Rents ($52k), Outsourced Maintenance ($40k), Bad Debt Movement ($118k), MHAIDS recoveries adjustment ($387k) which has an offset in Inter DHB income, and other minor variances. Excluding MHAIDS the movement was ($935k).
  - IDF Outflows $342k favourable for the month, driven by current year wash-ups.
  - Other External Provider costs favourable $4,211k, driven largely Community Pharmacy Rebates, other HoP and ARC.
  - Interest, Depreciation & Capital Charge favourable $521k, reflecting a decrease in Capital Charge.

Section 5

Additional Financial Information & Updates

Financial Position as at 30 June 2021

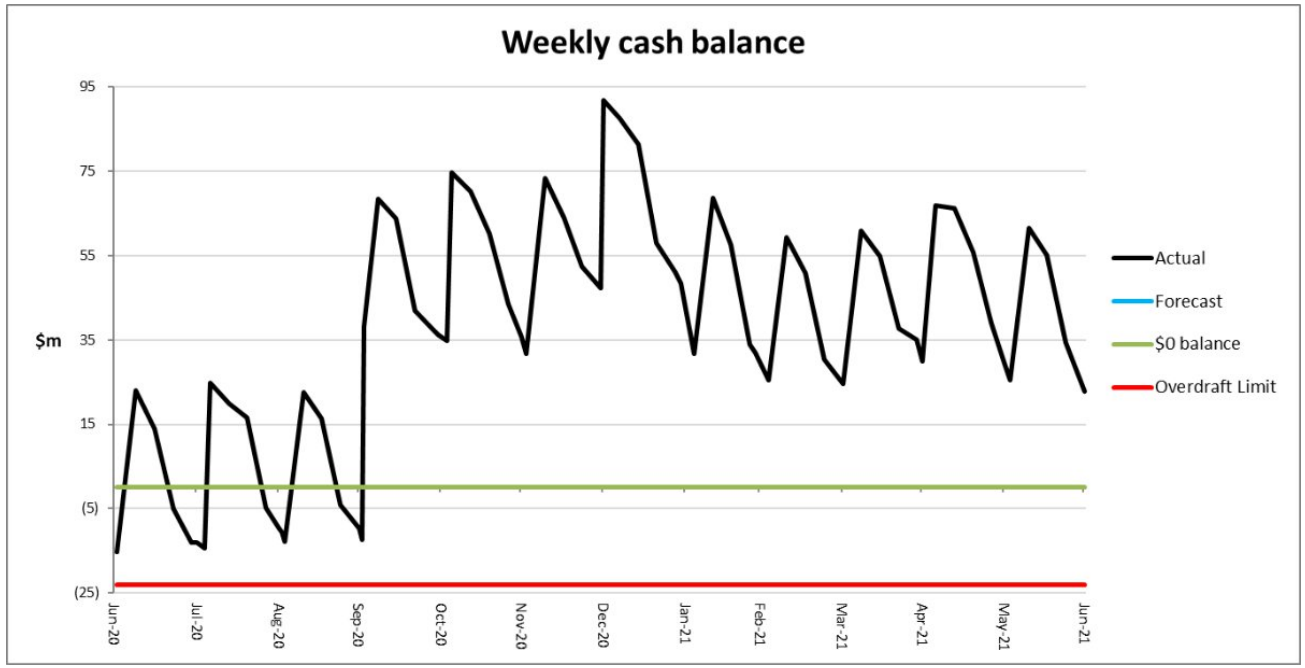
$000s	Actual	Budget	Variance	Jun 20	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	22,890	(3,570)	26,460	(10,986)	33,876	Average bank balance in Jun-21 was $46.6m ($35m equity injection received Oct-20)
Bank - Non DHB Funds *	5,236	4,927	309	4,927	309	
Accounts Receivable & Accrued Revenue	33,154	27,577	5,577	27,577	5,577	
Stock	2,322	2,200	123	2,199	124	
Prepayments	1,241	815	426	815	426	
Total Current Assets	**64,843**	**31,950**	**32,893**	**24,532**	**40,311**	
Fixed Assets						
Fixed Assets	223,741	264,033	(40,293)	229,790	(6,050)	
Work in Progress	9,218	8,201	1,017	14,001	(4,783)	
Total Fixed Assets	**232,958**	**272,235**	**(39,276)**	**243,791**	**(10,833)**	
Investments						
Investments in Associates	1,150	1,150	0	1,150	0	
Trust Funds Invested	1,221	1,347	(126)	1,347	(126)	
Total Investments	**2,371**	**2,497**	**(126)**	**2,497**	**(126)**	
Total Assets	**300,172**	**306,681**	**(6,509)**	**270,820**	**29,352**	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	79,570	63,414	(16,156)	73,615	(5,955)	Includes Holidays Act Provision of $30.2m
Crown Loans and Other Loans	42	42	0	42	0	
Current Employee Provisions	27,029	26,018	(1,011)	26,518	(511)	
Total Current Liabilities	**106,640**	**89,474**	**(17,167)**	**100,175**	**(6,466)**	
Non Current Liabilities						
Other Loans	136	180	44	178	42	
Long Term Employee Provisions	9,150	8,972	(178)	8,972	(178)	
Non DHB Liabilities	5,236	4,927	(309)	4,927	(309)	
Trust Funds	1,221	1,347	126	1,347	126	
Total Non Current Liabilities	**15,743**	**15,426**	**(317)**	**15,424**	**(319)**	
Total Liabilities	**122,383**	**104,899**	**(17,484)**	**115,598**	**(6,785)**	
Net Assets	**177,789**	**201,782**	**(23,993)**	**155,222**	**22,567**	
Equity						
Crown Equity	158,709	181,123	(22,414)	123,916	34,793	Equity Deficit Support injection received $35m
Revaluation Reserve	146,289	146,289	0	146,289	0	
Opening Retained Earnings	(114,982)	(114,982)	(0)	(76,199)	(38,784)	
Net Surplus / (Deficit)	(12,226)	(10,647)	(1,578)	(38,784)	26,558	
Total Equity	**177,789**	**201,782**	**(23,993)**	**155,222**	**22,567**	

* NHMG - National Haemophilia Management Group

Statement of Cash Flows to 30 June 2021

$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	Jun Actual
Operating Activities												
Government & Crown Agency Revenue	41,434	42,012	44,384	42,820	40,032	89,077	(1,303)	40,009	43,917	44,747	40,307	43,188
Receipts from Other DHBs (Including IDF)	9,112	10,490	8,932	18,597	8,010	13,752	6,345	9,493	10,593	10,646	9,000	7,455
Receipts from Other Government Sources	721	778	753	770	863	669	501	579	880	608	902	823
Other Revenue	1,833	1,581	(2,392)	1,408	(60)	(202)	3,478	63	(4,494)	1,709	4,950	(5,035)
Total Receipts	**53,100**	**54,861**	**51,678**	**63,595**	**48,845**	**103,296**	**9,021**	**50,144**	**50,897**	**57,711**	**55,158**	**46,431**
Payments for Personnel	(21,092)	(16,745)	(18,276)	(19,398)	(17,779)	(20,161)	(18,805)	(18,034)	(20,320)	(18,855)	(15,126)	(22,066)
Payments for Supplies (Excluding Capital Expenditure)	(4,686)	(5,368)	(4,330)	(4,464)	(3,394)	1,140	(6,009)	(12,721)	(10,312)	(2,523)	(11,788)	(571)
Capital Charge Paid	0	0	0	0	0	0	0	(3,868)	0	0	0	(4,613)
GST Movement	(710)	75	230	1,030	(1,535)	1,310	2,098	(4,899)	1,241	507	(915)	1,131
Payment to Own DHB Provider	0	(0)	(0)	(0)	120	30	30	(180)	(0)	(0)	(0)	0
Payment to Own DHB Governance & Funding Admin	0	0	0	0	(120)	(30)	(30)	180	0	0	0	0
Payments to Other DHBs (Including IDF)	(9,106)	(8,637)	(8,548)	(10,119)	(9,151)	(9,151)	(9,222)	(9,137)	(9,151)	(9,244)	(8,070)	(10,450)
Payments to Providers	(18,833)	(19,317)	(19,860)	(19,353)	(16,794)	(19,316)	(19,336)	(17,311)	(19,101)	(21,389)	(19,324)	(14,764)
Total Payments	**(54,427)**	**(49,991)**	**(50,784)**	**(52,305)**	**(48,652)**	**(46,177)**	**(51,274)**	**(65,970)**	**(57,642)**	**(51,504)**	**(55,222)**	**(51,334)**
Net Cashflow from Operating Activities	**(1,327)**	**4,871**	**894**	**11,290**	**193**	**57,119**	**(42,253)**	**(15,826)**	**(6,745)**	**6,206**	**(64)**	**(4,903)**
Investing Activities												
Interest Receipts	0	0	0	28	35	39	44	27	26	29	32	25
Total Receipts	**0**	**0**	**0**	**28**	**35**	**39**	**44**	**27**	**26**	**29**	**32**	**25**
Capital Expenditure	(913)	(1,399)	(964)	(512)	(595)	(1,028)	(1,226)	(567)	(604)	(870)	(631)	(1,452)
Increase in Investments and Restricted & Trust Funds Assets	99	57	13	(58)	(15)	(48)	17	(8)	(11)	(38)	73	46
Total Payments	**(814)**	**(1,343)**	**(951)**	**(571)**	**(610)**	**(1,076)**	**(1,208)**	**(575)**	**(616)**	**(907)**	**(559)**	**(1,407)**
Net Cashflow from Investing Activities	**(814)**	**(1,343)**	**(951)**	**(542)**	**(575)**	**(1,038)**	**(1,164)**	**(548)**	**(590)**	**(878)**	**(526)**	**(1,381)**
Financing Activities												
Equity Injections - Capital	0	0	0	0	0	0	0	0	0	0	0	(207)
Equity Injections - Deficit Support	0	0	0	35,000	0	0	0	0	0	0	0	0
Total Receipts	**0**	**0**	**0**	**35,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(207)**
Interest Paid on Finance Leases	(9)	(5)	(3)	(3)	(0)	(3)	(0)	0	(0)	0	(0)	(0)
Total Payments	**(9)**	**(5)**	**(3)**	**(3)**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**0**	**(0)**	**(0)**
Net Cashflow from Financing Activities	**(9)**	**(5)**	**(3)**	**34,997**	**(0)**	**(3)**	**(0)**	**0**	**(0)**	**0**	**(0)**	**(207)**
Total Cash In	53,100	54,861	51,678	98,624	48,880	103,335	9,065	50,171	50,923	57,740	55,191	46,249
Total Cash Out	(55,250)	(51,338)	(51,738)	(52,878)	(49,262)	(47,256)	(52,482)	(66,544)	(58,258)	(52,412)	(55,781)	(52,741)
Net Cashflow												
Opening Cash	(10,986)	(13,136)	(9,613)	(9,673)	36,073	35,691	91,770	48,352	31,979	24,644	29,972	29,382
Net Cash Movements	(2,150)	3,523	(60)	45,746	(382)	56,079	(43,417)	(16,374)	(7,335)	5,328	(590)	(6,492)
Closing Cash	**(13,136)**	**(9,613)**	**(9,673)**	**36,073**	**35,691**	**91,770**	**48,352**	**31,979**	**24,644**	**29,972**	**29,382**	**22,890**

Weekly Cash Flow – Actual to 30 June 2021



Note

- the overdraft facility shown in red is set at $23 million as at June 2021
- the lowest bank balance for the month of June was $22.9m

Summary of Leases – as at 30 June 2021

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases	**Occupants**							
Wainuiomata Health Centre	District Nurses (*Lease renewal currently in negotiation)		1,149	13,787		1/11/2017	31/10/2020*	Operating
Public Trust House Lower Hutt	Community Mental Health		23,915	286,976		1/09/2017	1/09/2023	Operating
CREDS - Johnsonville	Eating Disorders		5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health		10,241	122,887		15/03/2015	14/03/2025	Operating
Criterion Lane, Lagan Building, Upper Hutt	Physiotherapy & Counselling		2,626	31,510		5/01/2021	31/12/2023	Operating
Criterion Lane, Lagan Building, Upper Hutt	Midwives		575	6,897		16/06/2020	16/05/2023	Operating
CBD Towers Upper Hutt	Community Mental Health (*Lease status to be confirmed)		9,854	118,247		8/06/2015	7/06/2021*	Operating
Upper Hutt Health Centre	District Nurses		974	11,688		24/01/2015	1/02/2022	Operating
			54,704	**656,427**				
Car Park Leases								
CBD Towers Upper Hutt	Community Mental Health (*Lease status to be confirmed)		542	6,500		8/06/2015	7/06/2021*	Operating
			542	**6,500**				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (122 Vehicles, including 2 Nissan Leaf EV's)			38,341	460,089		Ongoing	Ongoing	Operating
			38,341	**460,089**				
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			**224,999**	**2,699,991**				

Treasury as at 30 June 2021

1) Short term funds / investment ($000)

NZHP banking activities for the month	Current month ($000)	Last month ($000)
Average balance for the month	$46,584	$51,028
Lowest balance for the month	$22,874	$29,361
Average interest rate	0.66%	0.74%
Net interest earned/(charged) for the month	$25	$32

2) Hedges

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

3) Foreign exchange transactions for the month ($)

No. of transactions involving foreign currency	4
Total value of transactions	$37,088 NZD
Largest transaction	$34,725 NZD

	No. of transactions	Equivalent NZD
AUD	2	$1,523
GBP		
SGD		
USD	2	$35,565
Total	**4**	$37,088

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	$8,206	$4,218	$296	$220	$214	$85	$467	$2,706
Ministry of Health	$2,064	$1,974	$35	$9	$37	$8	$4	($4)
Accident Compensation Corporation	$665	$357	$35	$84	($29)	($24)	$61	$180
Wairarapa District Health Board	$576	$127	$37	$101	$0	$115	$0	$196
Health Workforce NZ Limited	$211	$211	$0	$0	$0	$0	$0	$0
Wellington Southern Community Laboratories	$98	$99	$0	$0	$0	$0	$0	($0)
ESR Limited	$61	$61	$0	$0	$0	$0	$0	$0
Non Resident	$54	$0	$0	$0	$0	$0	$0	$54
Ministry of Social Development	$48	$48	$0	$0	$0	$0	$0	$0
Oranga Tamariki - Ministry for Children	$44	$44	$0	$0	$0	$0	$0	$0
Total Top 10 Debtors	**$12,027**	**$7,140**	**$403**	**$414**	**$222**	**$185**	**$532**	**$3,132**

Board Information – Public

1 September 2021

CCDHB Financial and Operational Performance Report – June 2021	
Action Required **The CCDHB Board notes:** (a) the DHB had a ($4.1m) deficit for the month of June 2021, being breakeven to budget before excluding COVID-19 and Holidays Act [2003] (b) the DHB year to date had a deficit of ($46.5m), being ($6.7m) unfavourable to budget before excluding COVID-19 and Holidays Act [2003] (c) in the twelve months we have incurred $4.0m additional net expenditure for COVID-19 and $8.7m against provision for Holidays Act [2003] (d) this means that the DHB has an overall YTD deficit of ($32.1m) from normal operations (excluding COVID-19 and Holidays Act) being $7.8m favourable to our underlying budget.	
Strategic Alignment	Financial Sustainability
Authors	Rosalie Percival, Chief Financial Officer Joy Farley, Director of Provider Services Rachel Haggerty, Director Strategy Planning & Performance
Endorsed by	Fionnagh Dougan, Chief Executive
Purpose	To update the Board and FRAC in relation to the financial performance and delivery against target performance for the DHB
Contributors	Finance Team, Mental Health and 2DHB Hospital Services, GM MHAIDS, Director Strategy Planning & Performance

Executive Summary

There is ongoing significant cost due to the COVID response into the 20/21 fiscal year, which has been largely funded by the Ministry. The Ministry have asked DHBs is to separately report unfunded net COVID impacts for 20/21, these being considered outside our responsible deficit and budgets. They have also advised that ongoing provisions for the liability due to Holidays Act remediation are to be reported separately to the base budget.

Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the twelve months to 30 June 2021 is $32.1m deficit, versus a budget deficit of $39.8m.

Additional net COVID related expenditure above funding, year to date is $4.0m.

The monthly provision for increasing Holidays Act liability is $952k and year to date the impact on the result is $8.7m

For the twelve months to 30 June 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $46.5m deficit.

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

Capital Cash Flow Expenditure was $61.6 million year to date.

We had a negative cash Balance at month-end of $28.9 million offset by positive "Special Funds" of $13.4 million, net negative cash balance of $15.5 million. It should be noted that there is a significant amount of the COVID response that has not been funded by the crown at this time and this has a negative cash impact on the DHB.

Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action the focus being to manage across our acute pathways and ensure continuation of planned care. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients; theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.

We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).

Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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.

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

Strategic Considerations

Service	Financial performance and funding is a key to delivering the services for the Wellington population and Tertiary services for the region.
People	Staff numbers are 216 FTE above our annual budget (however note lead DHB roles).
Financial	The YTD result for the DHB was ($32.1m) deficit from normal operations, against our DHB budget of ($39.8m). An additional ($4.0m) was spend on unfunded COVID-19 costs split between the provider and funder arm, and ($8.7m) was recognised for Holidays Act provisions.
Governance	The Board has a responsibility to scrutinise the financial reports alongside FRAC, and report back issues as identified.

Engagement/Consultation

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

Identified Risks

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

Attachment/s

1. Capital & Coast DHB Financial and Operational Performance Report – June 2021

Capital & Coast District Health Board

Monthly Financial and Operational Performance Report

For the period ending 30 June 2021 (unaudited)

Capital & Coast District Health Board
Ūpoko ki te Uru Hauora

Contents

Section 1

Financial and Performance Overview and Executive Summary

Executive Summary

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

- Excluding the COVID-19 net expenses and Holidays Act [2003] provision the DHB's result for the twelve months to 30 June 2021 is $33.3m deficit, versus a budget deficit of $39.8m.

- Additional net COVID related expenditure above funding, year to date is $4m.

- The monthly provision for increasing Holidays Act liability is $952k and year to date the impact on the result is $8.7m

- For the twelve months to 30 June 2021 the overall DHB year to date result, including COVID and Holidays Act costs is $46m deficit.

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

- Capital Expenditure including equity funded capital projects was $61.6m year to date.

- We had a negative cash Balance at month-end of $28.9 million offset by positive "Special Funds" of $13.4 million (net $15.5 million). It should be noted that there is a significant amount of the COVID response that remains unfunded by the crown at this time and this has a cash impact on the DHB. Overall the DHB cash balance is better than was budgeted for this point in time however the equity injection of $39.8m signalled in the 2021/22 Annual Plan will be requested for the 3rd quarter of the year.

Executive Summary continued

- Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action the focus being to manage across our acute pathways and ensure continuation of planned care. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients; theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.

- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).

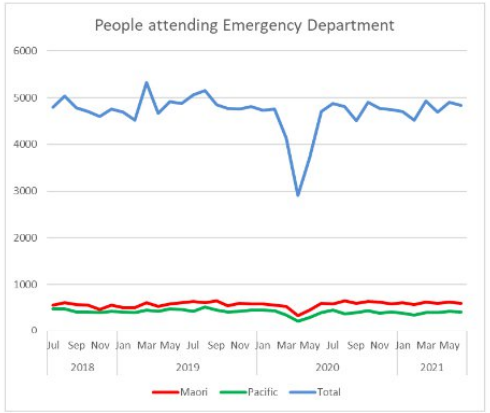
- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers are at critical levels in some areas; we are continually refining and reviewing processes to manage demand during busy periods and continue to work closely with our staff and union 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.

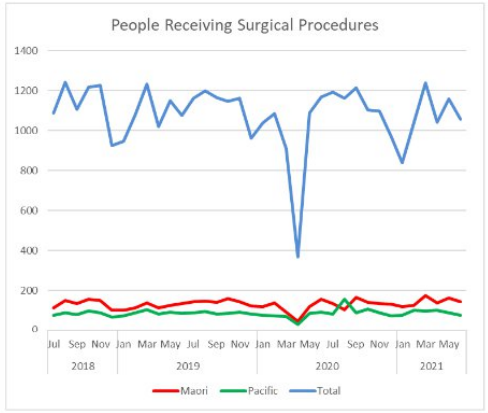
- The provider arm remains within budget YTD outside two extraordinary items (additional costs during COVID-19 and Holidays Act Provisions) not included within the budget. Targeted efficiency measures are in place however the pressure of clinical service demands and FTE management especially around annual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

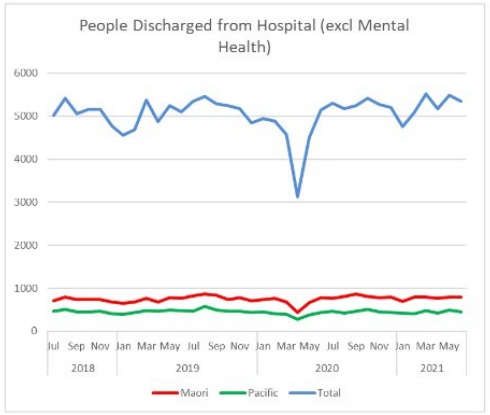
Performance Overview: Activity Context (People Served)

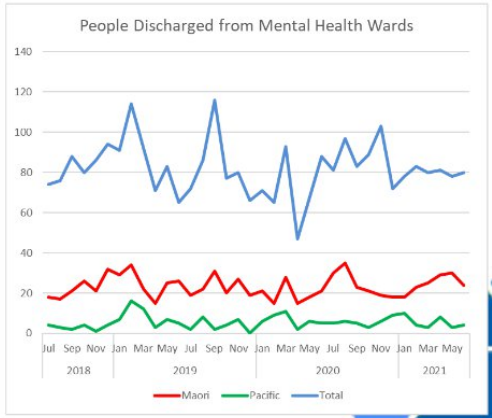
CCDHB funds services that touch thousands of people in our community every month. Unless otherwise indicated, the numbers below count individuals once and are based on CCDHB being the DHB of Service. Our services have returned to delivering services to our population without the restrictions due to COVID-19.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

People attending ED	**4,832**	601 Maori, 416 Pacific
People receiving Surgical Procedures (in main theatres)	**1,058**	144 Maori, 74 Pacific
People discharged from Kenepuru Community Hospital or Wellington Regional Hospital (excl Mental Health)	**5,342**	796 Maori, 449 Pacific
People discharged from Mental Health Wards	**80**	24 Maori, 4 Pacific



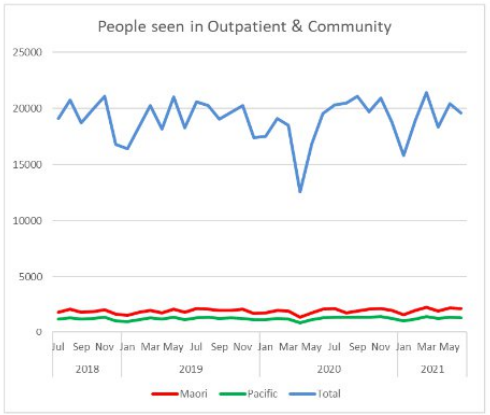


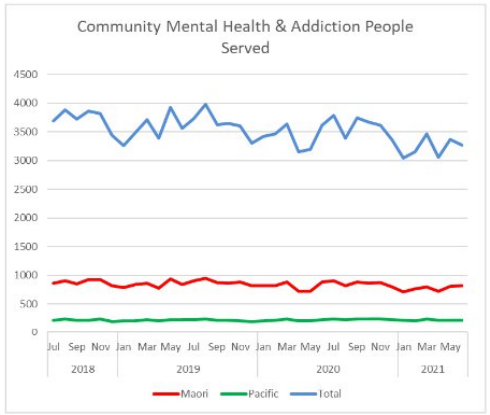


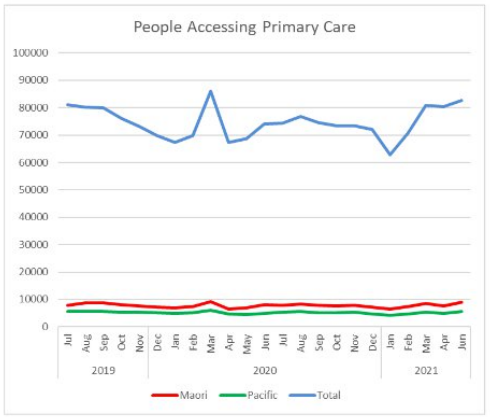


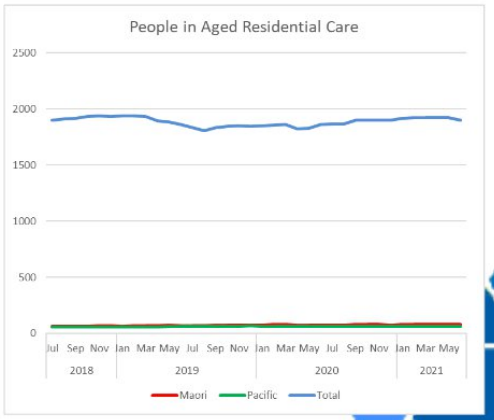
Performance Overview: Activity Context (People Served)

People seen in Outpatient & Community	**19,581**	2,143 Maori, 1,345 Pacific
Community Mental Health & Addiction People Served	**3,271**	819 Maori, 218 Pacific
People accessing primary care	**82,594**	8,943 Maori, 5,548 Pacific
People in Aged Residential Care	**1,902**	81 Maori, 62 Pacific









Financial Overview – June 2021

YTD Operating Position

$46m deficit

Incl. $3.4m COVID-19 costs
Incl. $8.7m Holidays Act

Against a budgeted YTD deficit of $39.8m. BAU Month result was $4m unfavourable. YTD $6.5m Favourable BAU variance.

YTD Provider Position

$54.6m deficit

Incl. $3.4m COVID-19 costs
Incl. $8.7m Holidays Act

Against a budgeted deficit of $49.5m. BAU Month result was $1.4m unfavourable. BAU YTD $5.2m favourable variance.

YTD Funder Position

$8m surplus

Incl. $15.8m COVID-19 costs

Against a budgeted Surplus of $9.6m. BAU Month result was $1.8m unfavourable result. YTD $6.9m unfavourable BAU variance.

YTD Capital Exp

$66.6m spend

Incl. $33.2m strategic capex

Against a KPI of a budgeted baseline (non-strategic) spend of $66.1m.
Strategic incorporates funded project such as Children's Hospital

YTD Activity vs Plan (CWDs)

2.52% ahead[1]

1786 CWDs ahead PVS plan (+80 IDF CWDs , but 154 Hutt ahead). Month result +361 CWDs excluding work in progress.

YTD Paid FTE

5,648[3]

YTD 216 above annual budget of 5,432 FTE (budget excludes lead DHB). There is 596 FTE vacancies at end May inclusive of lead DHB transfers.

Annual Leave Taken

($10.4m) annualised[4]

Underlying YTD annual leave taken is under by 3.9 days per FTE and Lieu leave taken for public holidays is short by 2.9 days.

[1] Note that the PVS (Price volume schedule for HHS/MHAIDS) is not total Surgical/Medical case-weight throughput largely due to Non-Residents & ACC. Also Outsourced PVS cases within this result cannot yet be compared to target, however a total of 2611 cwd outsourced (1525 events) ~$14.5m 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 – June 2021

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

ED (SSIED) 6 Hour rule	ESPI 5 Long Waits	Specialist Outpatient Long Waits	Serious Safety Events[2]
64.0%	386	TBC**	4
31.0% below the ED target of 95% Monthly -4.3%	Against a target of zero long waits a monthly movement of +33	Against a target of zero long waits, a monthly movement of -33 .**internal figures	An expectation is for nil SSEs at any point.

YTD Activity vs Plan (CWDs)	YTD Paid FTE	YTD Cost per WEIS
2.52% ahead[1]	3,684[3]	$6041*
1786 CWDs ahead PVS plan (+80 IDF CWDs , but 154 Hutt ahead). Month result +361 CWDs excluding work in progress.	YTD 34 above annual budget of 3,650 FTE. 274 FTE vacancies at month end.	Against a national case-weight price per WEIS of $5,545 (8% above).*to Jun 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 2611 cwd outsourced (1525 events) ~$14.5m 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

- Overall the funder has a YTD unfavourable variance of ($1.65m). Revenue is $32.1m ahead of budget mainly due to CCDHB having additional COVID accrued and paid revenue of $31.6m. This includes additional revenue for Pharmaceuticals to offset the effect of COVID in the unstable international market. The offsetting COVID costs are ($31.6m). Recovery of all costs remains the subject of negotiations with MoH agreeing a full cost recovery. The ongoing demand for managed isolation facilities, and community surveillance continues. Revenue provision includes historical costs incurred to make the hospital COVID ready which the Ministry has agreed to fund.
- The Provider Arm achieved most of the IDF targets except for PCT due to COVID lockdown impacts during the year. Reduced revenue from the Ministry of ($3.9m) for capital charge costs offsets a reduced cost in the Provider Arm.
- Cost of funding community services are ($8.6m) unfavourable to budget with Pharmaceuticals being ($8.2m) over budget. Of this overspend ($5.4m) is a historical pharmaceutical budget saving that was not able to be achieved. CCDHB has efficient prescribing practises and does not have an identifiable opportunity for improvement. The additional overspend reflects the impact of COVID related costs. Age residential care reflects the impact of stronger homecare support services and models of care for older people. Primary care demand driven services such as vaccination, urgent dental and other services are also underspent reflecting the impact of COVID.
- Additional funding for Mental Health and Child & Youth services of $4.3m has been received and has been contracted to NGO Providers, including primary mental health.
- Community, MIQ and Vaccine rollout COVID-19 response costs ($29m) mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by the Ministry.
- The COVID Vaccine programme has been progressing well and in line with MoH targets. There is considerable pressure over the next month as the general practises come on board. There is a risk we will be behind targets for the next four weeks. Strategies are being developed to close this gap using temporary vaccination sites.
- In this report we have also highlighted key areas of performance with a focus on our core services and achieving equity. It is recognised that these highlight significant need for improved service delivery and a pro-equity commissioning approach:
    - The pressure on our maternal services continues. The priorities In 2020/21 has been in building Maori and Pacific capacity., This has included invested in a new Māori and Pacific midwifery collective in Porirua, the training of five new Māori and Pacific lactation consultants, and a community breastfeeding education programme supporting Māori and Pacific women. Vacancies in LMCs is also not assisting,
    - CCDHB has engaged with our PHOs to increase Māori and Pacific enrolment following a decline in performance. Our PHOs have responded and we are seeing improvements as a result of their work.
    - We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to first specialist appointments (dermatology & respiratory), access to diagnostics (CT & MRI) and access to elective general surgery. Investment in CT has been prioritised to address the growing unmet demand and reduce diagnostic inequities by improving access. A mobile CT is expected to provide ~5,000 additional appointments per year and make it easier for patients to access diagnostics in the community.
    - We are working to improve patient flow by reviewing the journey from mental health inpatient units into stepdown facilities to create a smooth transition into lower levels of care. By providing a streamlined transition into lower levels of care, there is an opportunity to reduce length of stay. We are also implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED. This will complement our partnership with Police and Wellington Free Ambulance in prevent unnecessary acute attendances at Wellington regional Hospital.

Funder Financial Statement of Performance

Month			Variance		Capital & Coast DHB Funder Result - $000 Jun 2021	Year to Date			Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year		Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
72,885	72,885	68,138	0	4,747	Base Funding	874,620	874,620	817,657	0	56,963
5,643	4,665	7,553	978	(1,910)	Other MOH Revenue - Funder	57,207	55,979	74,486	1,228	(17,279)
5,186	0	0	5,186	5,186	COVID Revenue from MOH	30,685	0	0	30,685	30,685
285	45	53	239	231	Other Revenue	1,649	543	822	1,106	827
2,937	2,936	2,743	1	194	IDF Inflows PHOs	36,066	35,230	33,605	836	2,461
(2,178)	0	(1,130)	(2,178)	(1,048)	Inpatient WIP historical adjustment	(2,178)	0	(1,130)	(2,178)	(1,048)
21,683	18,517	20,251	3,166	1,432	IDF Inflows 20/21 Wash-up Prov	222,628	222,198	206,061	429	16,567
106,440	**99,048**	**97,608**	**7,392**	**8,832**	**Total Revenue**	**1,220,678**	**1,188,572**	**1,131,502**	**32,106**	**89,176**
					Internal Provider Payments					
824	824	958	0	134	DHB Governance & Administration	9,884	9,884	11,497	0	1,613
55,451	51,536	48,943	(3,915)	(6,508)	DHB Provider Arm Internal Costs - HHS	629,472	629,749	578,216	276	(51,256)
7,807	7,752	7,423	(56)	(385)	DHB Provider Arm Internal Costs - MH	93,249	93,019	88,958	(231)	(4,292)
(1,485)	1,942	2,433	3,427	3,918	DHB Provider Arm Internal costs - Corp	17,567	21,648	31,909	4,081	14,342
6,219	0	0	(6,219)	(6,219)	DHB Provider Arm Internal costs - COVID	15,373	0	0	(15,373)	(15,373)
68,816	**62,053**	**59,756**	**(6,763)**	**(9,060)**	**Total Internal Provider**	**765,545**	**754,299**	**710,580**	**(11,246)**	**(54,965)**
					External Provider Payments:					
7,184	5,703	5,348	(1,481)	(1,836)	- Pharmaceuticals	76,714	68,434	63,981	(8,280)	(12,733)
6,749	6,645	6,498	(104)	(251)	- Capitation	80,515	79,743	76,972	(773)	(3,543)
7,340	7,354	6,868	14	(472)	- Aged Care and Health of Older Persons	86,455	88,253	84,284	1,798	(2,171)
2,699	2,862	2,637	163	(62)	- Mental Health	34,657	34,344	30,838	(312)	(3,819)
918	807	743	(111)	(175)	- Child, Youth, Families	10,242	9,685	8,463	(557)	(1,779)
1,247	796	1,051	(452)	(196)	- Demand driven Primary Services	8,205	8,307	7,566	102	(638)
2,028	2,268	2,165	240	137	- Other services	26,593	27,214	26,735	621	142
4,473	3,814	3,294	(659)	(1,180)	- IDF Outflows Patients to other DHBs	46,475	45,767	42,574	(708)	(3,900)
5,253	5,240	4,944	(13)	(309)	- IDF Outflows Other	63,390	62,880	60,220	(510)	(3,170)
37,891	**35,489**	**33,548**	**(2,402)**	**(4,343)**	**Total External Providers**	**433,246**	**424,626**	**401,634**	**(8,620)**	**(31,612)**
1,279	0	3,335	(1,279)	2,057	- COVID in Community PHO, ARC	13,880	0	8,317	(13,880)	(5,563)
107,985	**97,542**	**96,640**	**(10,443)**	**(13,402)**	**Total Expenditure**	**1,212,671**	**1,178,925**	**1,120,531**	**(33,746)**	**(92,140)**
(1,545)	**1,505**	**969**	**(3,051)**	**(2,514)**	**Net Result**	**8,007**	**9,647**	**10,971**	**(1,640)**	**(2,964)**

Funder Financials – Variance Explanations

Revenue

SPP Funder Revenue Variances	Mth $000's	YTD $000's
COVID-19 Community funding	37	16,131
COVID-19 MIQ and Vaccine rollout	3,080	6,474
COVID-19 HHS & Planned Care	3,062	9,074
PHOs volume change funding	87	1,811
Mental Health, Aged Care, Family CFAs	468	4,324
Prior Year IDF Adj written back	(2,178)	(2,178)
HHS Cap charge and CWD 20/21	2,836	(3,530)
Year to Date Revenue Variances	**7,392**	**32,106**

External Revenue Variances

- COVID-19 actual funding and accrued provision of **$31.6m** in support of GP assessment testing, pharmaceutical costs, vaccine rollout, quarantine hotel staffing & response funding for Maori and Pacific groups. This also includes Ministry funding for historical HHS costs for conversion to a COVID ready hospital. Ongoing discussions with the Ministry indicate that the DHB will be fully funded for all COVID community, MIQ and Vaccine rollout costs.
- PHO additional wash-ups and volume funding of **$1.8m**. There are increased costs of ($1.6m) offsetting this revenue. New funding for Mental Health and Child & Youth services of **$4.3m** has been contracted to NGO Providers.

Internal Revenue Variances

- The Provider Arm achieved most of the IDF targets except for PCT. Prior year write off of historical IDF provision **($2.1m)**.The ministry reduced the capital charge funding due to a reduction in the interest rate charged. YTD reduction is **($3.6m)**.

Payments to Internal and External Providers

SPP Funder Payment Variances	Mth $000's	YTD $000's
COVID-19 Community funding	(1,279)	(13,880)
COVID-19 MIQ & Vaccine	(3,157)	(6,474)
COVID-19 HHS & Planned Care	(3,062)	(8,899)
Pharms increased volumes incl COVID	(1,035)	(2,918)
Pharms savings not achieved	(447)	(5,362)
PHOs volume variances offset	(166)	(1,573)
Other Volume driven costs	(1,629)	1,401
Capital Charge reduced funding	330	3,959
Year to Date Payment Variances	**(10,443)**	**(33,746)**

External Provider Payments:

- Community, MIQ and Vaccine rollout COVID-19 response costs **($29m)** mainly due to ongoing GP test assessment claims in support of the COVID-19 response as directed by the Ministry.
- Pharmaceuticals costs have been impacted by COVID-19 with increasing costs and fees unfavourable to budget by **($3m)**. The DHB has received additional COVID funding which offsets some of this cost pressure. The DHB had budgeted for pharmaceutical savings in 2020/21 pre COVID. Budgeted YTD savings of **($5.4m)** have not been achieved.
- PHO Capitation expenses are **($1.6m)** unfavourable. Additional costs due to volume changes are offset by additional revenue.
- Other Community NGO contracts have a net YTD variance of **$1.4m**. New funded NGO contracts offset lower volume trends due to COVID in NGO contracted services such as immunisations and aged care costs.

Internal Provider Payments:

- Reduced capital charge funding of **$3.9m** as per the Ministry has been passed through to Provider.

Inter District Flows (IDF)

IDF Inflow Categories Variance to Budget Target	YTD Jun 2021 $000's
Inpatient CWD	442
Outpatient Non DRG	(337)
PCT Pharms	(1,959)
PHO Volume changes	741
Other IDF Inflows	(152)
Total per Financials	**(1,265)**

Inter District Revenue Inflows

We have recognised changes in IDF inflows which has resulted in an unfavourable variance of ($1.3m) YTD, a ($600k) decrease to last month. Breakdown of the variance commented below:

- Inpatient Case weight IDF inflows are favourable by $400k which is driven by lower elective IDF flows.
- The majority of the lower IDF inflows (actuals) are caused by planed care inpatient lower volumes:
  - Acute: $2.2m: Cardiology ($1.5m), followed Oncology ($839k) Gen Med ($828k), Renal Med ($730k), Vascular Surgery ($695) and Neurosurgery ($556k), Offset by NICU $2.4m, Cardiothoracic $1.7m (with significant outsource earlier in the year), Neurology $1.5m, Maternity $677k
  - Planned Care: ($1.8m); Vascular $1.1m, followed by Cardiology $897k & Paediatric $494k offset by Cardiothoracic ($3.0m), Orthopaedic ($771k) Neurosurgery ($644k)& General Surgery ($436k)
- Outpatient Non DRG inflow relates to all IDF patient visits that do not require a overnight stay
- PCT Pharms under target inflow is offset by a equivalent reduction in Pharmaceutical expenditure causing a nil impact on the bottom line
- PHO Volume change inflows relates to a increase in PHO enrolments through a quarterly wash-up by the Ministry

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

Commissioning: Families & Wellbeing

What is this measure?

Mothers

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

Why is this important?

- Early engagement with an LMC provides an opportunity for screening, education and referral, and begins the primary-maternity continuity of care relationship.
- The early years of life set the foundation for lifelong health and wellbeing. Breastfeeding is associated with a range of life long physical and psychological benefits for babies.
- Newborn enrolment ensures access to affordable and essential health care as early as possible, such as childhood immunisation, community oral health and Well Child Tamariki Ora services.

How are we performing?

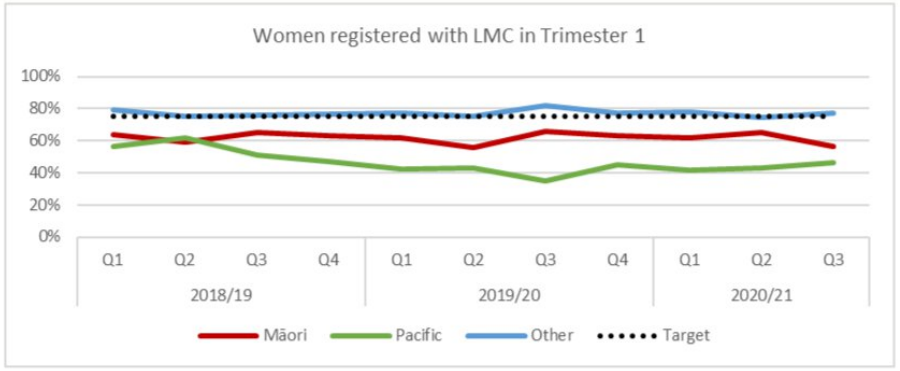
- Performance is below the 75% target for pregnant women registered with a LMC within the 1st trimester of pregnancy for Māori (57%) and Pacific (47%). Non-Māori, non-Pacific is above target at 77%.
- Performance is below the 80% target for infants exclusively or fully breast fed at two weeks for Māori (52%), pacific (52%) and non-Māori, non-Pacific (65%).
- Performance is below the 85% target for newborns enrolled in a PHO by three months for Māori (70%). Performance is above target for Pacific (100%) and non-Māori, non-Pacific (94%).

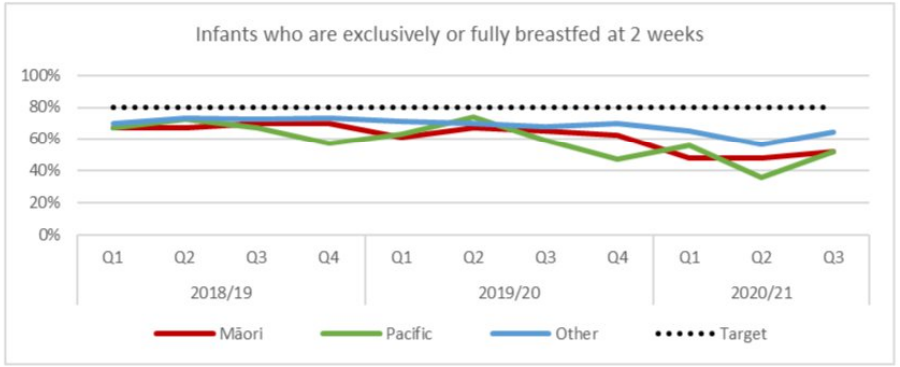
What is driving performance?

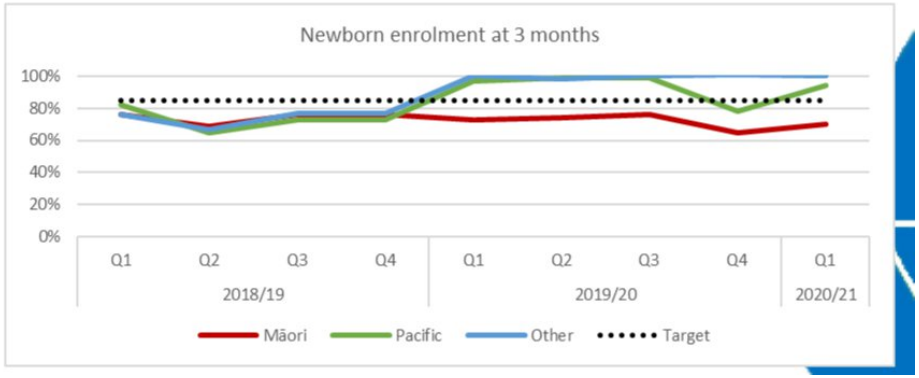
- In 2020/21, CCDHB invested in a new Māori and Pacific midwifery collective in Porirua, which we expect will improve access to antenatal care in Porirua and across the DHB catchment.
- CCDHB is supporting the training of five new Māori and Pacific lactation consultants. The benefits of this investment will begin to emerge when training has been completed (April 2022).
- CCDHB has initiated a community breastfeeding education programme supporting Māori and Pacific women.
- CCDHB has engaged with our PHOs to increase Māori and Pacific enrolment following a decline in performance. Our PHOs have responded and we are seeing improvements as a result of their work.

Management comment

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







Commissioning: Primary & Complex Care

What is this measure?

End of life

- % of clients assessed by InterRAI with an Enduring Power of Attorney (EPOA) in place
- % of clients assessed by InterRAI having funded Advanced Care Plan (ACP) consultation

Why is this important?

- An EPOA appoints someone to make decisions about an individual's personal care and welfare on their behalf.
- Advance Care Planning is a voluntary process of discussion and shared planning for future health care. The process assists the individual to identify their personal beliefs and values, and incorporates them into plans for future health care. This may indicate who the EPOA is. The 2DHB ACP aligns with the HQSC's national ACP overarching vision to "Empower New Zealanders to participate in planning their future care." This has a particular focus on removing inequities in healthcare and outcomes for Māori.

How are we performing?

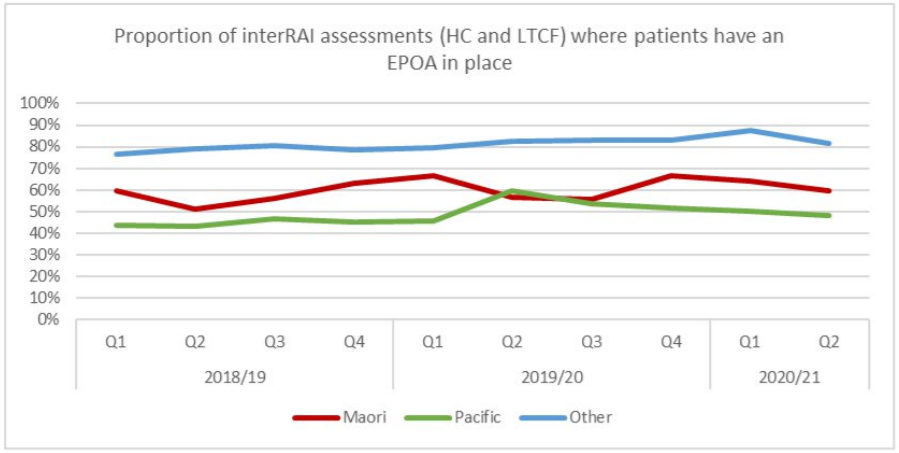
- There are no national or local targets for these performance measures.
- The proportion of people who have an EPOA in place for Māori is 60% and for Pacific is 48%. Performance for Non-Māori, non-Pacific is at 82%.
- The proportion of people who have an ACP in place for Māori is 3.4% and for Pacific is 3.1%. Performance for Non-Māori, non-Pacific is at 5.5%.

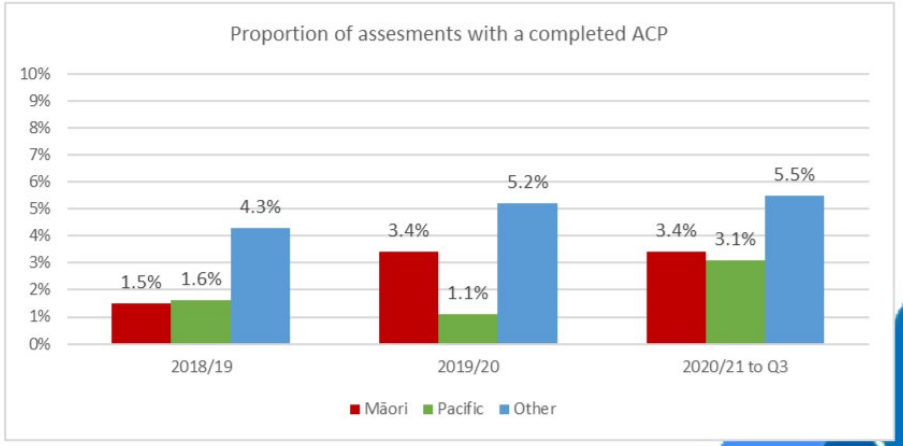
What is driving performance?

- At the end of 2020, Tū Ora Compass was funded to reimburse NGOs for completion of ACPs with clients.
- This investment took place because NGOs are ideally placed to undertake ACP conversations and support clients to complete ACPs, having and trusted relationships within communities with clients who could benefit from ACP. Additionally, NGOs often have a strong equity lens and serve diverse communities.

Management Comment

- The NGO-incentivised scheme for Advanced Care Plan completion recognises the valuable work of NGOs and provides financial support to undertake what can be challenging, lengthy and rich ACP conversations.
- The key benefits include: more ACPs completed and uploaded; client wishes are more accessible and can be followed by clinicians; further ACP promotion, support and socialisation to clients, whānau and staff.
- In 2020/21 to Q2, there has been 47 additional assessments with a completed ACP, compared to the same period in 2019/20.





Commissioning: Hospital & Speciality Services

What is this measure?

Planned Care

- Did not attend (DNA) rate for first specialist appointment (FSA)
- 95% of patients with accepted referrals for CT scans will receive their scan and results within 6 weeks
- 0% of patients given a commitment to treatment, but not yet treated within the required timeframe (ESPI 5)

Why is this important?

Equity: patients receive care that safely meets their needs, regardless of where they live and who they are.
Access: patients can access the care they need in the right place, with the right health provider.
Quality: Services are appropriate, safe, effective, efficient, respectful and support improved health.
Timeliness: patients receive care at the most appropriate time to support improved health.
Experience: You and your whānau work in partnership with healthcare providers to make informed choices and get care that responds to your needs, rights and preferences.

How are we performing?

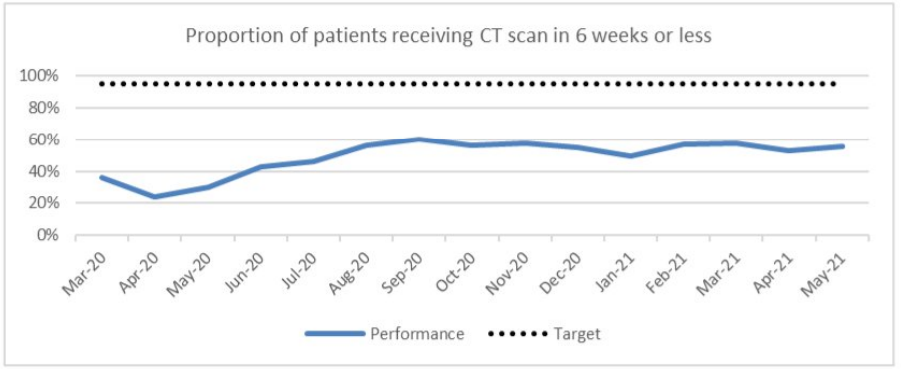
- The proportion of people who did not attend their FSA is 13% for Māori and 15% for Pacific. Performance for Non-Māori, non-Pacific is at 4%.
- Performance is below the 95% target for patients receiving their CT scan in 6 weeks or less. Performance in May 2021 was 55% and has increased from 30% in May 2020.
- The proportion of people given a commitment to treatment, but not yet treated within the required timeframe for Māori is 11% and for Pacific people is 11%. Performance for non-Māori, non-Pacific was 10%.

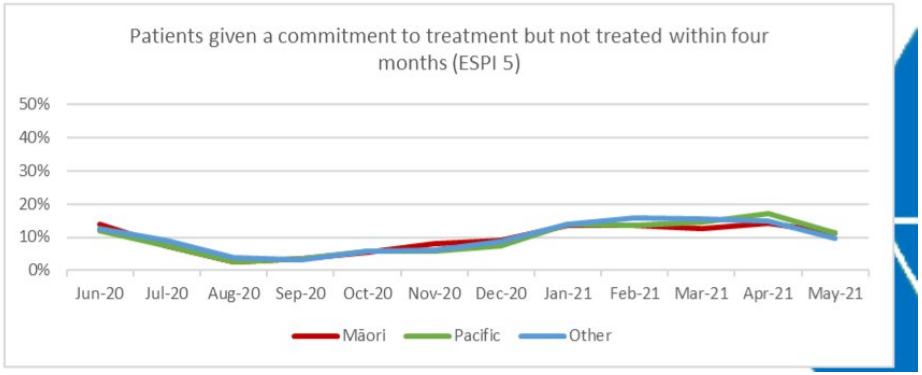
What is driving performance?

- There is significantly more activity than planned for this financial year and most of it is acute. The majority of the acute activity is surgical and this is impacting planned care provision.

Management comment:

- We continue to implement our planned care waiting list improvement action plan. Our focus areas include access to first specialist appointments (dermatology & respiratory), access to diagnostics (CT & MRI) and access to elective general surgery. CCDHB has chosen to focus our $4.2 million service delivery funding in areas of greatest need, and are focused on areas of increasing demand, inequities and historical performance.
- Investment in CT has been prioritised to address the growing unmet demand and reduce diagnostic inequities by improving access. A mobile CT is expected to provide ~5,000 additional appointments per year and make it easier for patients to access diagnostics in the community.





Commissioning: Mental Health & Addictions

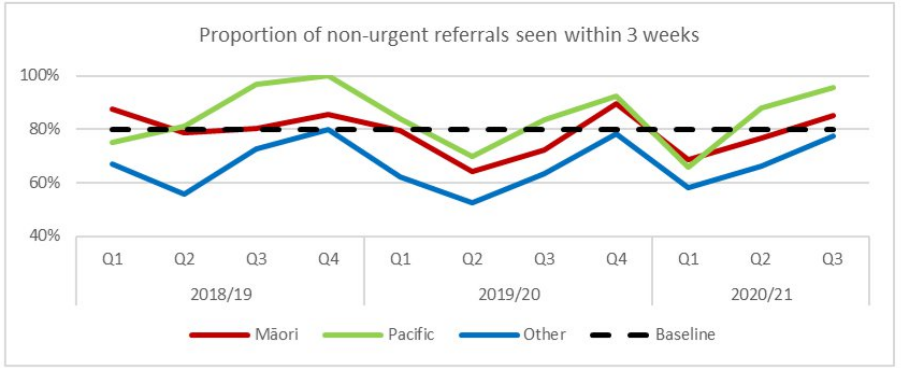
What is this measure?
- ≥80% of non-urgent referrals seen within 3 weeks
- Number of patients discharged from TWOM with a Length of Stay of more than 14 days
- Number of people aged 0-19 years referred to AOD services

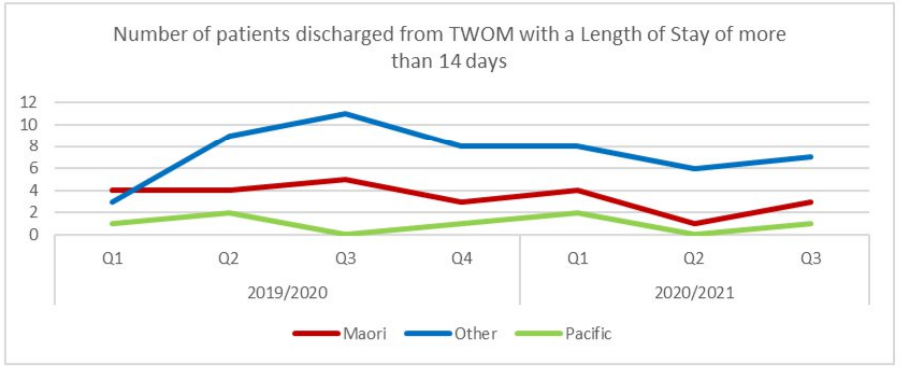
Why is this important?
- Reducing wait times corresponds to earlier treatment in the progression of illness and links to better outcomes. Timeliness is a key quality indicator
- The demand for acute inpatient services continues to grow. Length of stay has an impact on ward occupancy and therefore the capacity to respond to demand.
- Currently, there is no community based AOD service designed for youth, we are seeing a large proportion of youth presenting at EDs for AOD-related reasons, highlighting unmet need.

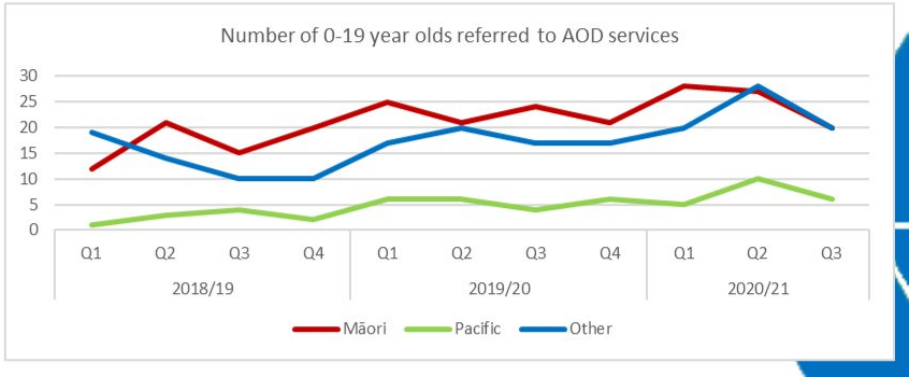
How are we performing?
- Performance is above the 80% target for non-urgent referrals seen within 3 weeks for Māori (85%), Pacific (95%). Performance is below target for Non-Māori, non-Pacific (77%).
- There has been an overall decrease in the number of people discharged from TWOM with a Length of Stay of more than 14 days. In the year to date, there have been 8 Māori, and 3 Pacific patients.
- In the year to date, 75 Māori youth have been referred to AOD services; 21 Pacific you have been referred.

What is driving performance?
- MHAIDS are developing smart systems as a key enabler of effective service delivery, including the Te Haika upgrade.
- The 3DHB Acute Care Continuum project is developing increased access to Crisis Respite services as an alternative to acute inpatient care or earlier discharge pathways.
- The 3DHB Model of Care for Addictions is being implemented. This will support improved health outcomes and improve our ability to achieve equity for our priority populations. Establishment of a new investment in primary and community mental health service will offer improved access to youth and adult clients.

Management comment
- We are working to improve patient flow by reviewing the journey from inpatient units into stepdown facilities to create a smooth transition into lower levels of care. By providing a streamlined transition into lower levels of care, there is an opportunity to reduce length of stay.
- We are implementing a mental health model of care in ED, and enhancing the support to mental health and addiction patients who present to ED.







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 16 years old receives the two doses. Ensuring equitable access to free COVID-19 vaccines is a priority for New Zealand.
- First we are protecting those most at risk of COVID-19.

How are we performing?

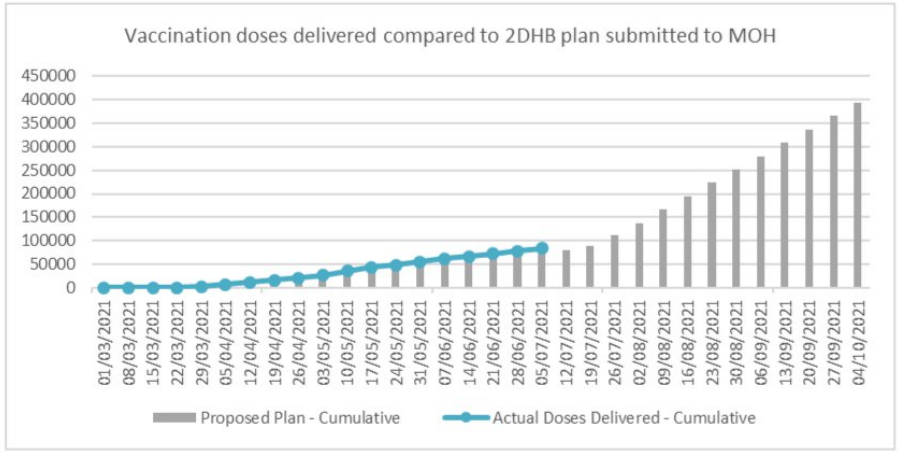
- **Group 1: Protect our border and MIQ workers**
  - Border and MIQ workers and employees and the people they live with

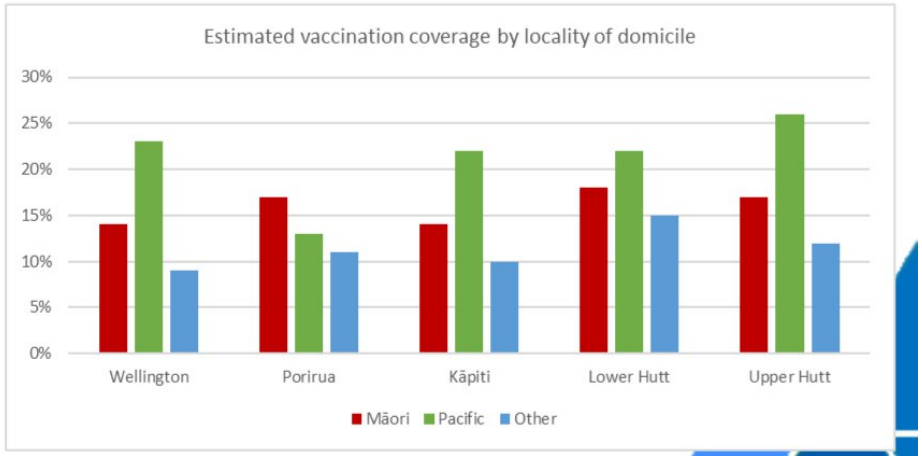
- **Group 2: Protect our high-risk frontline workers and people living in high-risk places**
  - High-risk frontline health care workers (public and private)
  - People living in long-term residential care
  - People working in long-term residential environments
  - Older Māori and Pacific people cared for by their whānau (and their carers and the people they live with)
  - People aged 65+ or with underlying health conditions or a disability living in the Counties Manukau DHB area

- **Group 3: Protect the people who are at risk of getting very sick from COVID-19**
  - People who are 65+
  - People with underlying health conditions1
  - Disabled people
  - People caring for a person with a disability
  - Pregnant people
  - People in custodial settings

- **Group 4: Protect everyone**
  - Everyone in Aotearoa New Zealand aged 16 and over not already eligible for a vaccine

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





Data Sources: COVID-19: Vaccination 2DHB Qlik App
Date Range: 22/02/2021 to 04/07/2021
Data current at: 05/07/2021 @11:00am

Section 2.2

Hospital Performance

Executive Summary – Hospital Performance

- Trends seen all year have built momentum over the past quarter. ED attendances and both discharges and caseweights for all services are climbing resulting in increased pressures from acuity and increased presentation numbers. The pressures in June see the principles of our Winter Plan in action the focus being to manage across our acute pathways and ensure continuation of planned care. The ministry is collating data on a weekly basis to develop a national view about the impact of the increased demand seen across the country.

- Planned care – the delivery of Specialist assessments or Treatment within 120 days continues to be a major challenge in managing this against acute volumes. We are making slow progress against our long wait patients; theatre utilisation is the focus across all services and planning with our SMOs to prioritise and backfill sessions is key to ensuring we manage our long-waiting patients. Filling anaesthetist shortages will contribute to this. We continue to liaise weekly with the Ministry planned care team seeking support and advice as we lead out our system improvement project aimed at making progress around all aspects of managing elective flow.

- We continue with the 2D Bed & Theatre Capacity project to identify and deliver solutions for short to medium term improvement in OT capacity across 3 Hospitals (Kenepuru, Wellington & Hutt).

- Workforce shortages across midwifery and nursing, allied health in particular sonographer social work and radiographers 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.

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

CCDHB Contract Activity Performance

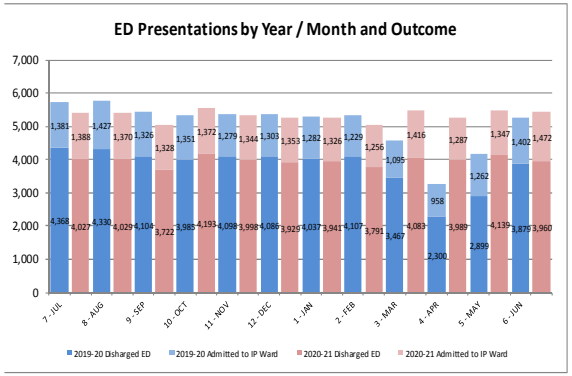
Capital and Coast DHB: June 2021

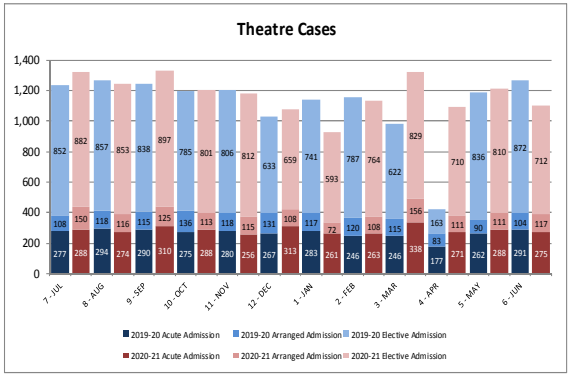
ED Presentations

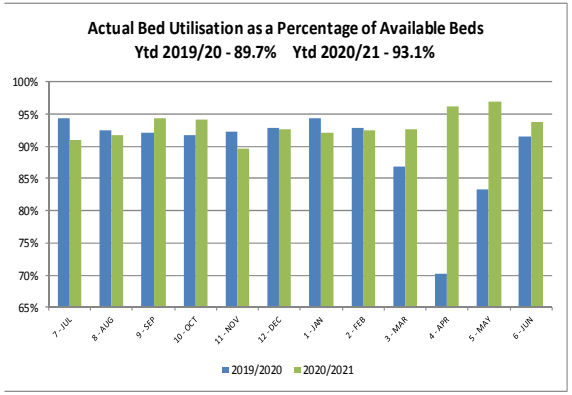
	2019/20	2020/21
YTD Totals	60,955	64,060
Change		3,105
% Change		5%

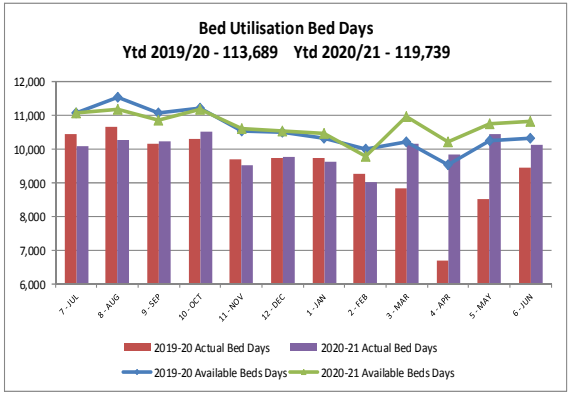
Theatre Cases

	2019/20	2020/21
YTD Totals	13,335	14,149
Change		814
% Change		6%









ED

- The total number of presentations to ED in June 2019 was 5,490 (this includes 459 DNWs)
- The total number of presentations to ED in June 2020 was 5,290 (this includes 338 DNWs)
- The total number of presentations to ED in June 2021 was 5,410 (this includes 428 DNWs)
- The overall total in June 2021 was similar to 2020 and 2019 but of note the total number of patients with a triage level 1-3 in June 2021 was 3,732 this is over 400 more than the totals in 2020 and 2019.

Bed Utilisation

- The utilisation of available of adult beds in core wards in June 2021 was 9.8% which is lower than the 91.4% rate recorded in June 2020. The number of available beds in June 2021 is higher than in June 2020 with more beds temporarily opened at Kenepuru in June 2021.
- The number of Elective theatre cases has decreased for the month of June 2021 by 18%
- (160 cases) when compared to June 2019. The decreases are spread across a number of specialties in particular Orthopaedics (-42) and Dental (-28).

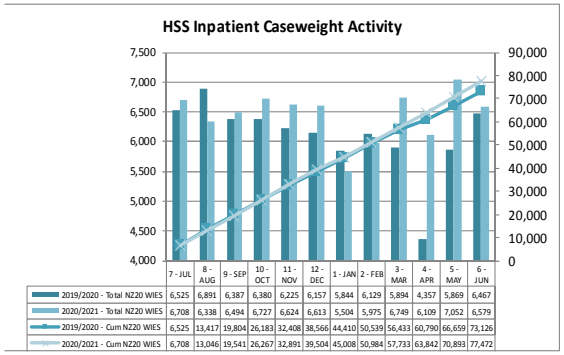
CCDHB Activity Performance

Capital and Coast DHB: June 2021

HSS Inpatient Caseweight Activity

	2019/20	2020/21
YTD Totals	73,126	77,472
Change		4,346
% Change		5.9%

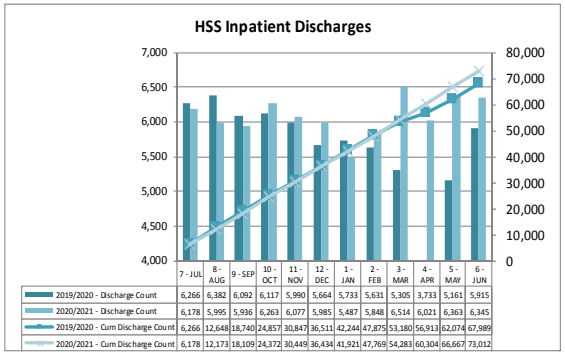
** This includes all Hospital Acitivty including ACC, Non Resident, Non-Casemix but excludes Mental Health*



HSS Inpatient Discharges

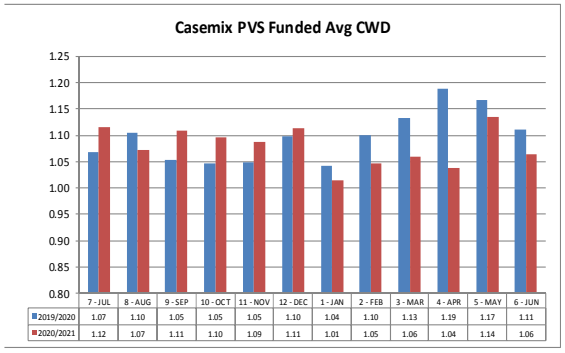
	2019/20	2020/21
YTD Totals	67,989	73,012
Change		5,023
% Change		7.4%

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



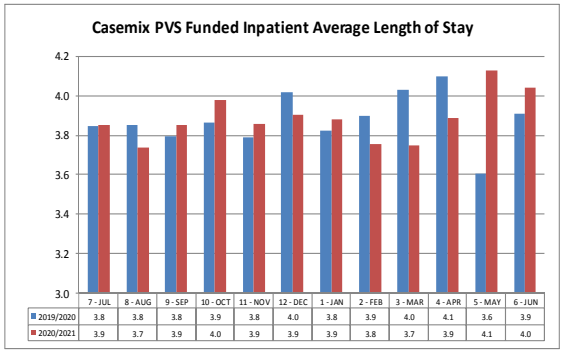
Casemix PVS Funded Avg CWD

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



Casemix PVS Funded Inpatient Average Length of Stay

	2019/20	2020/21
YTD Totals	3.87	3.89
Change		0.02
% Change		0.4%



Comparisons with same period last year:

- Local acute CWDs are higher than then previous financial year (1,923, CWDs) with an increase in discharges; a similar ALOS and average CWD. The discharge increase is driven primarily by Emergency Medicine and Orthopaedics. The CWD increase is driven primarily by Emergency Medicine, General Surgery and Neurology.
- Local Elective CWDs are higher than the previous financial year (562 CWDs) with an increase in discharges; a lower ALOS and a similar average CWD. The discharge increase is driven primarily by General Surgery, Cardiology and Vascular Surgery. The CWD increase is driven primarily by Cardiology, General Surgery, and Urology.
- IDF acute CWDs are higher (1,340 CWDs) than the previous financial year also with an increase in discharges; a lower ALOS and similar average CWD. The discharge increase is driven primarily by Emergency Medicine, Cardiology, Haematology and Urology. The CWD increase is driven primarily by Neonatal, Haematology and Neurology.
- IDF Elective CWDs are higher than the previous financial year (480 CWDs) with more discharges; a lower ALOS and lower average CWD. The discharge increase is driven primarily by Ophthalmology, Vascular Surgery and Paediatric Surgery. The CWD increase is driven primarily by Neurosurgery, Cardiology and Paediatric Surgery.
- In combination these four admission groups equate to an increase of 4,304 CWDs compared to the previous year. The services that most significantly impact this shift are Emergency Medicine (759), Haematology (437), General Surgery (399) and Neonatal (393.
- General Medicine is currently 160 CWDs year to date higher when compared to last the last financial year but the gap would have been higher if not for the WRH AHOP counting change (425 CWDs now counted as bed days).

Discharges:

- The number of publicly funded casemix discharges for the month of June 2021 which has increased by increased by 378 (6.9%) in comparison to the number of discharges recorded in June 2020. The increase can be largely attributed to a 54% increase in Paediatric Medicine (104) discharges and Obstetrics (85 Women, 40 Babies).
- The number of outsourced discharges recorded in June 2021 was 172 which is higher than previous months. CCDHB in 2021 has utilised Boulcott Hospital, Bowen Hospital, Southern Cross Hospital and Wakefield Hospital.

HHS Operational Performance Scorecard – period June 20 to June 21

Domain	Indicator	2021/22 Target	2020-Jun	2020-Jul	2020-Aug	2020-Sep	2020-Oct	2020-Nov	2020-Dec	2021-Jan	2021-Feb	2021-Mar	2021-Apr	2021-May	2021-Jun
Care	Serious Safety Events	TBD	5	15	9	11	5	19	6	12	13	3	9	6	4
	Total Reportable Events	TBD	1,087	1,168	1,269	1,370	1,359	1,417	1,511	1,424	1,483	1,450	1,399	1,522	1,311
Patient and Family Centred	Complaints Resolved within 35 calendar days	TBD	90.6%	86.4%	94.3%	93.9%	94.9%	90.9%	83.0%	93.1%	95.5%	92.3%	93.6%	93.5%	95.6%
	% Discharges with an Electronic Discharge summary	TBD													
Access	Emergency Presentations		5,281	5,415	5,399	5,050	5,565	5,342	5,282	5,267	5,047	5,499	5,276	5,486	5,432
	Emergency Presentations Per Day		176	175	174	168	180	178	170	170	180	177	176	177	181
	Emergency Length of Stay (ELOS) % within 6hrs	≥95%	74.6%	72.6%	68.5%	65.6%	65.1%	67.6%	65.9%	68.6%	62.5%	66.3%	63.3%	66.8%	64.0%
	ELOS % within 6hrs - non admitted	TBD	82.6%	79.8%	76.8%	75.2%	73.6%	73.7%	73.7%	75.8%	70.3%	75.6%	71.7%	76.1%	73.2%
	ELOS % within 6hrs - admitted	TBD	54.6%	53.5%	46.8%	41.3%	42.3%	51.3%	46.0%	49.6%	42.4%	42.7%	40.6%	41.2%	42.1%
	Total Elective Surgery Long Waits	Zero Long Waits	350	247	107	99	184	208	307	490	540	528	527	353	386
	Additions to Elective Surgery Wait List		1,505	1,520	1,376	1,543	1,397	1,391	1,288	921	1,242	1,449	1,213	1,424	1,136
	% Elective Surgery treated in time	TBD	71.3%	73.0%	84.2%	90.3%	89.0%	86.3%	88.5%	75.4%	75.6%	72.2%	72.1%	75.0%	82.2%
	No. surgeries rescheduled due to specialty bed availability	TBD	12	5	9	13	14	1	6	2	6	11	7	13	21
	Total Elective and Emergency Operations in Main Theatres	TBD	1,202	1,237	1,192	1,254	1,130	1,118	1,002	878	1,076	1,270	1,063	1,190	1,085
	Faster Cancer Treatment 31 Day - Decision to Treat to Treat	85%	91.0%	93.0%	85.0%	87.0%	82.0%	85.0%	87.0%	82.0%	90.0%	88.0%	85.0%	80.0%	94.0%
	Faster Cancer Treatment 62 Day - Referral to Treatment	90%	85.0%	94.0%	83.0%	88.0%	88.0%	83.0%	89.0%	87.0%	83.0%	95.0%	81.0%	85.0%	95.0%
	Specialist Outpatient Long Waits	Zero Long Waits	1,450	1,076	571	314	185	225	314	353	355	302	244	211	Tbc
	% Specialist Outpatients seen in time	Zero Long Waits	74.2%	74.1%	84.9%	90.0%	88.7%	92.1%	92.9%	89.1%	88.2%	85.6%	80.1%	90.6%	90.5%
	Outpatient Failure to Attend %	TBD	6.6%	7.1%	6.7%	7.0%	7.6%	7.7%	7.8%	7.3%	7.5%	7.2%	7.1%	7.3%	6.7%
	Maori Outpatient Failure to Attend %	TBD	13.6%	14.7%	13.8%	15.2%	15.3%	16.0%	16.6%	16.1%	16.1%	15.7%	15.8%	14.8%	14.7%
	Pacific Outpatient Failure to Attend %	TBD	16.2%	16.9%	14.4%	14.6%	16.3%	16.3%	18.8%	19.6%	17.8%	16.8%	15.6%	16.2%	15.2%
Financial Efficiency	Forecast full year surplus (deficit) ($million)		($44.2m)	($39.8m)	($39.8m)	($62.0m)	($62.0m)	($62.0m)	($62.0m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)	($62.4m)
	Contracted FTE (Internal labour)		4,976	4,976	5,035	5,237	5,267	5,263	5,257	5,256	5,344	5,346	5,366	5,364	5,341
	Paid FTE (Internal labour)		5,317	5,318	5,369	5,607	5,608	5,651	5,693	5,695	5,812	5,726	5,791	5,783	5,719
	% Main Theatre utilisation (Elective Sessions only)	85.0%	81.0%	83.0%	82.0%	82.0%	82.0%	80.0%	78.2%	81.0%	80.0%	83.0%	83.0%	81.0%	80.0%
Discharge and Occupancy	% Patients Discharged Before 11AM	TBD	21.9%	24.0%	22.8%	24.8%	22.2%	25.1%	22.6%	22.3%	21.9%	23.2%	25.3%	23.7%	23.5%
	Adult Long Stay Patients Not Yet Discharged (>14 days) WLG	TBD	29	30	35	51	33	34	37	37	38	41	37	35	38
	Adult Overnight Beds - Average Occupied WLG	TBD	357	362	363	382	378	363	360	355	373	381	381	386	387
	Adult Long Stay Patients Not Yet Discharged (>14 days) KEN	TBD	17	19	19	18	23	18	17	16	14	19	19	22	18
	Adult Overnight Beds - Average Occupied KEN	TBD	63	71	72	74	76	67	64	67	71	69	72	73	73
	Child Overnight Beds - Average Occupied	TBD	23	24	23	22	23	24	22	17	19	22	22	22	25
	NICU Beds - ave. beds occupied	36	29	28	31	38	36	33	35	38	39	44	39	42	36
ALOS	Overnight Patients - Average Length of Stay (days)	TBD	3.91	3.85	3.74	3.85	3.98	3.86	3.90	3.88	3.75	3.75	3.88	4.13	4.06
Care	Rate of Presentations to ED within 48 hours of discharge	TBD	3.8%	3.7%	3.7%	4.3%	4.6%	3.2%	3.2%	4.1%	4.0%	3.5%	4.7%	4.6%	4.0%
	Presentations to ED within 48 hours of discharge	TBD	203	199	201	215	254	171	170	218	202	194	247	253	218
Staff Experience	Staff Reportable Events	TBD	161	140	156	138	179	173	175	147	185	161	152	146	150
	% sick Leave v standard	TBD	3.5%	4.0%	4.0%	3.6%	3.4%	3.4%	3.2%	2.0%	2.7%	3.4%	3.2%	3.6%	3.8%
	Nursing vacancy	TBD	157.6	248.1	265.3	251.1	247.4	267.4	268.5	267.8	223.4	234.7	235.6	243.0	245.5
	% overtime v standard (medical)	TBD	1.6%	1.7%	1.9%	2.1%	1.9%	2.0%	1.8%	1.8%	2.0%	1.9%	1.8%	2.0%	1.9%

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

Shorter Stays in ED (SSIED)

What is this measure?

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

Why is this important?

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

How are we performing?

- On 23 June Wellington moved to Alert Level 2 at 11:59pm with Wellington returning to Alert Level 1 at 11:59pm on 29 June 2021. These alert levels did not appear to reduce the number of presentations to Wellington ED.
- CCDHB performance for June 2021 was 64.2% which is significantly lower than June 2019 (83%).
- CCDHB SSiED performance for June 2021 is 30.8% lower than the Target for SSiED. Breaches in ED have increased by 594 in June 2021 compared to June 2019. The performance for ED treated and discharged patients for June 2021 was 75%, which is a 3% reduction on the result for May 2021. The performance for ED admitted patients for June 2021 was 45%, which is 1% lower than the result for May 2021. In the last 4 weeks Wellington ED occupancy has exceeded 90% for at least 12 hours every day.
- Bed occupancy continues to be one of the most significant contributing factor to SSiED compliance. The occupancy percentage utilisation for June was 96% (optimum occupancy of 95%). The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) excluding Ward 4 North and ICU. The number of available adult beds in June 2021 was 347. The average general adult bed occupancy over the last three months has been 99% in Wellington and 91% at Kenepuru.
- During the month of June 2021 there were nil presentations where the patient(s) was suspected of having COVID-19.

Table One: ED performance 2019/20 and 2020/21

Performance	APR	MAY	JUN
2018-19	82%	83%	83%
2019-20	84%	83%	75%
2020-21	63%	67%	64%

Breaches	APR	MAY	JUN
2018-19	887	886	1,188
2019-20	498	680	1,259
2020-21	1,766	1,673	1,782

ED Volumes	APR	MAY	JUN
2018-19	4,939	5,204	5,031
2019-20	3,211	4,005	4,952
2020-21	4,798	5,074	4,982

What is driving performance?

- Our performance being less than target continues to be due to the increase of elective and acute surgical work. A significant increase in the acuity of acutely admitted patients have contributed to very high hospital occupancy and subsequent access block. We also have in place ongoing processes related to COVID-19 screening and precautions.
- We continue to operate parallel processes in our inpatient wards to manage COVID case definition vs. non-COVID patients. The requirement to enhance these processes were a major factor in worsening access blocks during the Wellington Alert level 2 lockdown in late June. Our acute flow programme of work continues as mentioned in the previous report. Unfortunately, these processes have reached a breaking point and do not result in any further improvement for patient waiting times and patient flow from ED.

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. The very small footprint of the Emergency Department cannot tolerate any delays in moving patients from ED to the wards and this, combined with the high hospital occupancy, contributes significantly to the very unsafe level of overcrowding in the ED.
- Other work streams continue to be progressed but is unlikely to have any noticeable effect on patient flow unless the capacity issue is addressed.
- It is important to note that while these initiatives are all very important and will continue, they will not make any further impact on the very poor SSiED performance at CCDHB without a complete revamp of the way in which acute patients present and are processed from the front door (including transition to assessment and observation units). This cannot happen within the current footprint and we are continuing the Front of Whare project that will identify the barriers and confirm the need for improved resources (facilities and personnel). This work is inextricably linked to other ongoing work to assess and address overall hospital capacity.

Planned Care – Inpatient Surgical Discharges/Minor Procedures

What is this measure?

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

Why is this important?

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

How are we performing?

- Total planned care results year-end report us unfavourable 695 to our planned target of 10,720.
- Planned care discharges performed at CCDHB results were 635 under delivered to a planned 9,673
- Inter-district outflow, discharges from other DHB's resulted in 60 under delivered to a planned 1,047.
- June month end result is unfavourable 4 to a plan of 863. In-house June results are reporting 15 behind our plan of 522, Our outsourcing volume for June was just 5 adverse to the planned 144, this is a good result considering we are still experiencing contractual restraints.
- Our IDF outflow position for June is 18 adverse to the planned 83. Our minor procedures measure is reporting 165 ahead of the planned 384 in June

What is driving performance?

- High volumes of cancellations due to acute demand is the main reason we did not meet our planned care targets, coupled with inability to outsource the planned volumes each month.

Management Comment

- Our focus remains on scheduling our longest-waiting patients in all specialities, and ensuring our theatre sessions are fully utilised. Work at Kenepuru remains on track for a handover to the services the second week of July. We plan to be back to full capacity at Kenepuru and resource OT 13 in Wellington that will provide additional operating time.
- We continue to outsource a reduced number of patients while contracts are finalised.
- SMOs continue to be involved with planning surgery based on those with greatest clinical urgency and long waiting times.

MRI and CT Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

- Waiting times for CT and MRI remain high as a result of historical insufficient capacity to meet demand. Subsequently, the percentage measure is low and has been for a long time but are slowly trending up, though flattening out in late 2020/early 2021 mainly due to high demand for both services.

What is driving performance?

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

Figure Two: CT wait times

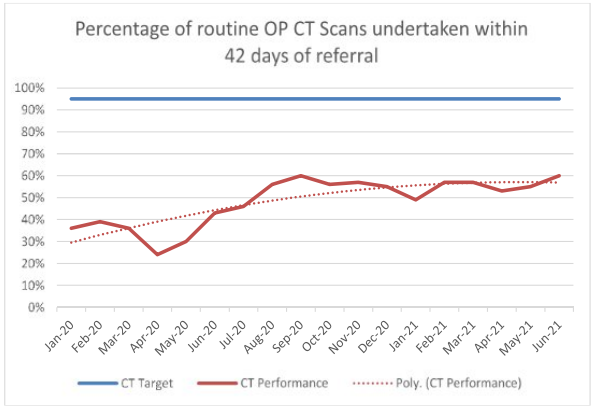
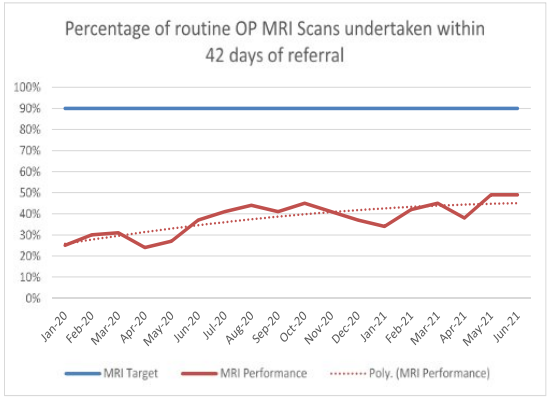


Figure Three: MRI wait times



Management Comment

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

Coronary

Coronary Angiography Waiting Times

What is this measure?

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

Why is this important?

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

How are we performing?

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

What is driving performance?

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

Management Comment

- The 2 consultants on parental leave have returned during June which will help maintenance of the target in future.

Acute Coronary Syndrome

Key clinical quality improvement indicators

What is this measure?

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

Why is this important?

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

How are we performing?

National Performance	78.2% (583/746)
Central Region	85.5% (130/152)
CCDHB	93.8% (30/32)
Hawkes Bay	63.2% (12/19)
Hutt Valley	83.3% (15/18)
Mid Central	83.3% (25/30)

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

What is driving performance?

- Achievement of the target differs for each centre. The referral to transfer is directly influenced by CCDHB, ultimately this relates to access to beds. Other factors include regional decision making timeframes, and timing of presentation.

Management Comment

- Staffing capacity is improving due to two SMO's returning from parental leave. The underlying issue remains access to beds. This has resulted in less flexibility and impacts on the service's ability to transfer regional patients in a timely manner when busy. This has been particularly problematic with the onset of winter pressures. Additional overnight beds are being used in the transit lounge which will mitigate some of this issue, allowing better patient flow.

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 June at 90% which equates to the aim of 90% of patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer.
- CCDHB is compliant with the 31 day indicator for June at 95% vs the aim of 85% of patients commencing treatment within 31 days from decision to treat.

What is driving performance?

- Of the three patients who breached the 62 day target two experienced delays in gaining a biopsy and pathology reporting, one experienced a delay in accessing a FSA appointment. The breaches occurred in the gynaecological, haematological and head and neck tumour streams. The patient with the head and neck cancer was Māori. 62 day compliance was 100% Pacifica (3/3 patients) and 50% for Māori (1/2 patients). Note acute presentations are excluded from the 62 day target.
- All four breaches in the 31 day indicator was due to capacity reasons – access to surgery for urological (2) and skin (1 at HVDHB) and radiation treatment for one urological patient.
- 31 day compliance was 100% for Māori, 100% Pacifica and 94% for other ethnicities.

Management Comment

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

Figure Eight: FCT 62 day target

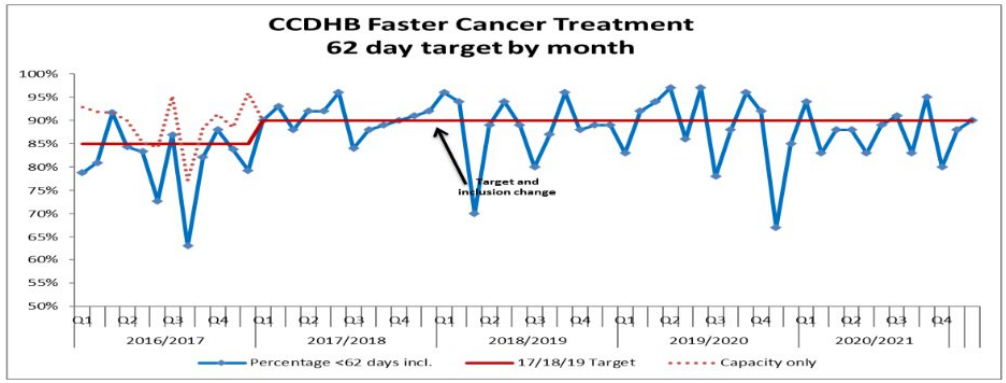
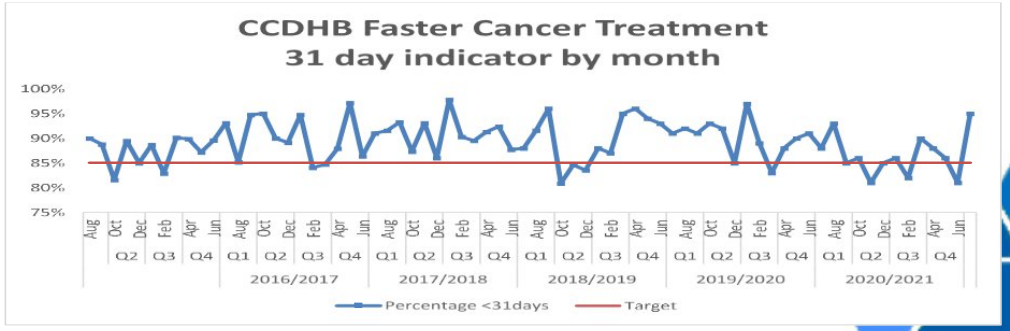


Figure Nine: FCT 31 day target



Colonoscopy

What is this measure?

Diagnostic colonoscopy

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

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

Surveillance colonoscopy

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

Why is this important?

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

How are we performing?

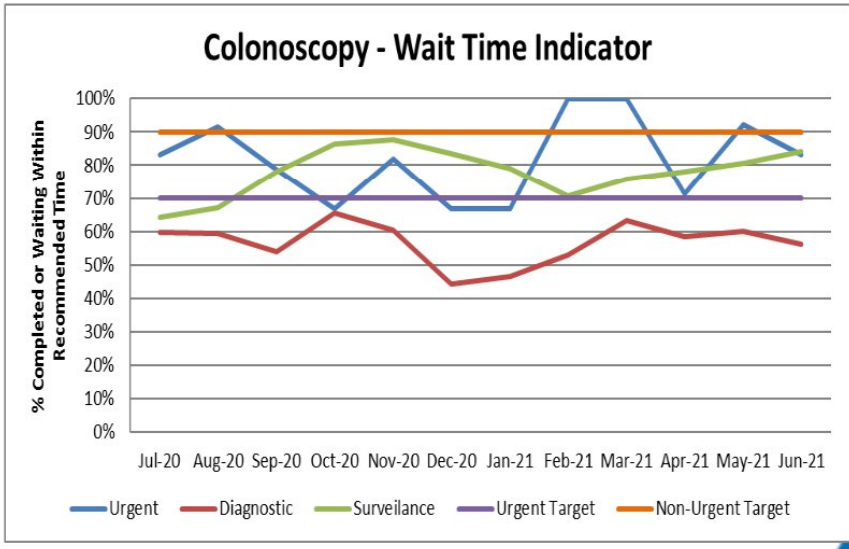
- CCDHB did not achieve the Ministry of Health target for urgent colonoscopies with a performance of 83.3% (target 90%). This was down from the 92.3% achieved in May. For diagnostic waits, we achieved 56.1% (target 70%) in June, which was a drop in performance on the 60.2% in May.
- We exceeded the Ministry of Health target for surveillance achieving 84.3.7%, (target 70%). This is an improvement on the May return of 80.7%.

What is driving performance?

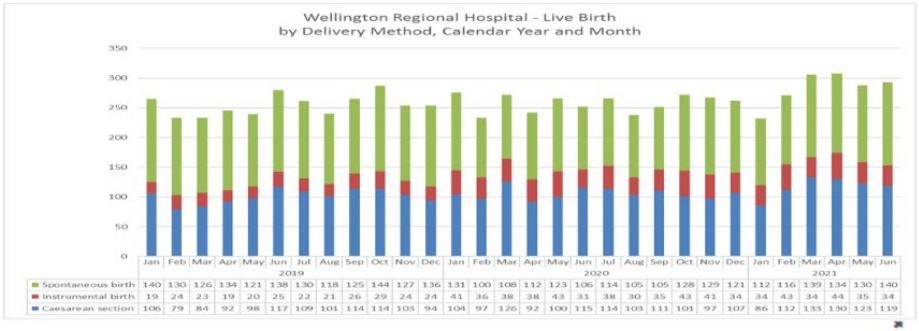
- As anticipated in the previous report, our performance in June has dropped, because of nurse staffing vacancies. This has resulted in fewer lists being available.

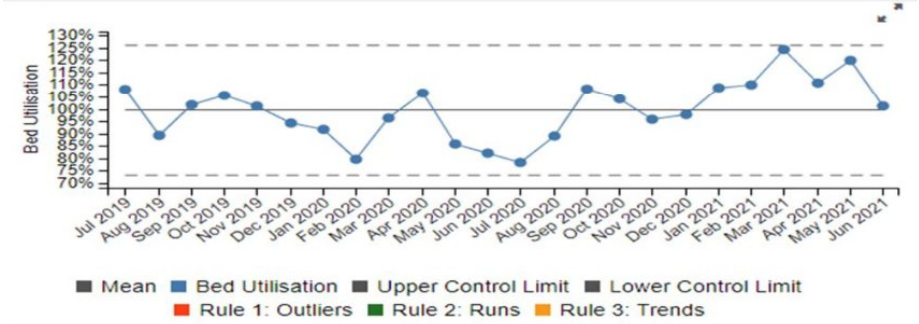
Management Comment

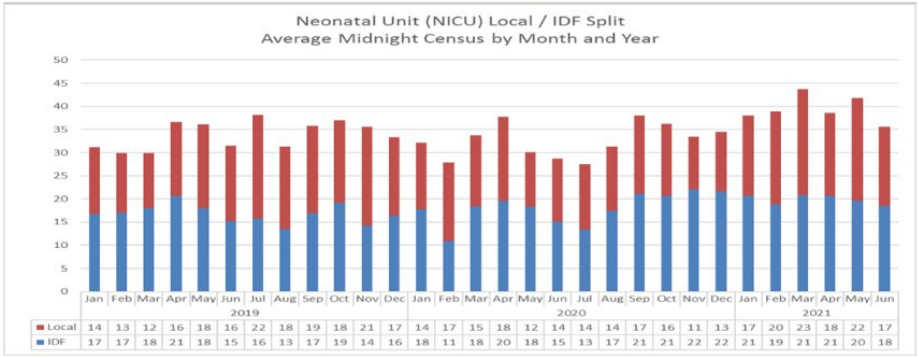
Recruitment and training of new staff is ongoing but it will take a number of months before we are back to normal staffing levels. A number of cases have been outsourced but this has been limited in June because of a similar lack of capacity in the private sector. A procurement exercise is currently underway to access more capacity.



Maternity and Neonatal Intensive Care services







What is the issue?

- The regions maternity units are experiencing increasing pressure due to high demand for inpatient services and workforce challenges.
- The Wellington Regional Hospital Maternity and Delivery Suite and continues to experience a high acuity and bed utilisation. Also impacted by this trend is our Neonatal Intensive Care service.
- To support the recruitment of midwives we continue with our international recruitment drive that links to our over all workforce plan led by our Chief Nurse
- Escalation plans are being challenged with continued presentations, high acuity, and continued shortages.
- We continue to work closely with our staff and union partners on workforce planning across the region noting this issue as requiring national solutions.
- Local options include use of all maternity services and beds across the region exploring different geographical patient flows – collection of data and analysis of patient flows is well underway.

Section 3

Financial Performance and Sustainability

Executive Summary Financial Performance and Position

- The DHB has budgeted a deficit of $39.8 million. The responsible deficit YTD was $7.8m favourable against budget.
- Two extraordinary items exist which are not included within the budget, which the ministry has advised are regarded as outside the DHBs performance assessment:
  - ($4m); COVID-19: additional costs during COVID-19
  - ($8.7m); Holidays Act Provisions
- The DHB had targeted a reasonable number of efficiency measures for the year ahead totalling $38m, which are required to meet our deficit position, $38 million relates to our YTD from both personnel vacancies, efficiency savings across all services and ICT gains through consolidation and rationalisation.
- The DHB also had a number of key safe care initiatives totalling $15.8m some of which are still due to start within the year.
- The DHB's cash is under pressure for 2020/21 due to level of deficit support lower than last years deficit and no cash funding provided for provider arm COVID-19 costs. This was mitigated at year end by a delay to payment of capital charge, increase in leave liabilities (as this is non cash) and significant delays to our capex spend (offset by non cash depreciation). The DHB by the start of June Bank Balance was in overdraft ($28.9m) with $13.4m in special fund balances.
- COVID-19 from the first outbreak continues to incur some additional costs and also disruption to normal BAU for some components of the hospital operation and management. We have put in place tracking and monitoring systems to enable all the costs to be captured and reported to the Ministry, the key items of which are shown on the next slide, this is in addition to the unfunded ($8m) from the prior financial year in which cash has not been provided.

COVID-19 Revenue and costs & Holidays Act

Last Year			Capital & Coast DHB Operating Results - $000s	This Year to Date			Total Provision/Expense	
COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	YTD June 2021	COVID-19 change from Trend - Provider	COVID-19 change from Trend - Funder	Holidays Act [2003]	COVID-19	Holidays Act [2003]
	(8,317)		Devolved MoH Revenue	(12,292)	(18,734)		(39,343)	0
			Non-Devolved MoH Revenue				0	0
2,037			Other Revenue	693			2,730	0
			IDF Inflow				0	0
			Inter DHB Provider Revenue			(44)	0	(44)
2,037	**(8,317)**	**0**	**Total Revenue**	**(11,599)**	**(18,734)**	**(44)**	**(36,613)**	**(44)**
			Personnel					
(1,610)		(2,049)	Medical	(6,336)		(2,376)	(7,946)	(26,513)
(1,620)		(9,145)	Nursing	(4,360)		(3,894)	(5,980)	(43,461)
		(1,370)	Allied Health			(648)	0	(7,234)
		32	Support			(174)	0	(1,941)
		168	Management & Administration			(741)	0	(8,209)
(3,230)	**0**	**(12,365)**	**Total Employee Cost**	**(10,696)**	**0**	**(7,833)**	**(13,926)**	**(87,358)**
			Outsourced Personnel					
(51)			Medical	(88)		(16)	(139)	(16)
			Nursing				0	0
			Allied Health				0	0
			Support				0	0
			Management & Administration				0	0
(51)	**0**	**0**	**Total Outsourced Personnel Cost**	**(88)**	**0**	**(16)**	**(139)**	**(16)**
2,834			Treatment related costs - Clinical Supp	(5,088)			(2,254)	0
(1,952)			Treatment related costs - Outsourced	(564)			(2,516)	0
(1,921)			Non Treatment Related Costs	(2,028)		(856)	(3,949)	(856)
			IDF Outflow				0	0
	(9,917)		Other External Provider Costs (SIP)		(15,828)		(25,745)	0
			Interest Depreciation & Capital Charge				0	0
(1,039)	**(9,917)**	**0**	**Total Other Expenditure**	**(7,680)**	**(15,828)**	**(856)**	**(34,464)**	**(856)**
(4,320)	**(9,917)**	**(12,365)**	**Total Expenditure**	**(18,464)**	**(15,828)**	**(8,705)**	**(48,529)**	**(88,230)**
6,357	**1,600**	**12,365**	**Net result**	**6,865**	**(2,905)**	**8,661**	**11,917**	**88,186**

- The year to date financial position includes $43.0m additional costs in relation to COVID-19.
- Revenue of $30.3m has been received to fund additional costs for community providers however this has not been sufficient for these costs
- Additional personnel costs of $8.7m have been accrued YTD for the Holidays Act
- COVID-19 costs are spread across personnel, clinical supplies, outsourced treatment and infrastructure and non-clinical costs.

CCDHB Operating Position – June 2021

Month - June 2021									Capital & Coast DHB	Year to Date								Annual		
			Variance		Adjustments			Variance	Operating Results - $000s				Variance		Adjustments			Variance			
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID/HA	Actuals exc COVID vs Budget	YTD June 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	COVID-19 change from Trend	Holidays Act [2003]	Actuals exc COVID-19 / HA	Actuals exc COVID vs Budget	Annual Budget	Last year	Last year exc HA/COVID/ NOS
83,714	77,550	75,691	6,164	8,023	5,186		78,528	978	Devolved MoH Revenue	962,513	930,600	892,143	31,913	70,369	31,026		931,487	887	930,600	892,143	883,827
1,970	3,554	2,420	(1,585)	(451)			1,970	(1,585)	Non-Devolved MoH Revenue	42,517	42,688	41,220	(172)	1,297			42,517	(172)	42,688	41,220	41,220
3,353	2,856	2,943	496	410	(0)		3,353	497	Other Revenue	52,921	34,596	36,600	18,325	16,322	(693)		53,614	19,018	34,596	36,600	38,636
24,620	21,452	22,994	3,167	1,626			24,620	3,167	IDF Inflow	258,694	257,429	239,666	1,265	19,028			258,694	1,265	257,429	239,666	239,666
3,866	763	941	3,103	2,926		0	3,866	3,103	Inter DHB Provider Revenue	42,120	9,247	8,560	32,872	33,560		44	42,120	32,872	9,247	8,560	8,560
117,522	**106,176**	**104,989**	**11,346**	**12,533**	**5,186**	**0**	**112,336**	**6,160**	**Total Revenue**	**1,358,764**	**1,274,560**	**1,218,189**	**84,204**	**140,575**	**30,333**	**44**	**1,328,431**	**53,871**	**1,274,560**	**1,218,189**	**1,211,909**
									Personnel												
17,188	15,369	16,493	(1,820)	(695)	573	200	16,415	(1,047)	Medical	191,452	185,399	175,829	(6,054)	(15,623)	6,336	2,376	182,740	2,658	185,399	175,829	172,170
21,882	19,949	28,799	(1,933)	6,917	885	328	20,668	(719)	Nursing	256,370	234,861	233,986	(21,510)	(22,384)	4,360	3,894	248,116	(13,256)	234,861	233,986	223,222
5,168	6,023	7,012	855	1,843		55	5,114	909	Allied Health	74,815	69,243	63,729	(5,572)	(11,085)		648	74,166	(4,924)	69,243	63,729	62,359
876	921	809	45	(67)		15	861	60	Support	10,994	10,977	9,759	(17)	(1,235)		174	10,820	157	10,977	9,759	9,790
5,318	6,512	5,354	1,194	36		62	5,255	1,256	Management & Administration	82,979	77,509	71,657	(5,470)	(11,322)		741	82,238	(4,729)	77,509	71,657	71,825
50,432	**48,774**	**58,466**	**(1,658)**	**8,035**	**1,458**	**660**	**48,314**	**460**	**Total Employee Cost**	**616,610**	**577,988**	**554,960**	**(38,622)**	**(61,650)**	**10,696**	**7,833**	**598,081**	**(20,093)**	**577,988**	**554,960**	**539,365**
									Outsourced Personnel												
995	439	468	(556)	(527)	(43)	(0)	1,038	(599)	Medical	8,416	5,280	6,671	(3,136)	(1,745)	88	16	8,312	(3,032)	5,280	6,671	6,620
384	25	24	(359)	(361)			384	(359)	Nursing	459	298	250	(161)	(209)			459	(161)	298	250	250
165	114	104	(51)	(61)			165	(51)	Allied Health	1,944	1,364	1,464	(580)	(480)			1,944	(580)	1,364	1,464	1,464
30	22	14	(8)	(16)			30	(8)	Support	221	262	287	41	65			221	41	262	287	287
525	81	401	(444)	(124)			525	(444)	Management & Administration	4,430	970	2,674	(3,460)	(1,756)			4,430	(3,460)	970	2,674	2,674
2,099	**681**	**1,011**	**(1,417)**	**(1,088)**	**(43)**	**(0)**	**2,142**	**(1,461)**	**Total Outsourced Personnel Cost**	**15,471**	**8,175**	**11,346**	**(7,296)**	**(4,125)**	**88**	**16**	**15,367**	**(7,192)**	**8,175**	**11,346**	**11,295**
13,237	10,999	10,780	(2,238)	(2,458)	2,750		10,488	511	Treatment related costs - Clinical Supp	140,211	133,194	124,009	(7,017)	(16,202)	5,088		135,123	(1,929)	133,194	124,009	126,843
2,920	2,469	2,107	(451)	(813)	0		2,920	(451)	Treatment related costs - Outsourced	27,169	28,959	23,749	1,789	(3,420)	564		26,605	2,353	28,959	23,749	21,797
13,247	7,108	7,658	(6,140)	(5,589)	49	293	12,905	(5,798)	Non Treatment Related Costs	152,291	83,461	78,547	(68,830)	(73,744)	2,028	856	149,406	(65,945)	83,461	78,547	76,627
7,159	8,965	9,887	1,806	2,728			7,159	1,806	IDF Outflow	76,848	107,584	102,847	30,736	25,999			76,848	30,736	107,584	102,847	102,847
31,878	26,523	19,823	(5,354)	(12,055)	(428)		32,306	(5,783)	Other External Provider Costs (SIP)	368,553	317,042	307,255	(51,511)	(61,298)	15,828		352,725	(35,683)	317,042	307,255	297,339
460	4,816	5,782	4,356	5,322			460	4,356	Interest Depreciation & Capital Charge	6,330	57,973	59,648	51,643	53,318			6,330	51,643	57,973	59,648	59,648
69,052	**60,881**	**56,036**	**(8,171)**	**(13,016)**	**2,371**	**293**	**66,238**	**(5,358)**	**Total Other Expenditure**	**773,182**	**728,213**	**696,056**	**(44,970)**	**(77,127)**	**23,508**	**856**	**747,037**	**(18,824)**	**728,213**	**696,056**	**685,100**
121,583	**110,336**	**115,513**	**(11,247)**	**(6,069)**	**3,786**	**952**	**116,694**	**(6,358)**	**Total Expenditure**	**1,405,263**	**1,314,375**	**1,262,362**	**(90,888)**	**(142,901)**	**34,293**	**8,705**	**1,360,485**	**(46,110)**	**1,314,375**	**1,262,362**	**1,235,761**
(4,060)	**(4,160)**	**(10,524)**	**99**	**6,464**	**1,400**	**(952)**	**(4,358)**	**(198)**	**Net result**	**(46,499)**	**(39,815)**	**(44,173)**	**(6,684)**	**(2,326)**	**(3,960)**	**(8,661)**	**(32,054)**	**7,761**	**(39,815)**	**(44,173)**	**(23,852)**

Note two adjustments are made for

1. COVID-19 and
2. Holidays Act.

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

Executive Summary – Financial Variances

- The DHB deficit year to date is ($46.5m). The variance to the YTD Budget is ($6.7m)
- Included within this result is recognition of the adjustment to the holiday act provision ($8.7m) and an estimated impact of COVID-19 of ($4.0m).
- Excluding the two items above brings the deficit for the year into deficit of ($32.1m) being $7.8m favourable to budget.
- Revenue is favourable by $84.2m YTD, after excluding COVID-19, lead DHB changes this is on budget. The variances are due to mental health national contracts, special fund/ research revenue offset by donation and interest revenue. Inpatient IDF revenue was recognised behind target by ($1.9m), with planned care (electives) set to target whilst the year gets underway.
- Personnel costs including outsourced is ($37m) YTD, excluding the Holidays Act provision ($6.5m) and the COVID-19 related costs of ($9.3m) incurred the net unfavourable variance is ($21.2m). This ($21.2m) net unfavourable variance has been more than offset by the transfer of Mental Health and ICT services to CCDHB from other DHBs ($18.1m). CCDHB receives revenue to fully cover the costs of the transferred services and this is recognised in the ytd result.
- Treatment related clinical supplies $3.0m is unfavourable with increased costs associated with Bloods, prostheses and grafts offset by a favourable movement in drugs and outreach clinics.
- Outsourced clinical services is favourable YTD by $2.2m; favourable movement due to outsourced surgical service delayed compared to budget plan, however this is offset by the increase in MRI, CT Scans and other radiology services.
- Non treatment related costs ($21.1m) YTD unfavourable, however after excluding COVID-19, lead DHB changes and impairment of the investment in CRISP Non Treatment related costs were breakeven.
- The funder arm is favourable YTD due to additional revenue from spend requirements for our community COVID-19 response which may not all be funded. Some new programmes in the NGO space have commenced alongside increased revenue from MoH to support these initiatives.

Analysis of the Operating Position – Revenue and Personnel

Revenue

- Revenue is $3.4m favourable YTD (after lead DHB and other items indicated on previous page) despite recognising IDFs being behind target by ($1.9m)
- The variance is due to revenue for special funds/research of $728k, Interest due to overdraft situations ($444k), Donations ($1m) MHAIDS non-lead DHB revenue of $1.5m Favourable and Insurance settlements. The funder arm is also favourable by $32.1m revenue however with offsetting community cost and COVID related costs in the Provider.

Personnel (including outsourced)

- Medical Personnel is $2.4m unfavourable for the month, YTD unfavourable by ($10.2m). The unfavourable position for the month is due to the transfer of costs to CCDHB for MHAIDs services ~$1.2m, Holidays Act provisions ($200k) and the year to date exc MHAIDS, Holidays Act was an unfavourable variance of ($2.4m) is driven by vacancies across other services, most notably surgery and Women's and Children's services offset by COVID expenditure.
- Nursing Personnel is ($2.5m) unfavourable to budget for the month, YTD ($23.8m) unfavourable. This is driven by overspend to budget for MHAIDs, partially driven by the transfer of staff from other DHBs to CCDHB.
- Allied Personnel labour is $787k favourable to budget for the month, YTD ($5.8m) unfavourable to budget. $5.4m of the YTD variance results from the transfer of staff from other DHBs to CCDHB.
- Support Personnel labour month position is unfavourable by $38k, YTD favourable by $21k.
- Management/Admin Personnel is favourable in the month by $489k, YTD unfavourable by ($10.5m). $5.7m YTD of this variance has corresponding offsetting revenue within ICT, the remainder is spread across the organisation and driven largely by the use of outsourced contractors.

Section 4

Financial Position

Cash Management – June 2021

Month : Jun 2021					Capital & Coast DHB Statement of Cashflows	Year to Date				
			Variance						Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD Jun 2021	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					Operating Activities					
89,525	111,708	46,947	(22,183)	42,578	Receipts	1,362,200	1,340,498	1,228,747	21,702	133,453
					Payments					
61,584	45,979	41,481	(15,605)	(20,103)	Payments to employees	599,227	551,693	530,469	(47,535)	(68,758)
40,767	64,029	(11,670)	23,262	(52,437)	Payments to suppliers	727,457	769,693	651,319	42,237	(76,138)
9,328	11,365	0	2,036	(9,328)	Capital Charge paid	31,174	34,829	12,297	3,655	(18,877)
(1,247)	(137)	654	1,111	1,901	GST (net)	(3,197)	1,641	1,595	4,838	4,792
110,433	121,236	30,465	10,803	(79,968)	Payments - total	1,354,660	1,357,856	1,195,679	3,195	(158,981)
(20,907)	(9,527)	16,482	(11,380)	(37,389)	Net cash flow from operating Activities	7,540	(17,357)	33,068	24,897	(25,528)
					Investing Activities					
27	70	31	43	4	Receipts	207	895	1,400	688	1,193
					Payments					
3,283	5,511	8,464	2,228	5,181	Purchase of fixed assets	61,648	137,292	45,602	75,644	(16,046)
3,283	5,511	8,464	2,228	5,181	Payments - total	61,648	137,292	45,602	75,644	(16,046)
(3,256)	(5,441)	(8,433)	2,270	5,185	Net cash flow from investing Activities	(61,441)	(136,397)	(44,203)	76,332	(14,853)
					Financing Activities					
(3,484)	36,331	(6,517)	(39,815)	3,033	Receipts	20,221	107,493	21,287	(87,272)	(1,066)
					Payments					
0	0	0	0	0	Interest payments	8	0	0	(8)	(8)
0	0	0	0	0	Payments - total	8	0	0	(8)	(8)
(3,484)	36,331	(6,517)	(39,815)	3,033	Net cash flow from financing Activities	20,213	107,493	21,287	(87,280)	(1,074)
(27,647)	21,363	1,532	(48,925)	(29,171)	Net inflow/(outflow) of CCDHB funds	(33,688)	(46,262)	10,153	13,949	(41,456)
12,195	(49,389)	16,704	(61,583)	4,510	Opening cash	18,236	18,236	8,083	0	(10,153)
86,069	148,109	40,461	(61,955)	45,616	Net inflow funds	1,382,628	1,448,886	1,251,434	(64,882)	133,580
113,716	126,747	38,929	13,031	(74,786)	Net (outflow) funds	1,416,317	1,495,148	1,241,281	78,831	(175,035)
(27,647)	21,363	1,532	(48,925)	(29,171)	Net inflow/(outflow) of CCDHB funds	(33,688)	(46,262)	10,153	13,949	(41,456)
(15,452)	(28,026)	18,236	12,574	(33,688)	Closing cash	(15,452)	(28,026)	18,236	12,573	(33,688)

RECONCILIATION OF CASH FLOW TO OPERATING BALANCE

	YTD Jun 2021		
	Actual $000	Budget $000	Variance $000
Net Cashflow from Operating	7,540	(7,830)	15,370
Non operating financial asset items	(172)	-	(172)
Non operating non financial asset items	(3,580)	(2,805)	(776)
Non cash PPE movements	(32,891)	(29,485)	(3,406)
Working Capital Movement			
Inventory	398	-	398
Receipts and Prepayments	27,014	12,100	14,914
Payables and Accruals	(44,805)	(7,636)	(37,169)
Total Working Capital movement	**(17,393)**	**4,464**	**(21,857)**
Operating balance	**(46,497)**	**(35,656)**	(10,841)

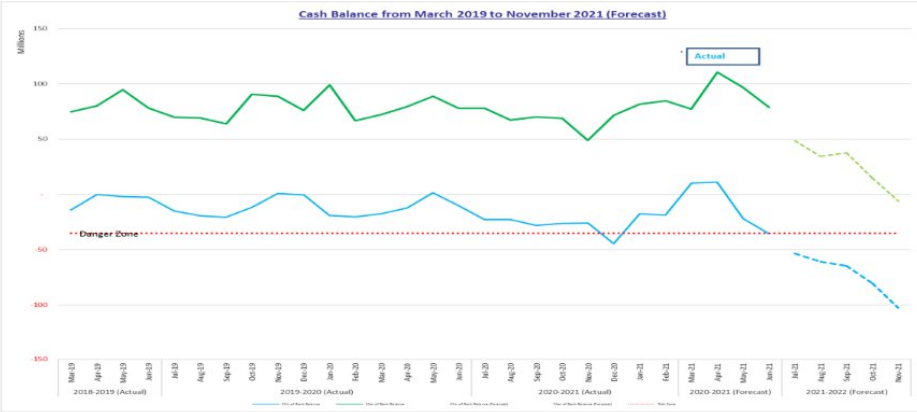
Net inflow cash: June $27.6m (Unfavourable)

Net cash flow from operating activities un-favourable this month due to $9.3m capital charge payment and three fortnight payroll in this month.

Net outflow of Investment activities represents the capital repayment $3.5m (the repayment of funding for additional cost re Property Revaluation).

Debt Management / Cash Forecast – June 2021

Aged Debtors report ($'000)	Total	Current	1-30	31 - 60	61 - 90	91+	Previous Period
Ministry of Health	8000	5344	463	378	101	1714	9623
Other DHB's	8793	3901	1075	328	38	3451	6717
Kenepuru A&M	219	38	15	22	144	0	227
ACC	215	77	-28	46	0	120	183
Misc Other	3347	1372	108	115	-1	1753	2915
Total Debtors	20,574	10,732	1,633	889	282	7,038	19,665
less : Provision for Doubtful Debts	(4,075)						(3,668)
Net Debtors	16,499						15,997



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 $2.0m.

3. Kenepuru A&M includes significant number of low value patient transactions. Provision for the overdue debts is $143k

4. 'Misc Other' debtors includes non resident debt of approx. $1.85m. About 86% of the non resident debt have payment arrangements in place. The balance will be referred to collection agencies if unpaid.

Cash Management

The DHB will require further $20m equity injection in July 2021.

Cash forecast July 21: High:+$79m, Low:-$40m, improved by cash management process.

Balance Sheet / Cashflow – as at 30 June 2021

May-21	Month : Jun 2021						Capital & Coast DHB Balance Sheet
					Variance		
ADtual	Actual	Budget	At Jun 2020	At Jun 2020	Actual vs Budget	Actual vs Jun 2020	YTD Jun 2021
31	31	31	31	31	0	0	Bank
928	3	(0)	6,523	6,523	3	(6,520)	Bank NZHP
13,561	13,391	11,683	11,683	11,683	1,709	1,709	Trust funds
63,930	60,022	49,375	46,342	46,342	10,647	13,680	Accounts receivable
9,466	9,393	8,995	8,995	8,995	398	398	Inventory/Stock
7,902	7,141	6,257	6,257	6,257	884	884	Prepayments
95,818	**89,982**	**76,341**	**79,831**	**79,831**	**13,641**	**10,151**	**Total current assets**
509,015	505,931	629,070	522,978	522,978	(123,139)	(17,047)	Fixed assets
14,847	14,847	14,847	9,859	11,626	0	4,988	Work in Progress - CRISP
94,034	96,377	50,096	59,084	57,317	46,281	37,293	Work in progress
617,896	**617,155**	**694,013**	**591,921**	**591,921**	**(76,858)**	**25,234**	**Total fixed assets**
1,150	1,150	1,150	1,150	1,150	0	0	Investment in Allied Laundry
1,150	**1,150**	**1,150**	**1,150**	**1,150**	**0**	**0**	**Total investments**
714,864	**708,287**	**771,504**	**672,901**	**672,901**	**(63,217)**	**35,385**	**Total Assets**
2,325	28,877	39,739	0	0	10,862	(28,877)	Bank overdraft HBL
96,762	91,559	64,504	76,604	76,604	(27,055)	(14,955)	Accounts payable, Accruals and provisions
7,840	0	0	(252)	(252)	0	(252)	Capital Charge payable
593	593	593	593	593	0	0	Insurance liability
11,441	16,759	36,144	36,144	36,144	19,386	19,386	Current Employee Provisions
180,467	179,786	140,857	140,857	140,857	(38,929)	(38,929)	Accrued Employee Leave
22,515	5,682	7,299	7,299	7,299	1,618	1,618	Accrued Employee salary & Wages
321,944	**323,256**	**289,137**	**261,245**	**261,245**	**(34,119)**	**(62,010)**	**Total current liabilities**
92	90	95	95	95	5	5	Restricted special funds
605	605	605	605	605	0	0	Insurance liability
6,564	6,222	6,564	6,563	6,564	343	342	Long-term employee provisions
7,262	**6,916**	**7,264**	**7,263**	**7,264**	**348**	**347**	**Total non-current liabilities**
329,206	**330,172**	**296,402**	**268,509**	**268,510**	**(33,771)**	**(61,663)**	**Total Liabilities**
385,659	378,115	475,102	404,392	404,391	(96,988)	(26,278)	Net Assets
833,446	833,446	883,935	816,257	813,224	(50,489)	17,189	Crown Equity
0	(3,484)	(3,484)	(3,484)	(3,484)	0	0	Capital repaid
0	0	0	0	0	0	0	Capital Injection
130,659	130,659	130,660	130,659	130,659	(1)	0	Reserves
(578,447)	(582,507)	(575,823)	(536,008)	(536,008)	(6,685)	(46,499)	Retained earnings
385,658	**378,114**	**475,103**	**404,392**	**404,392**	**(96,990)**	**(26,277)**	**Total Equity**

Balance Sheet

1. DHB's cash balance at the end of June is $11m favourable.
2. Accounts receivable is higher than the budgeted by $14.5m, increase funding from MoH.
3. WIP-CRISP reduced by $10.5m due to the impairment and write-off.
4. Accounts payable, accruals and provisions is higher than budget primarily due to a timing differences
5. Employee liabilities are higher than the budgeted. This is due to an unbudgeted employee costs (MHAIDs) approx. $3m per month;

Cash flow

1. The net cash flow from operating activities is unfavourable to the budget--three fortnight payroll in this month.
2. The net cash flow from investment activities is unfavourable to the budget due to repayment of capital;

Financial ratios

1. Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities. DHB's current ratio is 0.28 (May: 0.30).

2. Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB's total liability to equity ratio is 47:53 (May: 40:60).

Note

1. Balance Sheet subject to change due to Revaluation of Land and Buildings currently in progress as at 30 June, which will be reflected through Comprehensive Income

Capital Expenditure Summary June 2021

Capital Expenditure Spend on Approved Projects

Asset Category	Approved Capex Budget	PY Spend to 30 June 2020	September Quarter actual spend	December Quarter actual spend	March Quarter actual spend	June Quarter actual spend	Actual YTD Spend	Actual LTD Spend	To spend/Carry forward to FY21-22
Buildings	9,468,096	-	225,088	820,879	479,840	1,892,293	3,418,101	3,418,101	6,049,996
Clinical Equipment	13,731,917	-	643,250	1,506,284	1,113,275	2,541,043	5,803,853	5,803,853	7,928,064
ICT	2,709,961	-	41,960	142,786	373,375	641,876	1,199,998	1,199,998	1,509,964
2020-21 projects	**25,909,974**	-	**910,298**	**2,469,950**	**1,966,490**	**5,075,213**	**10,421,951**	**10,421,951**	**15,488,023**
Buildings	17,941,282	8,814,096	1,322,531	898,532	826,409	737,775	3,785,247	12,599,343	5,341,939
Clinical Equipment	44,232,069	21,222,465	7,233,721	5,910,378	1,213,901	1,230,808	15,588,807	36,811,272	7,420,797
ICT	9,172,562	6,711,200	1,051,219	279,928	256,897	47,183	1,635,228	8,346,427	826,135
Prior Year projects	**71,345,913**	**36,747,760**	**9,607,472**	**7,088,837**	**2,297,207**	**2,015,766**	**21,009,282**	**57,757,042**	**13,588,871**
Total	**97,255,887**	**36,747,760**	**10,517,770**	**9,558,787**	**4,263,698**	**7,090,979**	**31,431,233**	**68,178,993**	**29,076,894**

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

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

- Total spend to the end of June 2021 was $31.4m and (compared to $29.9m in the 2020 financial year)
- The total cash spend is lower than the depreciation funding of $36m due to some key factors including: overseas and local supply chain issues, delays in business case development from clinical equipment not available to trial
- The value of approved but not completed projects to be carried forward to 2021/22 is $29m
- The 2021/22 capital plan was approved in July 2021. Projects worth $8.7m have been approved and are being progressed

Board Information – Public

1 September 2021

The Pro-Equity People-based Commissioning Policy and the Equity Communications and Engagement Strategy

Action Required

The Boards approve:

(a) our DHBs' progress in relation to implementing the Equity Goal, Definition and Principles with the achievement of two significant milestones:

i. the Pro-Equity People-based Commissioning Policy describing the standards health commissioners must meet when commissioning new health services and/or recommissioning existing services to improve health equity for our priority populations: Māori, Pacific people, and disabled people.

ii. the Equity communications and engagement strategy communicating our DHBs' equity commitment and the framework for density proactive progress towards our DHBs' Equity Goal.

Strategic Alignment	CCDHB Health System Plan 2030 HVDHB Our Vision for Change 2017-2027 CCDHB Taurite Ora Māori Health Strategy 2019-2030 HVDHB Te Pae Amorangi, Māori Health Strategy 2018-2027 The Pacific Health & Wellbeing Strategic Plan for the Wellington Region, 2020-2025 Sub-Regional Disability Strategy 2017 – 2022; Wairarapa, Hutt Valley and Capital & Coast District Health Boards
Presented by	Fionnagh Dougan, Chief Executive Rachel Haggerty, Executive Director, Strategy, Planning and Performance
Purpose	To inform the Boards of the completion of two significant milestones implementing our DHBs' Equity Goal, Definition and Principles: the Pro-Equity, People-based Commissioning Policy and the Equity communications and engagement strategy.
Contributors	Helen Mexted, Director, Communications and Engagement Catherine Inder, Principal Advisor, Strategy, Planning and Performance Rachel Haggerty, Executive Director, Strategy, Planning and Performance Arawhetu Gray, Director, Māori Health Junior Ulu, Director, Pacific Health Rachel Noble, General Manager, Disability Roger Palairet, Chief Legal Officer
Consultation	Rachel Haggerty, Executive Director, Strategy, Planning and Performance Arawhetu Gray, Director, Māori Health Junior Ulu, Director, Pacific Health Rachel Noble, General Manager, Disability Roger Palairet, Chief Legal Officer

Executive Summary

Our DHBs are in the process of reshaping themselves as pro-equity organisations and have delivered against two significant milestones: a Pro-Equity, People-based Commissioning Policy and an Equity communications and engagement strategy.

These are the first deliverables of a plan to implement the agreed Equity Definition, Goal, and Principles by ensuring there is clear guidance and direction to address the inequities that exist for our priority populations: Māori, Pacific peoples and Disabled people.

Strategic Considerations

Service	The Pro-Equity People-based Commissioning Policy and the Equity communications and engagement strategy will help all services and community providers understand their responsibility to improve equity for our priority populations and provide guidance on how to do so.
People	The Pro-Equity People-based Commissioning Policy ensures that health commissioners have the mandate and guidance to enabling them to allocate health system resource to address inequities. The Equity communications and engagement strategy outlines the work and is aimed enable staff to understand what the Equity Goal, Definition and Principles mean for them. Priority populations accessing health services can expect to find services more available, accessible, affordable, acceptable, and appropriate.
Financial	All investment (workforce, organisation, service provision) needs to be considered through an equity lens. Resources will be prioritised to systematically address inequities proportionate to address the inequities that exist.
Governance	Our DHBs are establishing a pro-equity governance structure to support implementation of our DHBs' strategic priorities.

Engagement/Consultation

Patient/Family	None
Clinician/Staff	A staff pro-equity commissioning working group contributed to the development of the Pro-Equity, People-based Commissioning Policy
Community	Te Upoko o te Ika Māori Council (TUI MC) Sub-Regional Disability Advisory Group

Identified Risks

The Pro-Equity People-based Commissioning Policy and the Equity communications and engagement strategy mitigate the reputational risks associated with public and workforce perceptions that reprioritisation of resources to achieve equity is unfair for those who do not experience inequities.

Attachment/s

1. Pro-Equity People-based Commissioning Strategy
2. Equity communications and engagement strategy.

1. PURPOSE

The purpose of this paper is to inform the Boards of the completion of two significant milestones on our DHBs' journey to reshape themselves as pro-equity organisations beginning with the implementation of our DHBs' Equity Goal, Definition and Principles. The milestones are the delivery of the:

- Pro-Equity, People-based Commissioning Policy (the Policy)
- Equity communications and engagement strategy promoting the Equity Goal, Definition and Principles.

2. BACKGROUND

On 23 March 2021, our Boards' approved the Equity Definition, Goal, and Principles - the fundamentals for transforming our DHBs into pro-equity organisations.

The development of the Policy is committed to in *Taurite Ora Māori Health Strategy 2019-2030* (*Taurite Ora*) and is a key performance indicator for *Taurite Ora's* implementation.

The policy and the communications and engagement approach are the first deliverables of a plan to implement the Equity Definition, Goal, and Principles by ensuring there is clear guidance and direction to address the inequities that exist for our priority populations: Māori, Pacific peoples and Disabled people.

Equity and pro-equity approaches have been integrated into the 2DHB strategic priorities.

3. THE POLICY

Overview

The Policy embeds a policy framework that firstly, upholds our DHBs' Te Tiriti o Waitangi obligations by recognising the Crown's special relationship with Māori; secondly, implements the Equity Goal, Definition, and Principles; and, thirdly, identifies our responsibilities to improve health outcomes for our priority populations: Māori, Pacific peoples, and Disabled people.

The Policy describes the standards that health commissioners must meet when commissioning new health services and supports and/or recommissioning existing services and supports. Health commissioners have obligations to:

- uphold the principles of Te Tiriti o Waitangi, as they apply to the health and disability sector
- incorporate the Equity principles into all aspects of their commissioning practice
- ensure the commissioning strategies and investment choices are proportionate and will address the equity gaps for Māori, Pacific peoples and Disabled people
- ensure health services and supports are focused on improving equity.

The commissioning cycle is traditionally presented as consisting of four overlapping and non-sequential phases: analyse, plan, do, and review. Our DHBs' 'Pro-equity, people-based Commissioning Cycle' conceptualises the four phases as: The People we Serve, Designing with our Partners and Communities, Implementing, and Reviewing.

Scope

Compliance with this Policy is mandatory for Strategy, Planning and Performance; the Māori Health; and the Pacific Health Directorates recognising these directorates control a significant portion of the investment in our health system and have the opportunity to drive system change incrementally. Compliance with this Policy is discretionary but recommended for all other Hutt Valley DHB and Capital & Coast DHB directorates and teams. This policy applies to the commissioning of:

- all new health services, including capital investment
- existing health services that are being reconfigured and redesigned
- existing health services that are being decommissioned.

Support

Health commissioning is a collaborative, multidisciplinary activity and health commissioners need to learn and embed a range of skills and competencies. Managers need to support their staff to both commission services to improve equity and to acquire the necessary skills and competencies to implement this policy.

Consultation

The Policy has been consulted on with Te Upoko o te Ika Māori Council (TUI MC) and the Sub-Regional Disability Advisory Group and their advice resulted in small but meaningful changes to the Policy.

4. THE COMMUNICATIONS AND ENGAGEMENT STRATEGY

The Equity communications and engagement strategy outlines a framework to communicate the whole of system work programme that is focused on transforming the inequities that exist for our priority populations: Māori, Pacific peoples and disabled people across our region.

The framework will launch our equity commitment and communicate proactive progress towards our DHBs' Equity Goal and Pro-Equity Policy Framework and initiatives under three phases:

1. Launching our equity commitment
2. Launching our pro-equity policy framework
3. Profiling our pro-equity initiatives.

Pro-Equity People-based Commissioning Policy

1. Context for this policy

1.1 Hutt Valley and Capital & Coast DHBs (our DHBs) have responsibility for improving the performance of our health care system and encouraging better health and wellbeing and more equitable outcomes for all our communities.

1.2 Health inequities appear very early in life, accumulate over the life course, and are reflected in most common causes of death, injury and hospitalisation. The social determinants of health, stigmatisation, racism, ableism, and poorer access to health and social services all increase the likelihood of poor health and other outcomes.

1.3 This policy makes it clear that for our DHBs equity is the outcome.

Te Tiriti o Waitangi

1.4 Te Tiriti o Waitangi is a foundational document for the health and disability sector and commits our DHBs to upholding the special relationship between Māori and the Crown. The fact that Māori health outcomes are so poor does not reflect our Te Tiriti o Waitangi commitments (see section 4.2) and represents a failure of the health and disability system.

Equity Goal, Definition and Principles

1.5 Our DHBs' are determined to reshape themselves as pro-equity organisations. The Executive Leadership Team and our DHBs' Boards have endorsed a definition of equity, a high-level goal to achieve health equity by 2030, and seven equity principles.

Equity definition: in the Hutt Valley and Capital & Coast districts, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Equity goal: achieve Health Equity by 2030 as measured by:

- Consumer input, Access, Quality, Experience and direct Results.
- Influence on fundamental causes and social determinants.

Equity principles (abridged see the Appendix for the full version):

- Privilege their Voice
- Include Whānau
- Empower Consumers
- Prioritise Access
- Offer Kaupapa Māori (and equivalent) Options
- Invest Proportionately

- Challenge Discrimination.

1.6 This policy is a key component of the operational framework to translate the **Equity goal, definition and principles** into policies and practices that will transform our DHBs into pro-equity organisations.

1.7 The development of this policy is committed to in *Taurite Ora Māori Health Strategy 2019-2030* (*Taurite Ora*) and is a key performance indicator for *Taurite Ora*'s implementation.

Priority populations

1.8 Our DHBs have recognised the inequities experienced by our priority populations: Māori, Pacific peoples and Disabled people. These unfair and unjust outcomes, and our DHBs' failure to improve them over decades, are starkly presented in:

- *Taurite Ora*
- *Te Pae Amorangi, Māori Health Strategy 2018-2027*
- *The Pacific Health & Wellbeing Strategic Plan for the Wellington Region, 2020-2025*
- *Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services*.

1.9 **Pacific peoples** (see the definitions section) - are diverse communities with unique values, languages, ways of knowing, social capital, and lived experiences. Pacific communities do not receive equitable care. Varying degrees of social isolation, acculturation, the impact of migration, and different views of illness between Pacific communities all impact on our DHBs ability to provide services that meet the needs of Pacific peoples appropriately.

1.10 **Disabled people** (see the definitions section) - improving equity for disabled people is a commitment to upholding human rights, and an important step towards more equitable healthcare for all New Zealanders. People with disabilities are frequent users of health services, both for their impairment/disability and their general health. Improving equity for disabled people is a challenge because it is a large and very diverse community, and disabled people face unique and varied complexities and barriers in healthcare.

1.11 The United Nations Convention on the Rights of Persons with Disabilities was ratified by New Zealand in 2008 and gives voice, visibility and legitimacy to disabled people. It protects the dignity of disabled people and ensures their right to health services.

Disadvantaged communities

1.12 Our priority populations are not alone in experiencing health inequities. Social and economic disadvantages, racism, discrimination, and stigmatisation have significant negative effects on other communities in our DHBs including people with enduring

mental health and addiction problems; refugees and migrants; people from gender and sexual minorities; and communities experiencing social and economic deprivation.

1.13 'Health commissioners' (see the definitions section) need to take intersectionality-informed approaches to reduce and eliminate inequities by recognising the intersecting nature of systems of oppression. Race, religion, class, gender, sexuality, ethnicity, nationality, ability, and age are not distinct and mutually exclusive entities. These overlap, combine, and compound driving vulnerability and marginalisation and shaping distinct identities, for example, Māori disabled people and their whānau identify as Tāngata Whaikaha.

2. Purpose

2.1 Our DHBs have an obligation to address avoidable, unfair, and unjust differences in health and have committed to fundamentally rethinking and changing how they 'commission' (see the definitions section) health services in order to deliver on our DHBs' Equity goal to achieve health equity by 2030. Because health commissioners allocate and distribute health system resources they play a critical role in achieving health equity

2.2 Being pro-equity requires health commissioners to actively challenge the status quo; be bold and aspirational for our priority populations; and commit to distributing and redistributing resources to improve equity and to taking action to disrupt inequities.

2.3 This policy describes the standards that health commissioners must meet when commissioning new health services and supports and/or recommissioning existing services and supports. Health commissioners have obligations to:

- uphold the principles of *Te Tiriti o Waitangi*, as they apply to the health and disability sector
- incorporate the **Equity principles** into all aspects of their commissioning practice
- ensure the commissioning strategies and investment choices are proportionate and will address the equity gaps for Māori, Pacific peoples and disabled people
- ensure health services and supports are focused on improving equity.

3. Scope and implementation

3.1 Compliance with this policy is mandatory for Strategy, Planning and Performance; the Māori Health; and the Pacific Health Directorates in the Hutt Valley and Capital & Coast DHBs. This approach recognises these directorates control a significant portion of the investment in our health system and have the opportunity to drive system change incrementally.

3.2 Compliance with this policy is discretionary but recommended for all other Hutt Valley DHB and Capital & Coast DHB directorates and teams.

3.3 This policy applies to the commissioning of:

- all new health services, including capital investment
- existing health services that are being reconfigured and redesigned
- existing health services that are being decommissioned.

3.4 The application of this policy is discretionary but recommended for these contract management-related activities:

- the management of system and provider performance
- the monitoring of investment and health outcomes.

3.5 The Director, Strategy Planning and Performance, will develop a phased work programme for our 2DHB wide full implementation of this policy.

3.6 The implementation of the equity goal, definition, goal and principles also includes a communications and engagement strategy; a workforce development strategy; and an organisational development strategy designed to support all DHB staff to understand what the equity fundamentals mean for them and how to incorporate into their roles.

4. The legal foundation

4.1 The New Zealand Public Health and Disability Act 2000 (the NZPHD Act) creates District Health Boards and sets out their roles and duties. Te Tiriti o Waitangi is a foundational document for the health and disability sector. Section 4 of the NZPHD Act creates a statutory link between Te Tiriti o Waitangi and Māori health by requiring DHBs to recognise and respect the principles of Te Tiriti o Waitangi and to work with and be responsive to Māori when developing, planning, managing and investing in services that impact on Māori communities.

4.2 Our DHBs have an important leadership role serving mana whenua in the Hutt Valley and Capital & Coast areas and actively working towards enabling Māori to live long and well. *Whakamaua: Māori Health Action Plan 2020–2025*[1] provides an updated

[1] Ministry of Health. 2020. Whakamaua: Māori Health Action Plan 2020–2025.

statement of the Te Tiriti o Waitangi principles applicable to the health and disability sector, as articulated by the Courts and the Waitangi Tribunal.[2] The principles are:

- **Tino Rangatiratanga** - providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity** - being committed to achieving equitable health outcomes for Māori.
- **Active protection** - acting to the fullest extent practicable to achieve equitable health outcomes for Māori by being well-informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options** - providing for and properly resourcing kaupapa Māori health and disability services and ensuring they are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership** - working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers of the primary health system for Māori.

4.3 Section 22 (d), (e) and (f) of the NZPHD Act commits DHBs to promoting inclusion for people with disabilities and reducing health inequities, as follows:

- Promoting the inclusion and participation in society and independence of people with disabilities.
- Reducing health disparities by improving health outcomes for Māori and other population groups.
- Reducing, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

5. Roles and Responsibilities

5.1 Health commissioning is a collaborative, multidisciplinary activity and health commissioners need to learn and embed a range of skills and competencies. Managers need to support their staff to both commission services to improve equity and to acquire the necessary skills and competencies to implement this policy.

5.2 Health commissioners must take responsibility for their professional development by growing their understanding of each priority population's experience of inequities; world views; foundational documents; and priorities for change.

5.3 Health commissioners need to pay special attention to principle 7 of the **Equity principles** – Challenge Discrimination. This principle requires health commissioners to examine, be accountable for and mitigate their own conscious and unconscious biases

Wellington: Ministry of Health.

[2] Ibid, page 2.

and develop their ability to call out discrimination in all its forms – personal, institutional and structural.

5.4 All staff in Strategy, Planning and Performance; the Māori Health; and the Pacific Health Directorates will receive training on this policy.

5.5 The Director, Strategy, Planning and Performance is responsible for updating this document.

6. Overview of Pro-Equity People-based Commissioning

6.1 Health commissioners use the 'available resources' (see the definitions section) to achieve the best outcomes for people, in the places where they live, in the fairest, most efficient, effective and sustainable way, in a continual, iterative cycle.

6.2 Health commissioning is often misunderstood as solely the commissioning of new and innovative services. The reality of commissioning is the hard work involved in supporting providers to fulfil their commitments; and, especially, monitoring and managing provider performance to ensure they are focused on improving equity.

6.3 The commissioning cycle is traditionally presented as consisting of four overlapping and non-sequential phases: analyse, plan, do, and review. Our DHBs' 'Pro-equity, People-based Commissioning Cycle' conceptualises the four phases as: The People we Serve, Designing with our Partners and Communities, Implementing, and Reviewing.

6.4 Health commissioners will, at the discretion of their manager, provide a written deliverable, at the end of each phase of the commissioning cycle, documenting their pro-equity commissioning practice. In most cases, these should form part of the health commissioner's business as usual responsibilities and accountabilities.

- **The People we Serve** – a memo presenting the case for change
- **Designing with our Partners and Communities** – the necessary approval documents
- **Implementing** – a work plan that reflects our DHBs agreed strategic priorities and/or project plan
- **Reviewing** – the necessary documents presenting the results.

6.5 When commissioning new services and supports, health commissioners need to recognise the expertise of the Māori Health and the Pacific Health Directorates and the Disability Team in Strategy, Planning and Performance by engaging early and maintaining engagement throughout the commissioning process.

6.6 Health commissioners also need to recognise that partners, communities and many providers operate from a strong values base and are funded to meet their communities' health needs and a broad range of other needs (social, housing,

income). Longevity, consistency, a holistic approach and a strong sense of vocation are features of their practice. Partners, communities and providers can be reluctant to enter into partnerships to codevelop services with new health commissioners.

6.7 Health commissioners need to take a long term view and build their knowledge and understanding of prior history working with our DHBs and draw on it to guide and strengthen these relationships. Health commissioners also need to capture and pass on the lessons learned to new staff.

7. The People we Serve

7.1 Health commissioners must gather as much demographic, utilisation and outcomes information as necessary to understand the landscape of health outcomes and equity. Where possible, this includes information about people and places.

7.2 **Understanding people and the places where they live**

- People: demographic information including ethnicity, age and gender
- Place: place-based information including locality and socio-economic deprivation.

7.3 **Understanding current state**

- the service currently being delivered
- existing investment and allocation of available resources
- the people who are currently accessing the service
- what is working well in the current service
- people's flow through the service system
- people's experience of the service
- health and other outcomes.

7.4 **Understanding health need**

- the evidence base, including gold standard evidence and the voices of lived experience
- the 'best outcomes' (see the definitions section)
- the people who need the service, including emerging need
- the people who are not accessing the service
- the barriers to people accessing services
- the nature and size of the equity gaps

- the drivers of the equity gap

7.5 **Understanding future state**

- what needs to change
- what is needed and what is possible
- existing investment and allocation of available resources and what is needed
- alignment to government policy
- legal, financial and strategic constraints.

7.6 **Case for change** - health commissioners will document their findings in a narrative that summarises the results of the analysis and presents the case for change.

8. Designing with our partners and communities

8.1 **Engaging communities** - health commissioners must identify and engage the people who can codevelop solutions to address the equity gap and other challenges:

- Māori partners in fulfilment of our Te Tiriti o Waitangi obligations
- our priority populations and the communities and groups experiencing inequities
- people with lived experience of the health needs
- other experts – clinical, cultural, service providers.

8.2 **Enabling 'codevelopment'** (see definitions section) - health commissioners must work closely with partners, communities, groups, and other experts to:

- develop and implement transparent and robust processes that will facilitate their contribution to codeveloping solutions
- consider co-facilitating forums and processes
- ensure their world views and priorities for service and system change are fully understood and recorded
- identify options for service and system changes based on the available resources,
- clearly document decisions and the reasoning, especially if these do not support the partners' priorities and preferences.

8.3 **Codeveloping solutions** - health commissioners must work closely with partners, communities, groups, and other experts to:

- allocate the available resources proportionately across the service system taking into account:

  - DHB and Government strategic priorities
  - the support needed to grow and maintain high-trust relationships
- plan to implement service system changes.

8.4 **The necessary approval documents** – a business case (operational and/or capital); project plan; or internal memo that addresses the case for change for endorsement, at the appropriate delegation level, for the proposed service and system changes.

9. Implementing

9.1 **Codeveloping equitable services and systems** – health commissioners must work closely with partners, communities and key stakeholders, to implement and embed the agreed service and system changes including what is needed to monitor and evaluate progress towards equity of access and outcomes.

9.2 **Enabling thriving providers** – health commissioners must support providers to develop their capacity and capability to improve equity and deliver good outcomes by:

- anticipating issues and working in a strengths-based way to resolve them
- listening and problem solving when issues arise
- being flexible and, where possible, supporting providers by providing additional support and resources.

9.3 **Sustaining high trust relationships** – health commissioners must commit to growing and sustaining good relationships with partners, communities and providers. This means:

- holding regular face to face meetings
- creating opportunities for supportive informal check-ins and catch-ups
- responding to reasonable requests
- keeping their commitments
- respecting and validating insights into what is working well and what needs to change
- providing a warm handover when staff changes are necessary.

9.4 **A work or project plan** – health commissioners will develop annual work plans that reflect our DHBs' agree strategic priorities and enable partners, communities and providers to track progress towards improving equity.

10. Reviewing

10.1 **Measuring equity of access and outcomes** – health commissioners need to work with partners, communities and providers, partners, and key stakeholders to codevelop monitoring and evaluation plans to drive continuous improvement towards equity of access and outcomes.

10.2 **Assessing pro-equity performance** – health commissioners must proactively and continuously monitor system and provider performance to:

- understand whether the equity gaps are being addressed and reducing and what are the underlying causes of the changes
- challenge underperformance in improving equity and develop improvement strategies
- when required, access management and expert support to proactively manage poor performance.

10.3 **Creating new evidence bases** – health commissioners have an obligation to help build the evidence base for improving access and outcomes for people experiencing inequitable health outcomes. This means:`

- prioritising resources for robust evaluations of pro-equity health services
- ensuring evaluators possess the qualities to work effectively with partners, communities, providers and key stakeholders
- ensuring partners, communities, providers and key stakeholders have what they need to contribute to evaluation activities
- ensuring the methodologies and the findings will have meaning and value for partners, communities, providers and key stakeholders
- evaluating formatively to identify critical success factors and to accelerate progress towards achieving equity
- summative evaluations to inform ongoing planning and future investment strategies
- exploring the potential for partnerships with experts to build new evidence bases.

10.4 **The necessary documents describing the results** – health commissioners could be involved in codeveloping a range of written deliverables including new metrics and goals towards achieving equity; evaluation plans and reports; and provider improvement plans.

11. Definitions

11.1 **Available resources** – includes Vote Health funding (both DHB and Ministry of Health) and where there is the potential for integrated commissioning, other Votes, and philanthropic funding. It also includes workforces, both paid and voluntary; and assets, both tangible (equipment, land, buildings and infrastructure) and intangible (networks, brand, indigenous knowledge, natural leaders).

11.2 **Best outcomes** - equitable outcomes that are meaningful to the people we serve and meet national expectations and other requirements.

11.3 **Commission, commissioning** – at its simplest, commissioning is the process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

11.4 **Codevelop, codevelopment** – involves health commissioners, partners, and communities with different expertise sharing power and collaboratively working together to make services more effective and efficient, and in the long-term more sustainable. Health commissioners can use of a range of methodologies to codevelop services including coproduction, codesign and results-based accountability.

11.5 **Health commissioners** – includes all staff employed in Strategy, Planning and Performance; the Māori Health; and the Pacific Health Directorates. This definition recognises that health commissioning is a collaborative activity where many people contribute, frequently in multidisciplinary teams, where individuals have different responsibilities and accountabilities.

11.6 **Pacific peoples** – is an umbrella term used to describe a population made up of 16 distinct and diverse cultures of peoples from Melanesia, Polynesia and Micronesia. In the Greater Wellington Region the seven largest ethnic groups are Samoan, Tongan, Cook Island Maori, Niuean, Fijian, Tokelauan and Tuvaluan.

11.7 **Disabled people** - many people in the disability community identify proudly with the word disability, however it is uncomfortable for others. Other terms used frequently and sometimes interchangeably are impairment and chronic condition. Many people with a progressive disability do not see themselves as having a disability but will acknowledge having an impairment. In our DHBs, we use the definition in the United Nations Convention on the Rights of Persons with Disabilities that includes those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

Pro-Equity People-based Commissioning

Appendix

1. Privilege their Voice	**Amplify and value the voice of individuals and families/whānau from priority groups. Put them at the centre**. Seek out and give favourable treatment to their views. Ensure these sit at the heart of information gathering and decision making – in strategy, policy, process, service design and delivery.
2. Include Whānau	**Expand the focus from individuals to include the family unit (as defined by the individual)**. Design and deliver services that are oriented not just to individuals – but also to their whānau and household realities and circumstances. Explore and design so as to mitigate confounding factors to good health in the whānau environment.
3. Empower Consumers (Rangatiratanga)	Actively work to **empower individuals, whānau and communities to take control of their health, and become agents of their own change**. Foster their mana motuhake (autonomy, independence, self-management). Share power, influence and decision-making over the design, delivery and governance of health services.
4. Prioritise Access	Prioritise service access, quality and experience - by adapting service strategy, policy, process, design and delivery to ensure key services for individuals and whānau from priority groups are available, accessible, affordable, acceptable and appropriate.
5. Offer Kaupapa Māori (and equivalent) Options	**Transform health services by developing and fostering Kaupapa services** alongside generic service models - to enable choice for Māori, Pacific, Disability, other priority group consumers. Kaupapa services cover models of care and services designed and delivered by Māori, Pacific, Disability and other priority groups for all. Equally, hold general healthcare models and services accountable for transforming and prioritising culturally safe care that caters for Māori and other indigenous traditions and worldviews, and disability worldviews, in ways that address disadvantage in care access or quality.
6. Invest Proportionately	**Intensify care for those who have less resources and experience the greatest levels of avoidable poor health**. Deploy reasonable additional resources where required, proportionate to address the inequities that exist.
7. Challenge Discrimination	Advance an environment of open communication, supported inquiry, learning and development around discrimination in all forms, including racism, ableism and bias. Support employees and partners in the conversation. Call out conscious and unconscious discrimination on all levels - personal, institutional and structural.

Equity Communications and Engagement Strategy

Our equity commitment

Hutt Valley and Capital & Coast DHBs recognise that people across our population have differences in health that are not only avoidable, but unfair and unjust. The DHBs recognise that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes. Hutt Valley and Capital & Coast DHBs will work with our tangata whenua, our people and our partners across the sub-region to achieve health equity by 2030, while upholding our obligations as a Te Tiriti partner.

Our whole-of-system work programme will be underpinned by a focus on transforming the inequities that exist for Māori, and for our priority populations; Pacific peoples and disabled people across our region.

Our equity goal

Our DHBs will reshape themselves as pro-equity organisations as we transition to Health NZ and the Māori Health Authority.

We will achieve health equity in our region by 2030 as measured by:

Consumer input, access, quality, experience and direct Results.

Influence on fundamental causes and social determinants.

Our seven equity principles

Our seven equity principles guide our approach to achieving equitable health care and outcomes for our population.

Privilege their Voice

Amplify and value the voice of individuals and families/whānau from priority groups.

Focus on Whānau

Expand the focus from individuals to include the family unit (as defined by the individual).

Empower individuals, whānau & communities

Actively work to empower communities to take control of their health.

Invest Proportionately

Intensify care for those who have less resources and experience the greatest levels of avoidable poor health.

Prioritise Access

Prioritise service access, quality and experience.

Challenge Discrimination

Including racism, ableism and bias.

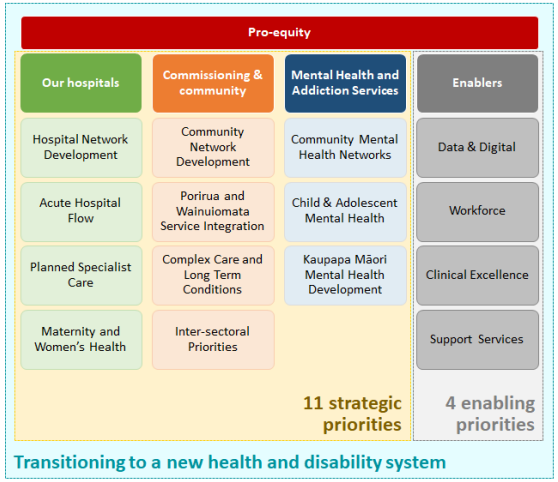
Offer Kaupapa Māori and equivalent options

Enable choice for priority groups.

Strategic alignment

We recognise the crown's obligations under Te Tiriti to uphold its relationship with Māori including addressing inequities. Our DHBs have recognised the inequities experienced by Māori and our other priority populations: Pacific peoples and disabled people. These inequities have been identified across our DHB strategies and underpin our strategic direction through to 2022. An increased focus on achieving equity is crucial to our transition in line with the Government's Health and Disability System Review changes.

These inequities are presented and identified in Taurite Ora, Te Pae Amorangi, The Pacific Health & Wellbeing Strategic Plan, the Sub-Regional Disability Strategy and Living Life Well.



Our framework

We will launch our equity commitment and communicate proactive progress towards our DHBs' Equity Goal our Pro-Equity Policy Framework and initiatives

1 Launching our equity commitment

Hutt Valley and Capital & Coast DHBs will launch a position statement (our equity commitment) internally and externally through a soft launch (PR/web/social).

Our statement identifies our commitment to reshape our DHBs as pro-equity organisations.

2 Launching our pro-equity policy framework

We will launch our pro-equity policies to provide an operational framework for achieving our equity goals. The development and implementation of pro-equity commissioning, pro-equity workforce development and pro-equity organisational development policies will transform our DHBs into pro-equity organisations.

3 Profile our pro-equity initiatives

We will profile our pro-equity initiatives, achievements and progress across our DHBs through case studies, stories and regular reporting. Equity is a theme that underpins our communications strategies, and is a key pillar of our content streams.

Board Decision – Public

1 September 2021

Sale and Supply of Alcohol Act 2012 and Smokefree Aotearoa 2025 Goal

Action Required

The Boards agree:

(a) To adopt the position statement on the Sale and Supply of Alcohol Act 2012 (the Act) asking for a review of the Act (refer attachment 1 - appendix 1)

(b) To endorse the recommendations in section 1 of the report titled 'DHBs and the Smokefree Aotearoa 2025 Goal' (refer attachment 2).

The Boards note:

(c) The 20DHB Chairs and Chief Executives commissioned research in relation to the adverse health effects of alcohol and tobacco, with a view to supporting initiatives and opportunities within the sector to advocate for change to address alcohol related harm and support the Smokefree Aotearoa Goal 2025.

(d) The 20DHB Chairs and Chief Executives received the following final reports:

I. DHB Position Statement on the Sale and Supply of Alcohol Act 2012 – attachment 1.

II. DHBs and the Smokefree Aotearoa 2025 Goal – attachment 2.

Strategic Alignment	
Endorsed by	David Smol, Chair, Hutt Valley and Capital & Coast DHBs. Fionnagh Dougan, Chief Executive, Hutt Valley and Capital & Coast DHBs.
Presented by	David Smol, Chair, Hutt Valley and Capital & Coast DHBs.

Executive Summary

The DHB Chairs and Chief Executives commissioned research and advocacy in relation to the adverse health effects of alcohol and smoking. The resulting reports (attachments 1 and 2) were considered and endorsed by the DHB Chairs and Chief Executives at their meeting on 12 August 2021.

It was agreed that each Chair would seek the support of their Boards for the position statement regarding alcohol related harm and agree to the recommendations regarding the Smokefree Aotearoa Goal 2025 (refer attachment 2, section 1).

Alcohol related harm

The report (attachment 1) follows an earlier paper to DHB Chairs and Chief Executives summarising the gaps and opportunities for DHBs to address alcohol related harm. This more recent report, summarises the Sale and Supply of Alcohol Act 2012 ('the Act'), outlines the problems and deficiencies in the current legislative framework, and recommends changes to the Act to better address alcohol related harm. The position statement (refer attachment 1, appendix 1) calls for an urgent review of the Act, outlines a number of specific changes and also calls for a number of broader changes to address alcohol related harm and its inequities.

It is recommended that the Boards agree to adopt the position statement set out in appendix 1 of attachment 1.

Smokefree Aotearoa 2025

The report at attachment 2 sets out national progress in relation to achieving the Smokefree Aotearoa 2025 Goal and recommends areas for action by the DHBs. The recommendations include that DHBs review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters.

It is recommended that the Boards endorse the recommendations in section 1 of attachment 2.

Identified Risks

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

Attachment/s

1. DHB Position Statement on the Sale and Supply of Alcohol Act 2012
2. DHBs and the Smokefree Aotearoa 2025

IN-CONFIDENCE

All District Health Boards

DHB Position Statement on the Sale and Supply of Alcohol Act

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	DHB Position Statement on the Sale and Supply of Alcohol Act
Date:	12 August 2021

Decision ☒	**Discussion** ☐		**Information** ☐	
Seeking Funding	**Yes**	☐	**No**	☐
Funding Implications	**Yes**	☐	**No**	☐

Recommendation

It is recommended that DHB Chief Executives and Chairs:

- **Note** that a paper summarising alcohol related harm and considering gaps and opportunities to reduce this was presented to DHB CEs and Chairs in November 2020.
- **Note** that at that meeting DHB CEs and Chairs agreed to advocate for a review of the Sale and Supply of Alcohol Act 2012 (the Act) as one of 3 priority areas of action in relation to alcohol.
- **Note** that the Minister of Justice and the Minister of Health have expressed a willingness to review the Act and that this is likely to be a mid-range review focusing on amending the current Act rather than undertaking a full review.
- **Note** that unless we can create a sense of urgency, the review is likely to occur late in this electoral cycle.
- **Agree** to the Position Statement on the Sale and Supply of Alcohol Act 2012 (Appendix 1) asking for a review of the Act
- **Agree** that the top priorities for changes to the Act should be:

1. ***Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:***
   - Embedding Te Tiriti O Waitangi principles in the object of the Act
   - Ensuring the health system supports, invests in and enables:
     - Māori leadership and decision-making
     - Whanau-centred service provision and kaupapa Māori models of care
     - Workforce development, provider development and equitable funding
   - Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings

- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. ***Reduce the harm from high alcohol availability by:***
   - Reducing the default maximum national trading hours, especially the closing hour (e.g. to 9pm for off licences and 2am for on licences and club licences).
   - Abolish the Local Alcohol Policy (LAP) appeals process and mandate LAP development by Territorial Authorities
   - Enabling licence numbers to be lowered in vulnerable or high deprivation locations
   - Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process; and
     - Restricting online sale of alcohol and aligning the restrictions across all types of online alcohol retailers

3. ***Reduce the harm from alcohol advertising and sponsorship by:***
   - Strengthening section 237 of the Act (irresponsible promotion of alcohol) to implement comprehensive restrictions to alcohol advertising including sponsorship of sports and events.

- **Agree** to advocate for a full review of the Act by an independent external agency such as the Law Commission as a subsequent stage following finalisation of the immediate changes to the act.
- **Agree** to also advocate to implement the Law Commission Recommendations on alcohol pricing at the earliest opportunity, including minimum unit pricing (MUP) and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.
- **Request** that the Director General of Health provides advice to the Minister of Health and Minister of Justice to support a review of the Act.
- **Engage** in an advocacy process where all DHBs collaborate for collective action on alcohol harm reduction.

Summary

The Sale and Supply of Alcohol Act 2012 is widely acknowledged to have failed in its objective to minimise alcohol related harm. In a recent media statement Minister of Justice Kris Faafoi has expressed a willingness to review the Act. It is understood that this is likely to be a mid-range review focusing on amending the current Act rather than a full review of the Act.

This paper follows an earlier paper to DHB Chairs and CEs summarising the gaps and opportunities for DHBs to address alcohol related harm. The paper briefly summarises the Act, outlines some of the problems and deficiencies in the current Act, and proposes recommended changes to the Act in order to better address alcohol related harm. A position statement is proposed for DHB Chairs and CEs that calls for an urgent review to the Act, outlines a number of specific changes and also calls for a number of broader changes to address alcohol related harm and its inequities.

A wide range of people have contributed to the development of this paper including the prioritisation of recommended changes to the act. The paper has been widely circulated for input including to: the National Public Health Advocacy Steering Group, Te Hiringa Hauora (Health Promotion Agency), Public Health Clinical Network, Te Tumu Whakarae, Alcohol Healthwatch, Health Coalition Aotearoa and the Ministry of Health.

Background

Alcohol Related Harm

Alcohol is the most widely used drug in New Zealand and is a group 1 carcinogen. Every year more than 800 deaths are caused and more than 60,000 disability adjusted life years are estimated to be lost due to alcohol consumption. The consequences of hazardous alcohol consumption are borne by whānau, families and friends of those involved and exacerbates family harm, sexual assault, and is a major risk factor for suicide.

One in five New Zealanders aged 15 years and over are hazardous drinkers. Among the drinking population, one-quarter (25%) were found to drink hazardously. In 2019/20, this equated to 838,000 adults aged 15 years and over. Significant inequities exist and persist in drinking patterns. In 2019/20, Māori men and women were 1.6 times and 2.2 times more likely to drink hazardously when compared to non-Māori men and women, respectively.

Harmful alcohol use is a significant burden to society – its misuse is estimated to cost the government $7.8 billion per year.[1] By comparison, alcohol excise revenue was $1.064 billion in 2020, Alcohol also puts considerable pressure on the health sector, particularly emergency services, as well as on our police and justice systems.

Law Commission Report: Alcohol in our Lives: Curbing the Harm

In 2008, the Law Commission undertook a broad and comprehensive review of the role of alcohol in New Zealand led by Sir Geoffrey Palmer. This review was undertaken after nearly twenty years of liquor law liberalisation that occurred as a result of a review of liquor laws in the mid-1980s. The report to Parliament, 'Alcohol in our Lives: Curbing the Harm'[2], recommended significant changes to the sale and supply of liquor including reducing alcohol affordability and availability and restricting advertising and sponsorship.

Key policy recommendations included:

1. the introduction of a new Alcohol Harm Reduction Act;
2. raising the price of alcohol by an average of 10% through excise tax increases;
3. regulating irresponsible promotions that encourage the excessive consumption, or purchase, of alcohol;
4. returning the minimum purchase age for alcohol to 20 years;
5. strengthening the rights and responsibilities of parents for the supply of alcohol to minors;
6. introducing national maximum closing hours for both on and off-licences; (4am and 10pm respectively)
7. increasing the ability of local people to influence how and where alcohol is sold in their communities;
8. increasing personal responsibility for unacceptable or harmful behaviours induced by alcohol, including a civil cost-recovery regime for those picked up by the police when grossly intoxicated;
9. moving over time (5 years) to implement comprehensive restrictions to alcohol advertising and sponsorship.

Three Acts were agreed by parliament in response to the Law Commission's recommendations including:

[1] Nana, G. (2018). Alcohol costs - but, who pays? Presented at the Alcohol Action NZ Conference, Wellington, New Zealand.
[2] New Zealand Law Commission. Alcohol In Our Lives: Curbing the Harm, 2010.

1. Sale and Supply of Alcohol Act
2. Local Government (Alcohol Reform) Amendment Act
3. Summary Offences (Alcohol Reform) Amendment Act.

While the Act incorporates many of the recommendations from the Law Commission report, fundamental harm reduction recommendations were not implemented. These included the raising of the purchase age to 20 and limiting advertising to objective product information only. In 2014, the Ministerial Forum on Advertising and Sponsorship made comprehensive recommendations on banning alcohol advertising and sponsorship, which have not been responded to.

World Health Organisation SAFER Framework

The World Health Organization (WHO) SAFER Framework released in 2018 outlines five high-impact strategies to help governments reduce the harmful use of alcohol and related health, social and economic consequences.[3] The 5 high impact strategies are:

1. **S**trengthen restrictions on alcohol availability
2. **A**dvance and enforce drink driving counter measures
3. **F**acilitate access to screening, brief interventions and treatment
4. **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
5. **R**aise prices on alcohol through excise taxes and pricing policies.

New Zealand has made some progress in implementing aspects of WHO recommended best practice but there needs to be a comprehensive, evidence-based review of how the country protects it citizens against these harms – including a review of the provisions of the Act.

Public Support for reducing Alcohol related harm

There is strong public support for policies and approaches that reduce alcohol related harm as summarised in the table below.

Policy/strategy	**Law Commission submissions**	**Public Opinion Surveys**
Restricting/reducing hours of trading	78% for all off-licences 52% for on-licences	65.6% (support or strongly support) – HPA public opinion survey
Reducing number of outlets	69% for off-licences particularly small grocery stores/diaries	64.6% (thought there were too many) – HSC public opinion survey
Alcohol sponsorship		68% of New Zealanders support banning alcohol-related sponsorship at events that people under 18 may attend.
Increasing the price of alcohol		61% of persons polled supported increasing the price of alcohol if the revenue was earmarked for the funding of mental health and addiction services - UMR public opinion polling (February 2019)

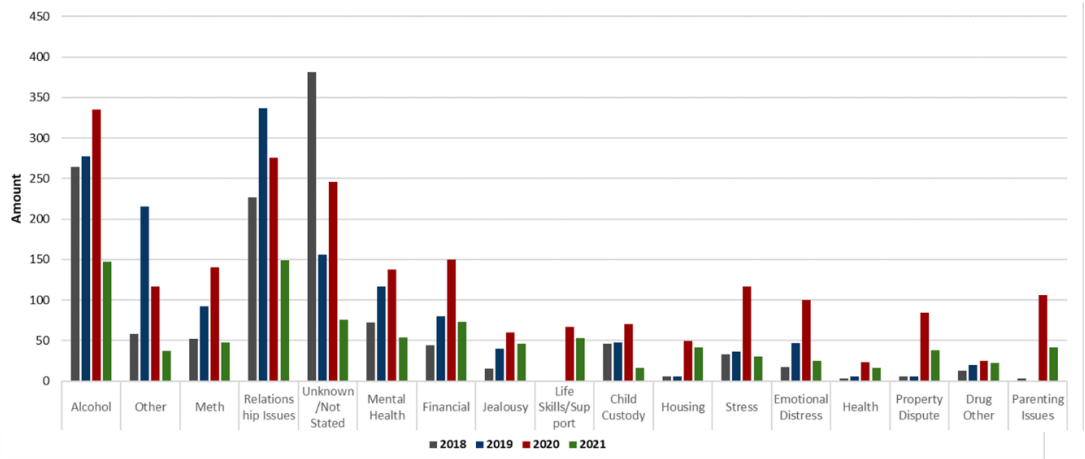
[3] World Health Organization. The SAFER initiative Geneva: WHO; 2018. http://www.who.int/substance_abuse/safer/en/

Inter-agency support for reducing Alcohol related harm

The following is a report on Whiria Te Muka which is an interagency programme in the Far North (Te Hiku) region which demonstrates that Alcohol is by far the highest reason for family violence incidents.

He Muka

Figure 2: Pressure points of incidents entered into Whiria Te Muka



- Alcohol remains the top pressure point for reported family violence in Te Hiku
- Relationship issues as a pressure point spiked in 2019 but has been steadily declining since
- Meth harm spiked as a pressure point to reported whānau harm in May 2020

Sale and Supply of Alcohol Act 2012

The Sale and Supply of Alcohol Act 2012 is administered by the Minister of Justice and replaced the Sale of Liquor Act 1989. The objectives of the Act are that:

a) The sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
b) The harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

Key features of the Sale and Supply of Alcohol Act 2012 include:

1. increasing the ability of communities to have a say about alcohol licensing in their local area
2. allowing local-level decision-making for all licence applications
3. requiring the consent of a parent or guardian before supplying alcohol to a minor
4. requiring anyone who supplies alcohol to under 18-year-olds to do so responsibly
5. strengthening the rules around the types of stores allowed to sell alcohol
6. introducing maximum default trading hours for licensed premises (8am-4am for on licences and club licences and 7am -11pm for off licences)
7. restricting supermarket and grocery store alcohol displays to a single area.

However, the Act made little or no change to the most cost-effective policy areas for reducing harm, including alcohol taxation, the minimum purchase age and control of alcohol marketing.

Problems with the Sale and Supply of Alcohol Act

The Sale and Supply of Alcohol Act has failed to deliver on its intended objective. Between 2011/12 and 2015/16, hazardous drinking prevalence increased every year and by 2014/15 and 2015/16 was significantly higher in the total population than in 2011/12. Marked increases in this period were found among wahine Māori and middle aged and older adults. Since 2015/16, hazardous drinking prevalence has remained stable.

Various reports have recommended changes to strengthen the Act[4,5,6]. That the Act is not performing as it was intended is widely acknowledged by numerous groups including health, non-government, community advocates, Medical Officers of Health, alcohol treatment services and politicians alike. In a recent media statement Minister of Justice Kris Faafoi said: [7]

"I consider it would be beneficial to review the Sale and Supply of Alcohol Act and I'm assessing the ability to do that within what is already a fairly full work programme in the Justice portfolio… I want to ensure alcohol regulation in New Zealand is fit for purpose and operates effectively."

As a demonstration of how poorly the Act regulates industry, products and social harms it was also used as an example of 'what not to do' during the development of the proposed cannabis legislation, developed for last year's referendum.

Te Tiriti o Waitangi

Colonisation and breaches of Te Tiriti o Waitangi have contributed to the disproportionate impact of alcohol-related harm on Māori. In response to this, Te Tiriti o Waitangi Healthcare claim Wai 2624 (Wai 2575)[8] has called for the government to work in partnership with iwi, hapū, whānau and communities, to reduce alcohol-related inequities for Māori.

The Act does not address the disproportionate impact that alcohol has on Māori, nor does it uphold and honour the Crown's obligations under Te Tiriti o Waitangi. There is no role for Māori leadership or consultation processes to ensure Māori voices are heard and involved in decision making. The object of the Act should incorporate the importance of the Crown and Māori relationship in considering sale and supply of alcohol and this commitment needs to be operationalised within the Act with urgency.

Lack of community input into local alcohol licensing decisions

A priority objective of Aotearoa New Zealand's liquor law reforms in 2012 was to "improve community input into local alcohol licensing decisions". Eight years later, this objective has been far from realised. Alcohol licences have not become "harder to get and easier to lose". In 2020, there were more than 11,000 businesses that sold alcohol in Aotearoa New Zealand. There are more places to buy alcohol in our most socio-economically deprived communities. Community members continue to take time out of their busy lives to object to alcohol licence applications in their neighbourhood, rarely achieving success.

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4 *He Ara Oranga - the* Government *Inquiry into Mental Health and Addiction* (2018).
5 *Reducing* Alcohol-*Related Harm* (New Zealand Medical Association, 2015).
6 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).
7 https://www.newsroom.co.nz/targeting-irresponsible-alcohol-promos
8 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_148205985/Wai%202624%2C%202.5.003.pdf

The 2019 Alcohol Regulatory and Licensing Authority annual report[9] noted the following:

"The Authority notes that the number of applications refused for new licences is very low compared to the number of applications being granted. The same can be said for applications for licence renewals and new manager's certificates. The reasons why there are so few refusals may be worthy of some investigation by policy officials to see if this is consistent with what was envisaged at the date of commencement of the Act"

Legalistic and ineffective Local Alcohol Policy Process

Provisions under the Act allow a Territorial Authority to adopt a Local Alcohol Policy (LAP) in consultation with their local community to control the number and location of premises in a district, the clustering of premises and trading hours. These legislative provisions offered Councils much hope to implement best practice measures to reduce alcohol harm. Development of a LAP is not mandatory.

However, experience suggests that the development of Local Alcohol Policies (LAPs) has been time consuming, expensive, overly legalistic and largely ineffective. The two big supermarket chains and the alcohol industry have blocked local government from minimising alcohol related harm through Local Alcohol Policies (LAPs) by funding expensive appeals.

As of May 2021, 41 (61%) of the 67 Councils in New Zealand have LAPs in place. The majority of policies have been watered down as they proceeded through the legal appeals process. Fifteen Councils have chosen not to proceed to developing a LAP. Our four largest population centres – Wellington, Hamilton City, Christchurch and Auckland – have no LAP in place. Christchurch City Council abandoned their policy after spending more than $1 million fighting it, Hamilton City have aborted too, as has the Far North District Council.

The legal fight has been lengthy and costly for ratepayers. In Auckland, a four-week public hearing before the Alcohol Regulatory and Licensing Authority in February 2017 has since proceeded to judicial review before the High Court. It has been heard at the Court of Appeal in June 2021. It is therefore unsurprising that in 2018 and 2019, two Local Government NZ remits were passed calling for urgent change to the appeal provision and review of the Act.

There are also problems with the level of evidence that is required to support Provisional LAPs, with the apparent insistence and weight being placed on available local data by both Industry and ARLA. For example, local 'proof' is required that particular off licence restrictions will result in the minimisation of harm, or that purchase of alcohol between 7am-9am results in direct harm.

Proposed changes to the Sale and Supply of Alcohol Act

It is clear that the Act has had little impact on the alcohol environment since being introduced other than a small reduction in on-licence and off-licence trading hours in urban centres (resulting from the end of 24-hour trading hours) and alcohol no longer being sold from premises that resemble dairies. By taking action to amend and strengthen sections of the Act, health outcomes across the population, particularly in vulnerable communities, can be improved.

Four key areas could potentially be addressed by amendments to the Act. These are:

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9 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation
2. Reduce the harm from high alcohol availability
3. Reduce the harm from alcohol advertising and sponsorship
4. Reduce the harm from cheap alcohol.

Consideration of these areas and potential changes to the Act is provided in the remainder of this section. This has been informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: Curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, the New Zealand Medical Association report *Reducing Alcohol-Related Harm* and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*[10].

The relative impact and cost effectiveness of various changes has also been considered. The graph below presents selected interventions from the University of Otago BODE^3 Cost Effectiveness Study comparing the benefits, potential savings and costs from a range of interventions in relation to alcohol. Most of the studies used have been developed in the Australian context.

This illustrates that taxation increases would deliver the greatest health benefits (220,000 quality adjusted life years) and potentially save the health system $3.58 billion dollars. Taxation increases however are likely to exceed the scope of a mid-range review and may need to be considered as part of a broader review of the Act.

Summary of the health impacts and cost effectiveness of alcohol interventions from the University of Otago BODE^3 Cost Effectiveness Study.

Intervention	Health Gain (QALYs)	Health system savings / costs	Intervention Costs	ICER
Tax increase	220,000	-3,580,000,000		Cost-saving
Comprehensive advertising ban	7,800	-16,400,000	20,000,000	Cost-saving
Licensing controls to restrict operating hours	2,700	11,900,000	20,000,000	4,504
Random breath testing	2,300		71,000,000	35,490
Mass media 'drink driving' campaigns	1,500	38,200,000	39,000,000	19,110
Residential treatment	460	75,100,000	59,000,000	163,804
Brief intervention by a GP	340	4,780,000	6,100,000	13,650
Increase in minimum legal drinking age	150	-218,000	640,000	Cost-saving

The tax increase is modelled on; 'applying an equal tax rate to all beverages equivalent to a 10% increase in the current excise applicable to spirits and ready-to-drink products'. This is calculated to result in a 50% increase in taxation (which is similar to the amount recommended by the Law Commission) and a 10.6% reduction in consumption.

Comprehensive advertising bans and licensing controls to restrict operating hours are the next most important interventions in terms of health gain. The evidence consistently shows that interventions to address alcohol related harm are highly cost effective and that taxation and regulatory changes at the national level show greatest health gain and cost effectiveness compared to health promotion or clinical interventions. By addressing the alcohol environment, they produce sustainable changes to population norms of drinking for this generation and the next to benefit.

10 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation

The Crown is currently failing in its duty to actively protect Māori from alcohol related harm. Māori are one of the groups most adversely affected by alcohol and yet the Act makes no special consideration or recognition of their place as tangata whenua. Emerging research has demonstrated links between Māori who face racism and alienation, and heavy drinking.

It would also be important to give effect to Te Tiriti principles in the act in a number of ways. This could include for example the following:

1. Māori have effective agency to self-determine the place of alcohol sale and supply (Tino Rangatiratanga)
2. Reduce levels of excessive consumption and alcohol related harm for Māori, reduce to at least the level of non-Māori, and differentials in the density of alcohol sale and promotion outlets to these communities are eliminated (Equity)
3. Regulators act to the fullest extent and err on the side of preventing harm with a precautionary principle where there is uncertainty (Active Protection)
4. Attention and mitigation is given to the specific pathways of harm for Māori not simply general pathways of harm for all communities (Options)
5. Māori – and all local communities – communities have equal power and agency on decisions, relative to commercial interests seeking to promote alcohol sale and use. Regulators must have a duty to hear and heed the quieter voices of those who have a legacy of feeling powerless (Partnership).

Te Hiringa Hauora (Health Promotion Agency) have work underway to identify what would be required to give effect to Te Tiriti O Waitangi. The recommendation below will be updated to align with the position advocated for by Te Hiringa Hauora. The National Māori Authority have also signalled that they are calling for a review of the Act and will begin consultation soon.[11] A partnership approach is needed for example having members of DLCs who are Māori .

Recommendation: Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding
- Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings
- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. Reduce the harm from high alcohol availability

The next four recommendations in this section focus on reducing the availability of alcohol by reducing the default national maximum trading hours, removing the LAPs (local alcohol policies) appeals process and making LAPs mandatory, changing the District Licensing Committee structure and hearings process, and lifting the legal purchase age. Each of these initiatives will minimise alcohol harm by reducing its accessibility and enabling greater community participation in decision-making processes regarding alcohol availability.

[11] http://www.voxy.co.nz/national/5/387572

Hours of sale

Aotearoa New Zealand's legislated default national trading hours (in the absence of a Local Alcohol Policy) are 8am to 4am for on-licences and club licences and 7am to 11pm for off -licences. Reducing the national trading hours can reduce harm and save lives. Many/all of the LAP appeals sought to establish longer trading hours than communities wanted. This could be circumvented by reducing the hours of sale at a national level via a legislative change.

Recommendation: Advocate for a reduction in the minimum default closing hours to 9pm for off licences and 2am for on licences and club licences

Number of licences

In New Zealand, the number of outlets licensed to sell alcohol more than doubled from 6,296 in 1990 to 14,424 in 2010.[12] A higher density of outlets is associated with increased consumption, particularly among young people, higher levels of harmful drinking as evidenced by more alcohol-related crime or anti-social behaviours, or a variety of secondary harms that can undermine community wellbeing.[13] [14]

New Zealand research has demonstrated that higher outlet density is more common in lower socio-economic neighbourhoods than in higher socio-economic neighbourhoods. Unsurprisingly, higher outlet density is associated with lower alcohol prices and longer opening hours. Where there are several outlets in one area, particularly off-licence outlets, alcohol discounting is one commonly used means for outlets to compete with each other. Lower prices can stimulate demand and facilitate heavier consumption.

Regulating the physical availability of alcohol is, therefore, a major tool available to reduce alcohol-related harms. Introducing a cap or a sinking lid on the number of off-licences available in a given area would limit the proliferation of new stores. We could for example argue a future trajectory for total number of off-licences which includes reducing density of the highest deprivation areas to those of the lowest – and that would mean every time a licence was given up it would not be replaced if an area was above its target level.

Recommendation: Advocate to enable the number of licences to be lowered particularly in vulnerable or high deprivation areas.

For example, by requiring the existing levels of density to be considered in licensing applications, beyond its effects on amenity and good order; and explicitly requiring the level of deprivation in the locality to be considered in licensing decisions.

LAP appeals process

As previously discussed the current LAP process is highly legalistic and not working as intended. Removing the appeals process would bring the LAP development and implementation process in line with other locality-specific social harm policies such as that which governs gambling, prostitution and psychoactive substances. Importantly these local government policies do not have an appeals process.

Removing the LAP appeals process and making them mandatory would enable Councils to use stronger controls to limit or reduce alcohol availability, especially in areas that have outlet high

[12] New Zealand Law Commission. 2009. Chapter 2. The Context for Reform. Information provided by the Liquor Licensing Authority.

[13] Connor JL, et al. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. J Epidemiol Community Health. 2011 Oct;65(10):841–6.

[14] Donnelly N, et al. Liquor Outlet Concentrations and Alcohol-related Neighbourhood Problems. Alcohol studies bulletin 2006, no. 8.

proliferation. A greater number of Territorial Authorities could look to set caps on the number of alcohol outlets in their districts, or even introduce sinking lid policies to reduce the existing density of outlets. Proximity controls (i.e. required distances between premises) and location controls (i.e. proximity to sensitive sites such as schools), may also be used to a greater extent following the removal of the LAP appeals process.

Recommendation: Advocate for the abolition of the Local Alcohol Policy appeals process and require LAPs to be mandatory

Community input into local alcohol licensing decisions

Despite the priority objective of the Alcohol Reform Bill being to "improve community input into local alcohol licensing decisions", communities still face many challenges in their participation in these processes.

Firstly, it is difficult for communities to become aware of licence applications in their neighbourhood. Once they do become aware, they have 15 working days to submit their objection. Once the application proceeds to a public hearing before a District Licensing Committee (DLC), they face a highly-legalistic process with cross-examination by well-resourced lawyers acting for the licence applicant.

Changes are required to the Act to enable greater community participation in matters of local alcohol availability. Cross-examination should be prohibited in the Act and District Licensing Committees should be replaced with a national panel of Commissioners, to ensure consistency in evaluation and decision-making and put an end to local government elected officials sitting on DLCs.

Recommendation: Amend the structure of District Licensing Committees and remove cross-examination from public hearings.

Age

The minimum purchase age in NZ is currently 18 years. The Law Commission Review recommended that this should be increased to 20. Given the inequities in consumption and harm experienced by rangatahi Māori, increasing the legal purchase age should be considered as pro-equity.

Evidence suggests that the longer a young person delays drinking, the more they are protected from alcohol harm and that each year a young person delays drinking, they are estimated to reduce their risk of becoming dependent on alcohol by 9–21%[15]. Studies have shown that the 1999 law change in Aotearoa New Zealand that lowered the purchase age from 20 to 18 years was associated with an increase in a number of alcohol-related harms for young people, including alcohol-related hospitalisations[16], prosecutions for driving with excess alcohol and disorder[17], and traffic crashes[18]. New Zealand research shows that almost 50% of all cases of alcohol abuse and dependence develop by the age of 20 years and 70% by the age of 25. As such, this is a critical and vulnerable period for the development of alcohol use disorders in New Zealand.

Recommendation: Advocate for an increase in the minimum purchase age to 20 as recommended by the Law Commission Report.

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15 Donaldson, L. Guidance on the consumption of alcohol by children and young people. London, UK: Department of Health, 2009.

16 Everitt, R., & Jones, P. (2002). Changing the minimum legal drinking age - its effect on a central city emergency department. New Zealand Medical Journal, 115(1146), 9-11.

17 Huckle, T, Pledger, M, & Casswell, S. (2006). Trends in alcohol-related harms and offences in a liberalized alcohol environment. Addiction, 101(2), 232-240.

18 Kypri, K, Davie, G, McElduff , P, Langley, J, & Connor, J. (2017). Long-term effects of lowering the alcohol minimum purchasing age on traffic crash injury rates in New Zealand. Drug and alcohol review, 36(2):178185.

Remote sales (also called online sales)

The writers of the Act, which received Royal Assent in 2012, began development of the Act in 2010 and were guided by the Law Commission's recommendations, could not have conceived of the role the internet would play in facilitating alcohol purchasing and consumption in Aotearoa New Zealand. This has been further exacerbated as a result of COVID 19 with alcohol sellers diversifying their business models. The rate of growth in the number of online alcohol sellers has been exponential. Currently, only retailers with a Section 40 endorsed liquor licence (i.e. online only sellers) are required to state their intention to sell online. All other physical off-licences (e.g. supermarkets, grocery stores, bottle stores), are permitted to sell online but are not required to register that they are selling online. As such, there is a substantial lack of information as to which premises are selling online and to which regions in New Zealand. Determining compliance with the Act is therefore challenging.

The Act needs to be modernised to take into account the various delivery services that deliver alcohol to residential addresses. As alcohol can be currently purchased online and delivered without any face-to-face interaction, there is a risk that underage or intoxicated persons may purchase and consume alcohol. Also, it is currently possible to have alcohol delivered in less than 30 minutes from time of purchase.

Recommendation: Restrict online alcohol sales and align the requirements for online alcohol sales with in-person sales including:

1. Require all online alcohol sellers to obtain a section 40 (remote sellers) liquor licence
2. Require the buyer and receiver to verify their age (i.e. make this mandatory in legislation)
3. Prohibit alcohol products to be left unattended at delivery
4. Require an intoxication assessment of the person who receives alcohol
5. Prohibit same day delivery
6. Require that the delivery should only occur within permitted trading hours of the physical premises or for online only sellers the more restrictive of the default national maximum trading hours or local alcohol policy.

3. Reduce the harm from alcohol advertising and sponsorship

Exposure to alcohol advertising is causally associated with earlier drinking initiation among adolescents and heavier drinking among adolescents who drink.[19] [20] Alcohol advertising also serves to normalise drinking and maintain our heavy drinking culture. Controls over the marketing of alcohol are important for delaying drinking initiation for young people and those who want to cut down or stop drinking. Around 80% of New Zealanders support increasing restrictions on alcohol advertising or promotion seen or heard by people under 18.[21]

Replacing alcohol sports sponsorship could be achieved through increasing the existing Health Promotion Agency levy that is placed on all alcohol products sold in Aotearoa New Zealand (for the purposes of undertaking activities to reduce alcohol harm). Funding the replacement of alcohol sports sponsorship would add as little as 6 cents to a bottle of wine, 2 cents to a can of beer, 2 cents to an RTD, and 7 cents to a bottle of spirits.

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19 Stautz K, Brown KG, King SE, Shemilt I, Marteau TM. Immediate effects of alcohol marketing communications and media portrayals on consumption and cognition: a systematic review and meta analysis of experimental studies. BMC Public Health 2016; 16: 465.

20 Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. J Stud Alcohol Drugs Suppl 2020; 113–24.

21 Health and Lifestyles survey Alcohol-related attitudes over time. See https://www.hpa.org.nz/sites/default/files/Alcohol-related%20attitudes%20over%20time%20October%202018.pdf

The Law Commission Report recommended that a phased programme should be in place with 5 years to limit exposure to alcohol promotion and restrict the content of alcohol promotion messages including alcohol related sponsorship. The Commission recommended a 3 stage programme be implemented. Only stage 1 of this programme has been implemented to date. Stage 2 measures are primarily aimed at reducing exposure to advertising particularly for young people. Stage 3 measures prohibits any alcohol advertising in any media other than advertising that communicates objective product information, including the characteristics of the beverage, the manner of its production and its price.

Alcohol advertising is currently addressed in section 237 of the Act. This section should be extended to prohibit all alcohol marketing across all media, as per requirements for tobacco and vaping products in New Zealand.

Recommendation: Advocate to strengthen section 237 of the Act by prohibiting alcohol marketing across all media, as per requirements for tobacco and vaping products.

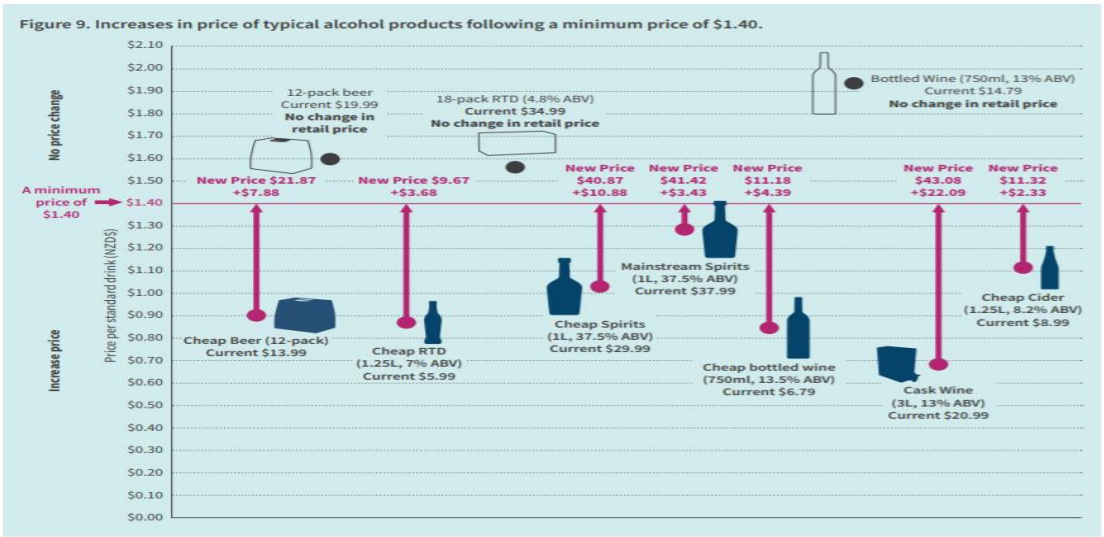
4. Reduce the harm from cheap alcohol

Pricing is one of the most influential drivers of alcohol consumption in the population. There are two complementary ways to tackle this issue –introducing a minimum unit price to address the harms from the cheapest alcohol for sale alongside increasing excise tax to shift population level patterns of consumption. Pricing changes could be introduced through the Sale and Supply of Alcohol Act but they are unlikely to be addressed as part of the mid-range review signalled by the government and therefore they should pursued by other means such as specific legislative initiatives.

Minimum Unit Pricing

Many countries and jurisdictions throughout the world have adopted legislation to set a floor price (minimum price) that alcohol can be sold. These policies are important in relation to cheap sales of alcohol from off-licences; where 84% of all alcohol is now purchased from in New Zealand. Research from Scotland demonstrates the positive impacts of Minimum Unit Pricing (MUP), especially on equity.[22]

Alcohol Health Watch, Roadmap for Alcohol Pricing Policies.=



[22] O'Donnell A, Anderson P, Jané-Llopis E, Manthey J, Kaner E, Rehm J. Immediate impact of minimum unit pricing on alcohol purchases in Scotland: Controlled interrupted time series analysis for 2015-18. BMJ 2019; l5274.

In the first year of MUP in Scotland, purchases of alcohol reduced the most among low income, heavy drinking households. Because the policy has the greatest impact on the purchases of very cheap alcohol (i.e. especially by low-income heavy drinkers), the positive impacts on health inequities from MUP are considerable, given the disproportionate harm that these drinkers experience. In particular, MUP is shown to be the most pro-equity alcohol pricing policy – having the potential to narrow socio-economic, alcohol-related health inequities the most. In a United Kingdom modelling study, it was estimated that 90% of the lives saved from MUP would be from lower socio-economic groups.

MUP should be introduced to lift the low cost of alcohol sold at off-licences, and predominantly purchased by heavy drinkers who buy the cheapest alcohol available - cask wine. This can be bought for 68c per standard drink. Very low priced bottled wine (beginning at $6.79), some RTDs (ready to drink ie. Spirit and soft drink pre-mixers) and some cheap beer would also be strongly affected by this increase. It will have a marginal affect or no effect on most other beverages, and will not generally affect the hospitality sector as their drinks are sold at prices well above these levels.

Recommendation: Advocate for the introduction of Minimum Unit Pricing

Increase Alcohol Excise taxes

Raising the price of alcohol is the most cost-effective measure to reduce alcohol consumption (in terms of cost per health life-years gained).[23] Increasing the price of alcohol has been shown to be associated with reductions in alcohol-related disease and injury outcomes, alcohol-impaired driving, motor vehicle crashes and injuries, death from cirrhosis, alcohol dependence, sexually transmitted infections, suicide, and violence (including rape, robbery, and violence towards children).[24] [25]

In 2017, all alcohol was more affordable than ever before. Currently, around 15-25% of the price of mainstream beers, wines and Ready to Drinks (RTDs) is excise tax. Due to the higher tax rate on high-strength spirits, around half of the price of a bottle of spirits is excise tax.

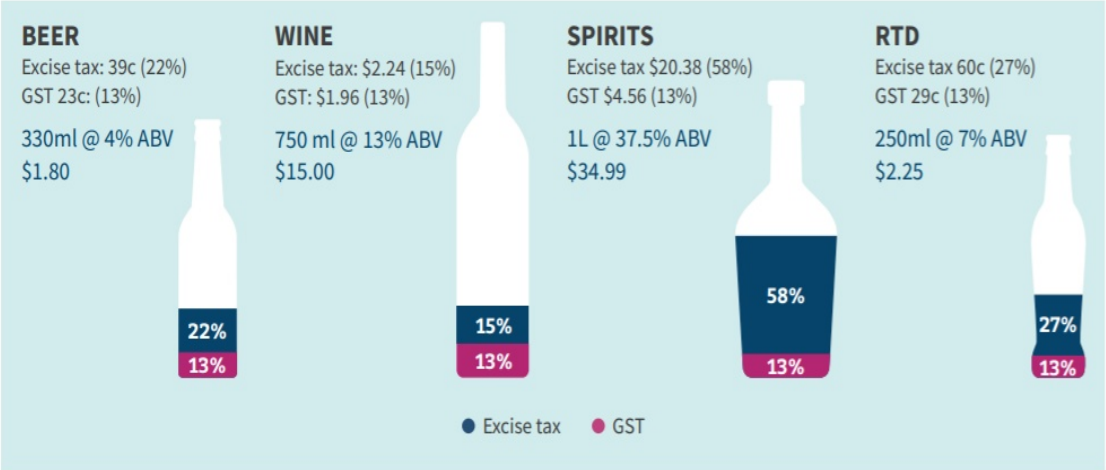
The Law Commission recommended that the alcohol excise tax rates increase by 50% – this would, on average, increase alcohol prices by around 10% and reduce overall consumption by 5%.22 A 50% tax increase would raise the price of a 12-pack of beer by <$3, a bottle of wine by $1.30, a bottle of spirits by $12 and a 12-pack of RTD by $4 (as at July 2020).

[23] Chisholm D, Moro D, Bertram M, et al. Are the "Best Buys" for Alcohol Control Still Valid? An Update on the Comparative Cost-Effectiveness of Alcohol Control Strategies at the Global Level. J Stud Alcohol Drugs 2018; 79: 514–22.

[24] Elder RW, Lawrence B, Ferguson A, et al. The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. Am J Prev Med 2010; 38: 217–29.

[25] Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta analysis of 1003 estimates from 112 studies. Addiction 2009; 104: 179–90.

Alcohol excise rates in Aotearoa New Zealand, Alcohol Health Watch, Roadmap for Alcohol Pricing Policies



The Ministry of Justice examined the effects of an 82% excise tax increase[26] and estimated that:

1. Harmful drinkers would reduce their annual consumption the most, by around 13.1%;
2. Low-risk drinkers would pay an additional $1.77 per week, increased risk drinkers $5.87 per week, and harmful drinkers $13.65 extra per week; and
3. Net cost savings to society from reduced harm were estimated to be $339 million in the first year, and $2.45 billion over ten years. The majority of these savings were from reduced costs to ACC, the justice sector and health system.

Tax prices are currently set through Customs and Excise but the Act could be amended to include a requirement that alcohol taxes are imposed to ensure that the price of alcohol remains at a level that is consistent with the Object of the Act.

Recommendation: Advocate for a substantive increase to alcohol excise in line with that recommended by the Law Commission.

Proposed DHB Position Statement

Appendix 1. sets out a proposed DHB position statement re the Sale and Supply of Alcohol Act. The intention is that DHBs collectively adopt the position statement in order to begin advocating for a modification and strengthening of the Act and eventually a full review of the Act. It is crucial to use this opportunity to position alcohol law reform as a key public health issue that offers significant potential to improve Māori health gain and reduce alcohol harm inequities. It is also intended that this position statement is circulated with health leaders and others to build consensus on the scope of the review.

[26] White J, Lynn R, Ong S-W, Whittington P, Clare C, Joy S. The Effectiveness of Alcohol Pricing Policies. 2014.https://www.justice.govt.nz/assets/Documents/Publications/effectiveness-of-alcohol-pricing policies.pdf (accessed April 30, 2018).

Currently 18 of the 20 DHBs have alcohol position statements. In November 2020, Hauora Tairawhiti conducted a stocktake that showed that all the current position statements noted the significance of alcohol related harm and advocated for national population-based policy changes including changes to tax, minimum age, and marketing. However, many of the statements did not specifically list the changes needed.

This position statement provides a brief, evidence-based, high level statement about the changes needed to the Act. This statement has been reviewed by alcohol-related harm experts. It provides a strong base for the Public Health Advocacy Team, DHBs and health leaders to advocate for alcohol harm minimisation work by clearly stating the policies and actions that the DHBs, and later Health NZ, should take.

These changes are informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*

Further work on reducing alcohol-related harm, such as reducing social harms, improvements to health services, alcohol and addiction treatments, and legislation beyond the Act are outside the scope of this paper.

Health sector leaders should have a collective view on what the review should entail, and one that is publicly available. This position statement will provide direction for the amendments to the Act.

Given that we are already eight months into this 36-month term it is likely that work to scope the terms of the review could begin by the end of this calendar year. It's therefore essential that DHB health leaders have a clear and collective view on what we want from this review.

Appendix 1. Proposed DHB Sale and Supply of Alcohol Act 2012 Position Statement

We, the Chairs and Chief Executives of the 20 District Health Boards, believe that the Sale and Supply of Alcohol Act 2012 must be amended and strengthened in order to prevent and minimise alcohol-related harm and inequities in Aotearoa New Zealand and uphold our obligations to Te Tiriti o Waitangi.

We are guided by the science, data and research:

1. Alcohol is a toxin and an intoxicant
2. Alcohol is a carcinogen
3. Alcohol causes premature death, disability, and injuries
4. Alcohol regulation must be understood as a (mental) health (and addictions) issue
5. Alcohol is New Zealand's most harmful drug.

Specific changes we want to see are:

Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding

Reduce the harm from high alcohol availability by

1. Reducing the default national maximum trading hours, by requiring the closing hours of 9pm for off licences and 2am for on licences and club licences.
2. Abolishing the appeals process for Local Alcohol Policies (LAPs) and make LAPs mandatory
3. Increasing the legal purchase age for alcohol from 18 years to 20 years.
4. Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process;
5. Restricting the online sale of alcohol and align the restrictions across all types of online alcohol retailers.

Reduce the harm from alcohol advertising and sponsorship by:

6. Strengthening section 237 of the Act by prohibiting alcohol marketing across all media.

A full review of the Act by an independent external agency such as the Law Commission is also called for. This should be undertaken as a subsequent stage following finalisation of the immediate changes to the act.

We also want to see the Law Commission Recommendations on alcohol pricing implemented at the earliest opportunity, including minimum unit pricing and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.

END

All District Health Boards

DHBs and the Smokefree Aotearoa 2025 Goal

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	District Health Board action to support the Smokefree Aotearoa 2025 Goal
Date:	12 August 2021

Decision ☒	**Discussion** ☐		**Information** ☐	
Seeking Funding	**Yes**	☐	**No**	☐
Funding Implications	**Yes**	☐	**No**	☐

1. Recommendations

It is recommended that DHB Chief Executives and Chairs:

- **Note** that cigarette smoking is the most readily preventable cause of health inequities in New Zealand and is responsible for at least two years of the life expectancy disadvantage experienced by Māori.
- **Note** that NZ is not on track to achieve the Smokefree Aotearoa 2025 Goal and that Māori are currently not forecast to reach the target until 2060.
- **Note** that the Government has recently consulted on a Smokefree Aotearoa 2025 Action Plan which is likely to greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities.
- **Note** that Dr Nick Chamberlain, as agreed at the combined DHB CE/Chairs meeting on 13 May 2021, submitted a submission on behalf of the DHB CEs on the Government's proposed Action Plan.
- **Note** that achieving the Smokefree 2025 Goal will require a fourfold increase in the number of successful quitters and a proportionate increase in stop smoking services and funding.
- **Note** that additional government funding has been allocated for stop smoking services in budget 2021, but this is not available until 2022/23 and that significant further increases or reprioritisation of resources are needed to achieve the Smokefree 2025 Goal.
- **Note** that stop smoking services are highly cost effective, every dollar spent on smoking cessation saves $10 in future healthcare costs and health gain, and the long term quit rate of smokers who access face to face group based stop smoking services is 4 times higher than those who do not participate in a programme.
- **Note** that only one DHB is currently achieving the Better help for smokers to quit – Primary Care health target**.**

- **Note** that there is considerable variation (up to 10 fold variation) across DHBs in the referral rate to stop smoking services, quit rates, and costs per quitter by stop smoking provider.
- **Agree** to advocate for full implementation of the Smokefree Aotearoa 2025 Action Plan.
- **Agree** to the National Public Health Advocacy team and DHB leads working collaboratively with the MOH to support the development of an investment plan for stop smoking services.
- **Agree** to fully support the MOH in future funding bids for stop smoking services.
- **Agree** to review DHB tobacco control expenditure and ensure that this is being optimally used to support Smokefree 2025 where possible within budgetary constraints.
- **Agree** to review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:
    - Increase the quality and quantity of referrals to stop smoking services, for example, by following up primary care attendees, hospital discharges, and opportunistic clinical interventions with appropriate support
    - Proactively engage with smokers to reduce drop off from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers
    - Scale up the capacity and capability of smoking cessation services
    - Support the adoption of best practice and local innovation and flexibility
    - Limit the public promotion of vaping products and less harmful nicotine delivery devices to only smokers who want to quit
    - Accelerate public health promotion to young people, non-smokers, and non-vapers to dissuade them from taking up vaping or smoking in the first instance.
    - Rigorously measure progress to support improvement.
- **Agree** to advocate to Pharmac to reduce the cost of nicotine replacement therapies (NRT), e.g. gums, patches, and mists.
- **Agree** to mental health and addiction service users being added to priority populations for stop smoking services due to the very high rates of smoking and within this population.
- **Note** the Ministry of Health vaping statements:
    - The best thing you can do for your health is to be smokefree and vape free
    - Vaping is not for children and young people
    - Vaping can help some people quit smoking
    - Vaping is not harmless, but it is much less harmful than smoking
    - Vaping is not for non-smokers.

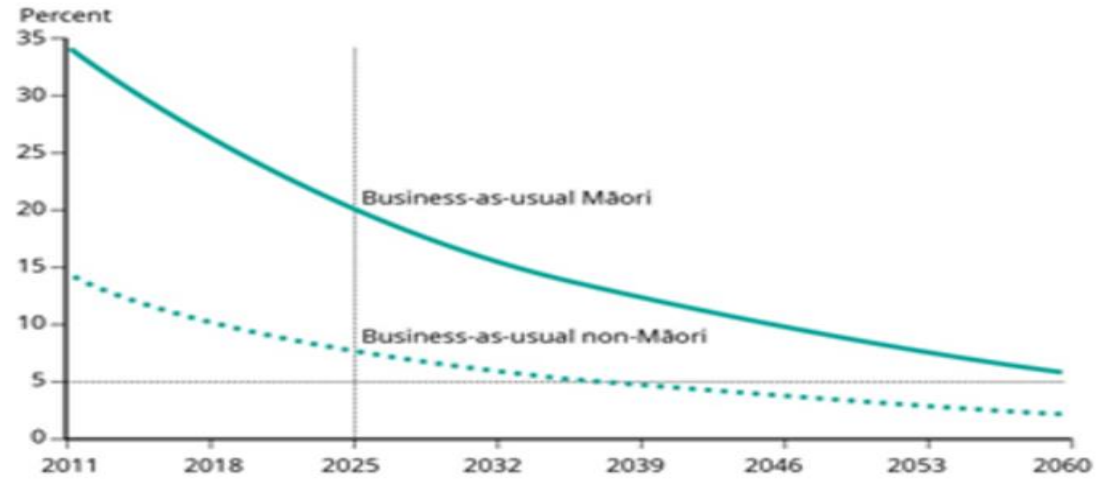
2. Background

In 2011 the Government adopted the Smokefree 2025 Goal of a minimal adult cigarette smoking rate which is widely interpreted as being less than 5% for all New Zealanders.

Cigarette smoking is uniquely harmful and kills 14 New Zealanders every day; 2 in 3 cigarette smokers will die as a result of smoking, each losing about ten years of life expectancy. Cigarette smoking is the most readily preventable cause of health inequity in New Zealand and is responsible for at least two years of the life expectancy disadvantage experience by Māori. People smoke for the nicotine, but die from the toxic ingredients in burnt tobacco.

It is possible to readily reduce the health and economic burdens from smoked tobacco. Over the last decade many important cigarette smoking control policies have been introduced including annual tax increases, point of sale ad bans, plain packaging. Adult daily smoking rates have declined since 2011 from 20% to 11.6% in 2019/20 but we have enormous remaining inequities with adult Māori and Pasifika smoking rates of 30% and 20% respectively. There have been noteworthy successes in reducing smoking rates in young people. In the 2019 ASH Year Ten Survey 2% of 14 and 15 year olds were daily cigarette smokers, with higher rates in Māori and Pasifika youth.

Projections of adult smoking prevalence (for daily smoking) for Māori and non-Māori to 2060



Source: Blakely et al 2018

Critically, we are not currently on track to achieve the Smokefree 2025 goal, especially for Māori, Pasifika and people on low incomes – cigarette smoking is essentially a marker of social and economic disadvantage. Mental health and addiction service users have particularly high rates of smoking with a rate of smoking of about 43% total population, rising to 70% for Māori and 59% for Pacific (WDHB data, March 2021). At the current rate of progress Māori are not forecast to achieve the target until 2060, as shown in the graph below.

3. The National Plan to Achieve the Smokefree Aotearoa 2025 Goal

In April 2021 the Government released a draft discussion document on a national plan for achieving the Smokefree Aotearoa 2025 Goal. The plan recognises the importance of ongoing evidence based interventions to encourage more cigarette smokers to make more quit attempts more often through mass and targeted media campaigns supported by the wider availability of cessation support including the use of reduced harm products. The plan proposes 5 key action areas including:

- Strengthening the tobacco control system
- Making smoked tobacco products less available
- Making smoked tobacco products less addictive and less appealing
- Making tobacco products less affordable
- Enhancing existing initiatives

If the action plan and the actions proposed in it can be successfully implemented it will greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities. Achieving the Smokefree 2025 Goal will however require a fourfold increase in the number of smoking quitters and a proportionate increase in smoking cessation services and funding as outlined below.

Additional funding has been provided in the recent budget as shown in the table below. However, this is insufficient to achieve the scale of the increase in smoking quitters required. A $4.625m investment per year, at median cost per quitter of $4473 would yield 2635 additional quitters per year compared to the additional 40,000 quitters per annum that are required to meet the target as outlined below.

	2021/22	2022/23	23/24	24/25	**Total**
Scale up stop smoking services	n/a	4.625	4.625	4.625	**13.875**

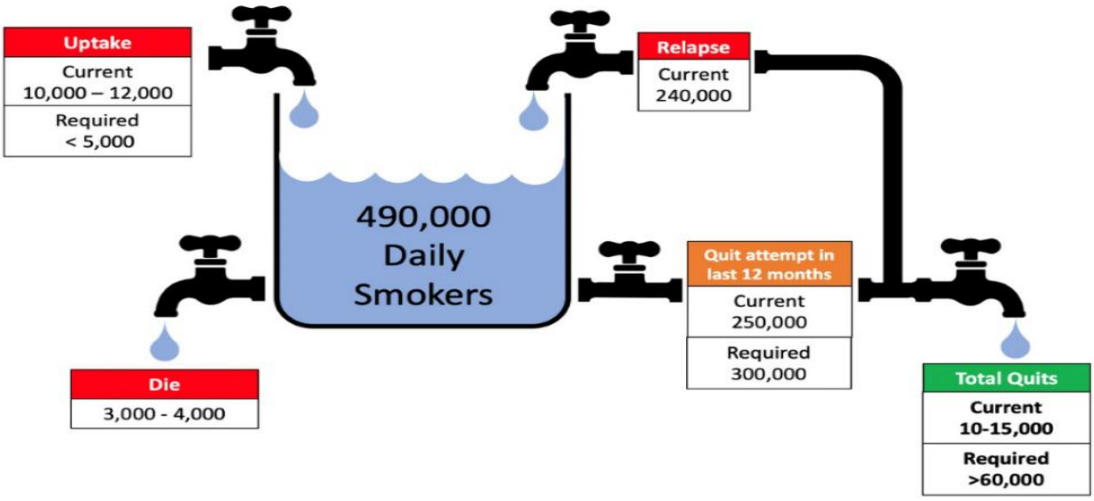
4. Increasing quit rates: the key to achieving Smokefree 2025

There are approximately 500,000 daily cigarette smokers in New Zealand. Reaching the 5% goal requires approximately 300,000 cigarette smokers to quit permanently by the end of 2025, i.e., in 4.5 years. This equates to roughly 60,000 successful quitters each year. At present we are achieving approximately 15,000 quitters each year. Thus, we need to dramatically increase successful quitting numbers by at least 40,000 a year; half the quitters must be Māori and one third Pasifika to achieve equitable cigarette smoking rates.

The Ministry of Health funds stop smoking providers to deliver multi-sessional behaviour support and NRT to people who want to quit smoking. The Ministry of Health priority audiences for service are young Māori wāhine (18 to 30), pregnant women, Māori, and Pasifika. Ready Steady Quit (WDHB and ADHB) are only able to see priority groups and plan to refer all other smokers to Quitline.

The Ministry of Health also provides tobacco control funding to all 20 DHBs to provide Tobacco Control Leadership and Coordination and support the Governments Health Targets. Funding for Smokefree Enforcement Officers is also provided to Public Health Units to enforce the Smokefree Environments Act.

Smoking quitters required to achieve the Smokefree Aotearoa 2025 Goal (Source: ASH)



Stop Smoking Services have been shown to be cost effective both internationally and in New Zealand. The cost of providing Stop Smoking Services is significantly less than the health costs of tobacco related diseases. According to the National Institute for Clinical Excellence (NICE) in the UK, every £1 spent on smoking cessation saves £10 in future health care costs and health gains.[1] A New Zealand modelling study has estimated that a targeted stop smoking support intervention that costs $100,000 a year would only need to support three to four people who smoke to quit to break even ($25 - $33,000/quitter). The MOH contracted face-to-face Stop Smoking Services currently cost significantly less than this, ranging from $653 - $3857 per quitter (median cost $1755) for the period July to December 2020.

Group based smoking cessation programmes provide the most effective smoking cessation support. The long term quit rate of smokers who access face to face group based smoking cessation services is 4 times higher than those who do not receive support to quit.[2]

DHBs, with their 'captive' smoking populations (information on admission and in primary health care), are in a unique position to encourage and support cigarette smokers to transition towards less harmful alternatives and smokefree status. Over 500,000 people who smoke are seen in primary care every quarter. There are also approximately 150,000 middle-aged patients discharged from public hospitals each year with smoking induced conditions such as cardiovascular and many cancers, and patients with mental illnesses who have very high smoking rates. These patients are a priority for becoming smokefree but will need DHB and community-based support and encouragement. Consideration should be given to funding DHB/hospital services to provide cessation support, so that there is continuity in care as there is a large drop-off upon referral from hospital to an external stop smoking service.

[1] Health Economics Research Group, Estimating Return on Investment of Tobacco Control: Tobacco Control Return on Investment tool, NICE 2014

[2] Bauld et al, English Stop-Smoking Services: One-Year Outcomes. International Journal of Environmental Research and Public Health, 2016 Dec; 13(12): 1175.

5. Tobacco harm minimisation

People smoke for the nicotine, but die from the tar. Nicotine is not a cause of disease. In terms of tobacco harm minimisation less harmful alternatives to cigarettes such as patches, gum, lozenges, nicotine sprays and now newer vaping products need to be made available to smokers who want to quit tobacco.

The Ministry of Health has produced a national position statement on vaping in the context of Smokefree 2025 (see Appendix 1). This is currently being reviewed and revised. Key messages in the position statement include:

- The best thing smokers can do is to quit smoking for good
- Vaping products are intended for smokers only
- Vaping products carry much less risk than smoking cigarettes but are not risk free
- Stop smoking services must support smokers who choose to use vaping products to quit
- There is not international evidence that vaping products are undermining the long term decline in cigarette smoking, and may in fact be contributing to it.

Current evidence states that vaping is 95% less harmful than cigarettes[3]. Nick Wilson and colleagues have recently reviewed the health risks associated with vaping and suggested that the overall harm to health from vaping was estimated to be 33% that of smoking.[4] They state that this should be considered to be the likely upper level of vaping risk.

The Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020 came into force in November 2020, amending the Smoke-free Environments Act 1990. The new Act strikes a balance between ensuring vaping products are available for smokers who want to quit smoking, and making sure these products aren't marketed or sold to non-smokers, especially young people under the age of 18 years. Minister Verrall has requested that public health units initiate controlled purchase orders (CPOs) of vaping outlets to ensure that vaping products are being sold in accordance with the Act.

DHBs and Smoking Cessation Services are ideally placed to help distribute vaping products to those that have been unable to quit smoking and to those identified in primary or secondary care services. A number of DHBs are currently utilising vaping products as part of their armamentarium in helping smokers quit tobacco.

The cost of NRT is a barrier for whānau, with a course of NRT costing more than a packet of cigarettes. Pharmac currently subsidises some but not all NRT products. Mists and inhalers for instance are not currently subsidised and some interventions are known to work better for some groups than others.

In summary, the health and economic benefits to middle aged and older patients of successful quitting are immense. The economic benefits to the DHBs from reduced readmissions after quitting are also immense and occur in the short-term, i.e., in the months after quitting.

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[3] PH England report

[4] Wilson N., et al. Improving on estimates of the potential relative harm to health from using modern ENDS (vaping) compared to tobacco smoking. MedRxiv preprint 27 June 2021. https://www.medrxiv.org/content/10.1101/2020.12.22.20248737v2

6. Accelerating progress towards the Smokefree 2025 Goal is possible

Several potential drivers of success are now available:

1. The Government is explicitly committed to the goal as evidenced by comments by Associate Health Minister Hon Ayesha Verrall, the Minister responsible for Smokefree 2025.
2. The options available to cigarette smokers who want to quit are increasing rapidly including vaping devices. These alternative nicotine delivery devices are effective in helping some smokers quit, are cheaper and much less harmful than conventional cigarettes.
3. Legislation was passed in 2020 to ensure that these alternative nicotine products will be widely available, safe and fully regulated. In addition, the legislation and associated regulations will do much to prevent young people from becoming dependent on these alternative nicotine products.
4. Most cigarette smokers express a desire to quit and have already made multiple attempts. The increased range of options now available will increase successful quit rates.

7. DHB Smokefree 2025 priorities

DHBs can and should do much more to accelerate progress towards the Smokefree 2025 Goal. Better help for smokers to quit – Primary Care continues to be a DHB health target. Only one DHB is currently achieving the 90% target and performance varies across DHBs from 56.1% to 91.4% (see appendix 2. for the full data). 395,000 were given brief advice to quit in Q2 2020/21, meeting the 90% target would have resulted in an additional 65,000 smokers receiving brief advice to quit. There is also considerable variation in the performance of stop smoking services as shown in Appendix 3, including an 8 fold variation in referral rates, a 10 fold variation in quit rates and a 6 fold variation in cost per quitter by DHB.

The Ministry of Health funds stop smoking services directly and also provides tobacco control funding to DHBs. The Ministry currently funds 16 stop smoking providers, with a number covering more than one DHB. Five of the 16 are DHB services, the others are a mix of PHOs, Whānau Ora providers or Māori Health Providers. Consideration could be given to amending existing contracts for high performing services with no ceiling on number of quitters per year, and conditional funding per patient for services that achieve beyond their annual targets to cover the additional costs that would be efficiently incurred to achieve more, provided there is evidence of growing their own workforce.

DHBs also have a responsibility for the health of their local population and commission and provide broader health services that refer to stop smoking services. There are challenges linking up these different services at a local level. There is also a lack of visibility and information sharing about how funding is utilised and services are provided. There is therefore a need to work collaboratively at a local level to optimise delivery of stop smoking services.

Counties Manukau Health Living Smokefree Service (LSS) is an example of best practice nationally and is described in Appendix 4. Given inequitable access to health services including primary care it is important that efforts to scale up stop smoking services are complemented by broader efforts to improve access to health services such as whānau ora.

Recommended areas for action

It is recommended that DHBs review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:

1. *Increase the quality and quantity of referrals to stop smoking services – systematic identification of people who smoke and referral to stop smoking services.*
    - Increasing referrals from primary and community services eg GPs, pharmacies, mental health providers, NGOs with a particular focus on achieving the Better help for smokers to quit health target.
    - Increasing referrals from secondary care by ensuring that all patients who are admitted as cigarette smokers should be encouraged and supported within hospital to be smokefree at all times and referred to smoking cessation.
    - Utilising other opportunistic clinical interventions to provide brief advice and referral to smoking cessation services.
2. *Proactively engage with smokers to reduce drop off in engagement from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers.*
    - Developing dedicated pathways and providers for Maori and Pacific smokers.
    - Reaching into Māori and Pacific communities to provide stop smoking support groups in their communities e.g. Kava groups, Pacific churches and marae.
    - Rigorously following up all smokers referred and supporting them to access stop smoking services that meet their needs at a convenient time, place and setting.
3. *Scale up stop smoking services to deliver the 4 fold increase in smoking quitters required assuming that additional funding is available to deliver this and being careful to ensure a genuine expansion in the trained workforce.*
    - Planning for and establishing smoking cessation services on a sufficient size and scale to deliver the Smokefree 2025 Goal.
    - Recruiting, training, and developing an expanded workforce.
4. *Support the adoption of best practice and supporting local innovation and flexibility.*
    - Developing and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau.
    - Ensuring that smoking cessation services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces, churches, sports club etc) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services.
    - Services also need to be tailored to meet the specific needs of the people they are supporting e.g. mental health and addiction service users often need a longer period of support, including support to reduce the amount they smoke before making a quit attempt.

- A variety of cessation methods and tools should be available for all patients, including modern alternative nicotine delivery devices.
- The use of incentives should be encouraged, including vouchers, nicotine replacement therapies, and free vaping starter kits.

5. *Limit the public promotion of vaping products only to smokers who want to quit*
   - Educate staff on the benefits of vaping products as a tool to help smokers quit.
   - Adopt vaping as a specific tool in the armamentarium of the Stop Smoking Services.
   - Provide free vaping products to key priority groups, with a particular focus on pregnant Māori woman and middle-aged people most at risk of disease and early death.
6. *Accelerate public health promotion to young people, non-smokers and non-vapers, to dissuade them from taking up vaping or smoking in the first instance.*
   - Educate the population on the importance of non-smokers not using vapes, particularly youth.
7. *Rigorously measure progress to support improvement.*
   - Ensure the availability of comprehensive and up-to-date cigarette smoking data including by age, sex, ethnicity, and deprivation. NZ Health Survey data will be useful but may require supplementation from other sources.
   - Regularly assess progress towards the Smokefree 2025 Goal.
   - Review DHB Smokefree activities and resources to ensure that the are operating at optimal efficiency and effectiveness.
   - Ministry of Health information should guide all DHB activities, including on lower risk alternatives to cigarettes.

Appendix 1:
The Ministry of Health's national position statement on vaping in the context of Smokefree 2025.

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

9 July 2021

To: DHB Chief Executives

Kia ora koutou katoa

I am writing in support of the Associate Minister of Health, Hon Dr Ayesha Verrall's, Smokefree 2025 priority.

The Government is committed to achieving an equitable Smokefree 2025. This requires us to reduce the burden of preventable death and disease caused by smoking, and to eliminate the health inequities associated with smoking.

Consultation on *Proposals for a Smokefree Aotearoa 2025 Action Plan* closed on 31 March and my officials are analysing these to inform the final action plan. Over 5,000 submissions were received. Thank you for your own well considered submission and for the joint work district health boards have underway to support Smokefree 2025.

It is my expectation that, as part of this work, district health boards will actively support the Government's position that vaping has a role to play in reducing the harm caused by smoking.

Health sector position statements

The following statements, agreed to by all district health boards as part of the development of the Vaping Facts website, remain a sound basis for your approach to vaping:

- the best thing you can do for your health is to be smokefree and vape free
- vaping is not for children or young people
- vaping can help some people quit smoking
- vaping is not harmless but it is much less harmful than smoking
- vaping is not for non-smokers.

The Ministry of Health's position statement (available on its website), which expands on these core statements, is under review and will be updated to take account of legislative developments and any changes in evidence.

Compliance and enforcement of the Smokefree Environments and Regulated Products Act 1990

The Smokefree Environments and Regulated Products Act 1990 (the Act) now regulates vaping products and smokeless tobacco devices, in addition to tobacco products and herbal smoking products.

The Act aims to balance the needs of adult smokers who want to quit using vaping or switch to a less harmful alternative with discouraging non-smokers, especially children and young people, from taking up vaping.

I expect public health units and the Ministry of Health to actively enforce the Act's smoking and vaping provisions, such as the prohibitions on sales to minors and the advertising and promotion restrictions (including online).

I understand that the Ministry is working with public health units to clarify expectations on enforcement activities related to the Act, including the new regulatory controls on vaping and vaping products.

Detailed information about the regulatory regime for vaping products can be found on the Ministry of Health's website: Vaping Regulatory Authority

Monitoring of vaping-related incidents

Please remind health workers to report any adverse vaping events to the Centre for Adverse Reactions Monitoring. This system is used to monitor vaping-related incidents. A specific form for reporting adverse reactions to vaping products is available on CARM's home page: New Zealand Pharmacovigilance Centre. To date, no reports of adverse events in minors from vaping products have been made.

Supporting schools

The Ministry is looking at how the health sector can better support schools to keep students vapefree. I am advised that public health units have been invited to participate in this work and look forward to seeing a coordinated approach develop, together with the education sector.

New regulations

Finally, proposals for regulations under the Act have been consulted on, and the final regulations are due to be approved by Cabinet shortly. I expect the regulations to be publicly notified on 13 July, before taking effect from 11 August 2021.

From that date, manufacturers and importers of vaping products may begin notifying their products and, to continue to be sold in New Zealand, all products must be notified before 11 February 2022. Products are required meet new safety standards before they can be notified.

If you have any questions or require further information about this letter, please contact Sally Stewart, Manager, Tobacco Control (sally.stewart@health.govt.nz).

Nāku noa, nā

Deborah Woodley
Deputy Director-General
Population Health and Prevention

Appendix 2:
Health Target Performance, Better help for smokers to quit - Primary care (Quarter 2 2020/21)

DHB Name	Target %	Achievement %
Auckland	90%	82.3%
Bay of Plenty	90%	87.3%
Canterbury	90%	71.2%
Capital & Coast	90%	80.2%
Counties Manukau	90%	84.3%
Hawke's Bay	90%	56.1%
Hutt Valley	90%	88.3%
Lakes	90%	69.3%
MidCentral	90%	82.9%
Nelson Marlborough	90%	72.9%
Northland	90%	68.5%
South Canterbury	90%	78.8%
Southern	90%	75.5%
Tairawhiti	90%	71.1%
Taranaki	90%	79.7%
Waikato	90%	80.0%
Wairarapa	90%	87.3%
Waitemata	90%	78.9%
West Coast	90%	91.4%
Whanganui	90%	76.9%
National	90%	78.0%

Appendix 3:
Smoking Cessation Performance by Provider, July to December 2020.

	Popn	Referrals	Referral rate per 100,000	Enrolments	CO Validated Quitters	Quit Rate per 100,000 popn	% Quitters	Cost per Quitter
Northland	181,640	764	421	438	108	59	25%	$1,667
ADHB WDHB	1233000	2571	209	1315	277	22	21%	$1,353
CMDHB	586930	3379	576	1046	434	74	41%	$653
Waikato - Tairawhiti	481145	1633	339	834	176	37	21%	$1,651
Bay of Plenty	245290	728	297	375	62	25	17%	$2,139
Lakes	117990	590	500	289	78	66	27%	$1,029
Taranaki	121065	275	227	126	31	26	25%	$2,208
Hawkes Bay	167020	168	101	122	74	44	61%	
Midcentral	181070	669	369	424	55	30	13%	$1,755
Whanaganui	64510	537	832	130	39	60	30%	$2,179
Capital and Coast - Hutt - Wairarapa	521120	1156	222	341	58	11	17%	$3,857
Nelson Marlborough	152920	341	223	216	44	29	20%	$1,931
Canterbury	589060	2061	350	721	180	31	25%	$2,584
South Canterbury	60,940	281	461	174	20	33	11%	$1,776
West Coast	32365	159	491	159	33	102	21%	$1,484
Southern	325770	1105	339	386	183	56	47%	$968

Appendix 4: Case Study: Counties Manukau Health

CM Health is currently funded by the Ministry of Health to provide both core tobacco control activities and the provision of Stop Smoking Services. CM Health employs a team of 8.5 FTE who provide tobacco control leadership, planning and strategy, analysis, support to achieve health targets, delivery of a triage service, health promotion, and national service development work. The Living Smokefree Service (LSS) employs a team of 10 FTE and delivers stop smoking services in individual, whānau or group settings with face to face, phone or digital support. The service currently receives over 7000 referrals per annum.

The LSS has one of the highest quit rates in New Zealand, with a 76.4% CO-validated quit rate at four weeks in 2019/20205. The cost per quitter for the period 2017/18 to 2019/20 was $1275.73, significantly less than the national average. The LSS is successful at equitably enrolling and supporting priority populations who smoke (Māori, Pacific peoples, pregnant women, people with mental illness and/or addictions, youth.

The collaboration between core tobacco control activities and the LSS service is a key enabler of the services success. This ensures that a whole-of-systems approach is used to implement the Smokefree Ask, Brief advice and Cessation support (ABC) in primary, secondary, maternity, mental health, community health and non-health settings. The core tobacco control advisors have strong relationships with staff in these different settings, support workforce development and training, and provide clinical supervision.

Achieving equity is a key focus area for the LSS, and this is achieved through a focus on the priority populations previously outlined, and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau. This includes employing a holistic approach to addressing the broader health, social, and cultural needs of whānau.

Services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services. The LSS also champions innovative approaches for smoking cessation, including unique contracting (for example outcome based contracting with incentives for community providers), incentive based programmes, and the use of e-cigarettes in smoking cessation.

[5] Quit rate denominator - people who smoke who set a quit date

Board Decision – Public

1 September 2021

3DHB Environmental Sustainability Strategy

Action Required

The Boards approve:

(a) 3DHB Sustainability Strategy (Attachment 1)

The Boards note:

(a) Attached Infrastructure Energy Efficiency and Decarbonisation Policy (Attachment 2)

(b) Attached Preliminary Infrastructure Energy Efficiency and Decarbonisation Implementation Plan (Attachment 3: *Energy Transition Accelerator report)*

(c) 6 monthly reports on this strategy, including the supporting Policies and Plans as appropriate, will be provided to the 2DHB and WrDHB Boards

Strategic Alignment	This Strategy aligns with domestic and international direct, regulation and commitments, including the New Zealand Carbon Neutral Government Programme, the UN Sustainable Development Goals and the commitments of the Global Green and Healthy Hospital Network.
Author	Jay Hadfield, Senior Advisor – Sustainability
Endorsed by	Rosalie Percival, 2DHB Chief Financial Officer
Presented by	Rosalie Percival, 2DHB Chief Financial Officer
Purpose	The Purpose of this paper is to seek Board approval for the attached 3DHB Sustainability Strategy.
Contributors	Frank van Ham, Executive Leader Finance & Corporate Services, Wairarapa DHB Sean Hurndell, Corporate Services Manager, Wairarapa DHB Emily Jiang, Energy Efficiency Engineer, CCDHB Darrell Chin, Property & Facilities Manager, HVDHB Horst Fischer, Director Procurement & Supply Chain, 2DHB Shane King, General Manager Non-Clinical Support and Delivery, 2DHB Kenny McCaul, Contracted Services Manager, CCDHB
Consultation	Consultation has been undertaken with subject matter experts across 3DHB, with those noted above providing input. All staff across 3DHB have also been given the opportunity to provide feedback on the Sustainability Strategy.

Executive Summary

1. Environmental sustainability is important to our staff, the public and the Government. The Public Sector is expected to take a lead in improving environmental outcomes and responding to the climate emergency.
2. The domestic and international context is increasing in complexity, and further domestic regulation and direction is expected. This is particularly true in regards to climate change mitigation (emissions reduction). The Wellington region DHBs (CCDHB, HVDHB and WrDHB, 3DHB) are proposing to utilise a joint Sustainability Strategy (the Strategy) to increase the effectiveness and impact from our work programmes.

3. The Strategy acts as a high level framework, providing principles for more detailed policies and plans to follow. It is expected that policies and plans will differ across the 3DHBs, particularly between 2DHB and WrDHB.
4. The first policy and plan established under this Strategy is a 2DHB Infrastructure Energy Efficiency and Decarbonisation policy and plan. These have been provided to the Board for noting. Similar policies and plans are to be developed for each of the work programme areas identified in the Strategic Sustainability Principles section of the Strategy.

Strategic Considerations

Service	In approving this Strategy, you are providing guidance on the level of importance that environmental sustainability is given in day to day decision making within the DHBs. In addition to ensuring that current and future regulations are complied with, this Strategy sets a vision for a health system that regenerates our ecosystem and recognises the importance that environmental conditions have on the health of our populations.
People	This Strategy does not have any explicit additional FTE requirements for 2DHB, however it does set out the expectation that adequate resourcing is given to ensure that the work programme established by it is met. Much of the required resource will be set out in the policies and plans that are established under the Strategy and will be required to follow standard RBC and budgeting processes.
Financial	This Strategy does not have any explicit additional financial requirements for 2DHB, however in order to comply with the principles, some projects or procurement decisions may require additional funding. The Strategy will not apply retrospectively to decisions already made, and financial implications will be considered for future decisions as part of normal business case and procurement processes.
Governance	The Strategy establishes a Sustainability Governance Group that is made up of Senior Executives from across 3DHB. The specific membership and Terms of Reference for this Group will be decided by 2DHB ELT and WrDHB ELT. 6 monthly reporting on alignment with the Strategy and progress on the outlined work programme will be provided to the Board.

Engagement/Consultation

Patient/Family	N/A
Clinician/Staff	Consultation has been undertaken with subject matter experts across 3DHB, with those noted above providing input. All staff across 3DHB have also been given the opportunity to provide feedback on the Sustainability Strategy.
Community	N/A

Identified Risks

Risk ID	Risk Description	Risk Owner	Current Control Description	Current Risk Rating	Projected Risk Rating
	Increase in complexity and cost of capital projects and renewals.	Steve Crombie	Principles of the strategy are included in the DHB minimum design standard, reducing the financial impacts by ensuring that sustainable design decisions are made early in the process.		
	Increase in procurement costs	Horst Fischer	Consideration of sustainability to the extent that is required by this strategy aligns with the Government Rules of Procurement. The 2DHB procurement policy under development will provide guidance on weightings of cost and broader outcomes (including sustainability)		
	If strategy is not approved, it may be more difficult to ensure compliance with government policy/ directives	Jay Hadfield	Compliance issues have been separately identified and funding approved for a compliance based work program.		

Attachment/s

1. 3DHB Environmental Sustainability Strategy
2. Infrastructure Energy Efficiency and Decarbonisation Implementation Plan
3. Energy Transition Accelerator report

3 DHB Sustainability Strategy

Foreword

This document sets out the sustainability strategy and operating framework for Capital and Coast District Health Board (CCDHB), Hutt Valley District Health Board (HVDHB) and Wairarapa District Health Board (WrDHB). It also provides direction for our contractors and tenants. The Strategy will support us to meet our obligations and responsibilities to legislation, government policy and international agreements. A strong and comprehensive sustainability strategy will also help us to meet our ambition to promote health and wellbeing, improve health outcomes and support people to live better lives. Climate Change in particular presents a real risk to these ambitions and it is unlikely that the impacts will be felt equitably.

The Health sector is a major contributor of climate warming emissions globally. We will also be at the forefront of managing the effects of increased severe weather events, heat waves, prevalence of tropical disease and the long term impacts of sea level rise. As Crown agents DHBs have been instructed to become carbon neutral by 2025. While some of this may be met through offsetting, the intent of the target is to reduce the gross emissions from the public sector and demonstrate leadership to the private sector.

Combined, CCDHB, HVDHB and WrDHB (3DHB) are amongst the largest employers and procurers in the lower north island. We have a unique role and responsibility in demonstrating and validating emission reduction activities and long term adaptation to reduce the negative impacts of the effects of climate change.

To achieve this, we will set emission reduction and energy efficiency targets. We will also take better stewardship of the products we use and make sure we have procurement policies that support this outcome.

Other areas of environmental sustainability are also important to DHBs. There is a growing body of evidence that points to the health benefits of connection to nature and healthy natural environments. DHBs are significant consumers of single use products and generators of waste. We use large amounts of water and the sites we operate place strain on municipal storm water systems. Our trade waste discharge is unique and challenging. Across 3DHB we operate over 400 light passenger vehicles. We provide a large number of meals to patients and staff in our hospitals and in the community. Hospitals are important to our communities but have traditionally been physically separated and isolated due to their institutional nature.

Our Sustainability Strategy forms an umbrella that covers this wide range of impacts and opportunities. Some areas, such as waste, transport and energy will have specific policies that sit beneath the overarching Sustainability framework.

All of our strategies, policies and implementation plans align with Central and Local Government objectives, and we will be active participants in public discourse on environmental action where it impacts health outcomes. Our health boards are taking a stance for healthcare without harm, and the broader importance of environmental sustainability to ensure the health of our communities now and into the future.

District Health Board Responsibilities

CCDHB, HVDHB and WrDHB receives funding to improve, promote and protect the health of around 500,000 people in:

- Wellington City and its suburbs
- Porirua
- parts of the Kapiti Coast such as Waikanae.
- Hutt Valley
- Wairarapa

CCDHB are also the leading provider of a number of specialist services, including neurosurgery, oncology, neonatal intensive care, and specialised mental health services, for the upper South and lower North Islands, a population of about 900,000 people.

There are five main sites where our services take place: The Wellington Regional Hospital Campus, the three adjacent sites in Porirua (Kenepuru Hospital, Puketiro Centre and our MHAIDS Forensic campus), Hutt Hospital, Wairarapa Hospital and the Kapiti Health Centre. There are other regional and out of region offices that support regional or national projects.

The New Zealand Public Health and Disability Act 2000 Section 22, Objective (j) requires that District Health Boards '*exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations*'.

The environmental impact of the health sector is far-reaching; other District Health Boards are committing valuable resources to prepare and adapt to the changing physical, social and economic challenges that environmental issues, particularly climate change will bring. As District Health Boards share similar goals and principles, this has provided vital links to discuss issues, exchange ideas and share learning to build resilience and knowledge across the sector.

Our organisations have a critical role in the community to reduce our environmental impact and disruption and harm to the communities we serve today and in the future. Our core values align with reducing carbon emissions and social inequities that are regarded as precursors to poverty and poor health outcomes.

Linking with our community and public sector organisations is regarded as essential and signals a new era for wider engagement and collaboration with other sectors.

3 DHB Vision and Values

CCDHB

Our vision

Keeping our community healthy and well.

Our values

Manaakitanga – Respect, caring, kindness
Kotahitanga – Connection, unity, equity
Rangatiratanga – Autonomy, integrity, excellence

HVDHB

Our Vision

Whānau Ora ki te Awakairangi
Healthy people, healthy families and healthy communities

Our Mission

Working together for health and wellbeing

Our Values

Always caring – respectful, kind, helpful
Can do – positive, learning and growing, appreciative
In partnership – welcoming, listens, communicates, involves
Being our best – innovating, professional, safe

WrDHB

Our Vision

To improve, promote and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Our Values

Together, we MAKE a difference

Manaakitanga – Respect

We care for each other, showing kindness and empathy in all that we do.

Auaha – Innovation

We are committed to finding future focused solutions and take personal responsibility to be better every day.

Kotahitanga – Relationships

Our diversity is our strength; we back each other and work together in partnership.

Eke Taumata – Equity

We are committed to doing the right thing, by ensuring equity and hauora are at the heart of everything we do.

3DHB Sustainability Vision

A health system that regenerates our ecosystem

3DHB Sustainability Objectives

- Recognise the mauri of our environment is intrinsic to the health of our people.
- Recognise that nature has an essential role in the delivery of healthcare
- Sustainability evolves from minimising negative impact to maximizing positive outcomes across all environments (natural, social, cultural and economic)
- Sustainability is the responsibility of all staff and we strive to inspire and motivate others
- Sustainability is considered in all decisions and investments

3DHB Sustainability Governance

To ensure that the work programs that are established under this strategy are aligned with the stated objectives, and the broader legislative, regulatory and international context a governance group consisting of senior representatives from each of the three DHBs. This governance group should include representation from both clinical and non-clinical leaders. Named the 3DHB Sustainability Governance Group, members, as appointed by the 3DHB ELTs are responsible for establishing their own Terms of Reference.

Staff Sustainability Groups

Each DHB (or a combination of DHBs) will support Staff Sustainability Groups, which provide advice and feedback on the sustainability work programme with a focus on implementation. These groups will be responsible for establishing their own Terms of Reference and providing regular reports to the 3DHB Sustainability Governance Group. The groups should be as representative as possible of departments and cohorts across the DHBs.

Legislative and Regulatory Context and Compliance

Alignment with domestic policy ensures that our work programme meets government and public expectations. Value for money and whole of system investment return is most likely to be maximised by seeking strategic alignment with national and international work programmes.

Climate Change/ Decarbonisation

In December 2020, the New Zealand Parliament declared a Climate Emergency. At the same time, the Government announced the Carbon Neutral Government Programme which committed the public sector to measure and report on emissions with a target of achieving Carbon Neutrality by 2025 (which may include offsetting)[1].

Governments around the world are ratifying the COP21 Paris Agreement[2] to limit global temperatures rising to well below 2 degrees Celsius and strive for 1.5 degrees Celsius. Under this agreement, the New Zealand Government is committed to reduce emissions by 30 percent below 2005 levels by 2030 and 50 per cent by 2050 (on 1990 levels)[3]. The COP21 Paris Agreement aligns with the UN Sustainability Development Goals[4] to address climate change but also poverty and social inequities which the New Zealand Government has adopted through the Living Standards Framework[5] to frame domestic policies over the next 15 years.

The Climate Change Response (Zero Carbon) Act, passed by Parliament in 2019 sets new domestic greenhouse gas emissions reduction targets for New Zealand to:

- reduce net emissions of all greenhouse gases (except biogenic methane) to zero by 2050
- reduce emissions of biogenic methane to 24–47 per cent below 2017 levels by 2050, including to 10 per cent below 2017 levels by 2030
- establish a system of emissions budgets to act as stepping stones towards the long-term target
- require the Government to develop and implement policies for climate change adaptation and mitigation
- establish a new, independent Climate Change Commission to provide expert advice and monitoring to help keep successive governments on track to meeting long-term goals. See the Climate Change Commission website.

It is likely that District Health Boards will be required to take action to comply with requirements of government policies for climate change adaptation and mitigation as well as reduce emissions to

[1] https://www.beehive.govt.nz/release/public-sector-be-carbon-neutral-2025

[2] https://unfccc.int/process-and-meetings/the-paris-agreement/the-paris-agreement, https://www.mfe.govt.nz/climate-change/why-climate-change-matters/global-response/paris-agreement

[3] https://www.mfe.govt.nz/climate-change/climate-change-and-government/emissions-reduction-targets/about-our-emissions

[4] https://sdgs.un.org/goals

[5] https://www.treasury.govt.nz/information-and-services/nz-economy/higher-living-standards/our-living-standards-framework

meet national emission budgets. At this stage, the Carbon Neutral Government Programme is the primary policy announced.

Waste Minimisation Act

Waste minimisation has become a high priority of the New Zealand public and Government. The 2010 New Zealand Waste Strategy aims to reduce the harm from waste and improve the efficiency of resource use[6]. DHBs are large resource consumers and waste producers, decisions made by CCDHB, HVDHB and WrDHB should align with the goals of the New Zealand Waste Strategy and other relevant international agreements.

3 Waters

Hospitals are large potable water users and producers of wastewater. The developed nature of our sites has a significant impact on municipal stormwater systems. A review of the three waters system (Drinking water, wastewater, stormwater) has been completed[7] and reforms to the sector are in the process of being developed and consulted on. DHBs should align with the recommendations where relevant. In particular, it should consider drinking water resiliency and stormwater detention and/or retention opportunities to support Local Government/ Regional Water Agency work programmes and increase resilience.

International Alignment

UN Sustainable Development Goals

To drive high level strategic planning throughout our organisations, we will use the United Nations Sustainable Development Goals as a framework for policies and sustainability programme[8].

The 17 goals cover health and wellbeing, climate action and other environmental, social and economic sustainability goals. Our DHBs can make a contribution over the long-term that will:

- Broaden our view of and response to sustainability opportunities from the single issue of climate action;
- Recognise the sustainability areas where 3DHB is already taking action and contributing to the UN agenda, for example, gender equality, equity of access etc., by virtue of its role as a major employer, trainer, health funder and provider;
- Align reporting on progress against the SDGs for the Ministry of Foreign Affairs as required.

[6] https://www.mfe.govt.nz/publications/waste/new-zealand-waste-strategy-reducing-harm-improving-efficiency/new-zealand%E2%80%99s-goals

[7] https://www.dia.govt.nz/Three-Waters-Reform-Programme

[8] https://sdgs.un.org/goals

Global Green Healthy Hospital Principles

HVDHB and WrDHB will join CCDHB as signatories of the Global Green Healthy Hospital (GGHH) programme[9]. The principles set out by GGHH are based on the idea of Health Care without Harm. The philosophy of this approach can be defined as follows:

> *A green and healthy hospital is one that promotes public health by continuously reducing its environmental impact and ultimately eliminating its contribution to the burden of disease. A green and healthy hospital recognizes the connection between human health and the environment and demonstrates that understanding through its governance, strategy and operations. It connects local needs with environmental action and practices primary prevention by actively engaging in efforts to foster community environmental health, health equity and a green economy.*

The principles that the DHBs' agree to support are:

- Leadership: Prioritize Environmental Health
- Chemicals: Substitute Harmful Chemicals with Safer Alternatives
- Waste: Reduce, Treat and Safely Dispose of Healthcare Waste
- Energy: Implement Energy Efficiency and Clean, Renewable Energy Generation
- Water: Reduce Hospital Water Consumption and Supply Potable Water
- Transportation: Improve Transportation Strategies for Patients and Staff
- Food: Purchase and Serve Sustainably Grown, Healthy Food
- Pharmaceuticals: Safely Manage and Dispose of Pharmaceuticals

[9] https://www.greenhospitals.net/sustainability-goals/

- Buildings: Support Green and Healthy Hospital Design and Construction
- Purchasing: Buy Safer and More Sustainable Products and Materials

Strategic Sustainability Principles

All initiatives undertaken to reduce environmental impact, and improve the sustainability of hospitals and health centers, must not impact the level of service provided or the comfort and recovery of patients. Opportunities with co-benefits which improve health outcomes should be given particular attention.

Staff promotion/ involvement/ education

The actions and practices of individual staff, contractors, tenants, teams and departments collectively has a large impact on the overall environmental performance of the DHBs. Staff should be supported to improve environmental outcomes through procurement/ purchasing decisions, clinical practice and broader behaviour change campaigns. Empowering staff to adopt an energy efficient culture in the workplace should be prioritised to instil the culture as part of ingrained, everyday practice.

There should be resources available on DHB intranets to staff to support improving environmental performance or reducing environmental impact on appropriate channels (e.g. intranet, staff emails). DHBs must resource sustainability functions to produce and maintain these resources as well as provide support to staff champions as appropriate.

Infrastructure Energy Efficiency and Decarbonisation

Comfortable and sustainable healthcare services rely on the provision of secure and low emissions energy. The efficient delivery of low emissions energy leads to improved health and environmental outcomes for patients, staff and the wider community.

Continual energy performance improvement (e.g. increased efficiency, reduced energy consumption and resource use), will be prioritised. Fossil fuels must be phased out for primary use and low emissions alternatives, including self-generation of renewable energy, should be prioritised to improve resiliency and decarbonise. Targets for energy consumption and its related emissions should be set and aligned with government directives. Energy performance will be benchmarked to enable comparisons between and within the DHBs' hospital campuses. New builds should strive for industry best practice energy performance.

The necessary information, skills and resources must be committed to ensure the successful achievement of the above objectives.

Travel Efficiency and Decarbonisation

Meeting government directives to decarbonise light passenger fleets requires significant changes to operations in DHBs. Support should be given to enable to decarbonisation of light passenger vehicles in fleets, as well as for staff owned vehicles.

Increasing the number of trips taken using public or active transport by staff should be a priority. Car parking priority should be given to staff who carpool, and/or use electric vehicles. Information and

infrastructure should be provided to staff on how to reduce the carbon impact of their commute and increase the positive outcomes of transport choices.

Air Travel for patients and staff entitled to continuing medical education are significant contributors to total carbon emissions. Where appropriate, these activities should be reduced through use of technology such as telehealth, webinars and virtual conferences.

Water Management

Sustainable water use, low impact waste water discharge and reducing storm water flows are all areas of opportunity for DHBs to reduce environmental impact. Where possible, opportunities to use water management to regenerate nature should be identified and invested in.

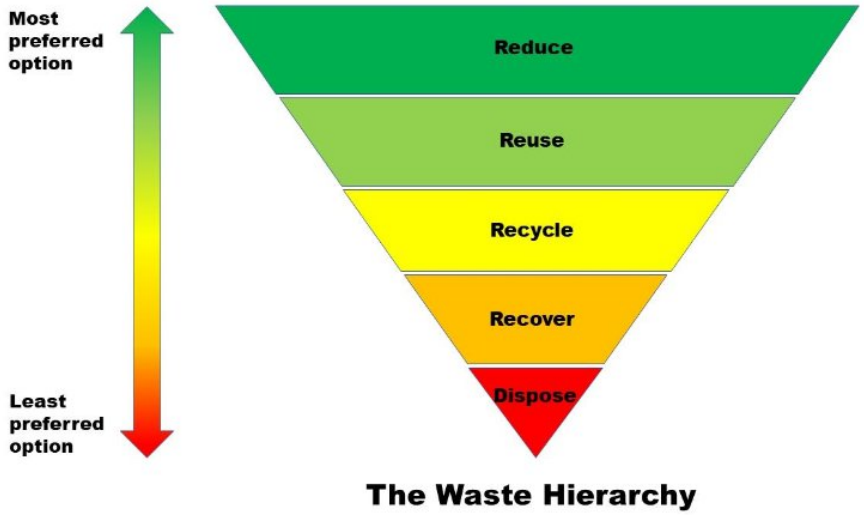
New buildings and projects that involve landscaping should follow relevant water sensitive urban design (WSUD) guides published by local government. Improving and increasing green spaces around hospital campuses to improve amenity and health recovery outcomes should include measures to mitigate storm water impacts, particularly detention or retention opportunities. Consideration should be given to benefits of WSUD on neighbouring properties and the wider community, including reducing the risk of flood events, improving resiliency and potential savings to the health system from lower numbers of storm/ flood related injuries. Consideration should be given to using regenerative design in water management systems.

Storm water should also be used to supplement fresh water supplies for non-potable uses such as toilet cisterns. Water retention opportunities should consider the resiliency benefits of reducing fresh water demand and increasing overall water storage capacity.

Waste water toxicity should be minimised through infrastructure investment and policy. This may include changes to drug disposal or waste management policies.

Waste Minimisation

The purpose of waste minimisation is to reduce the harm from the management and disposal of waste. Waste minimisation activities should follow the waste hierarchy:



The Waste Hierarchy

Waste impacts should be considered as part of procurement processes, including the quantity, toxicity, and available minimisation opportunities.

Sustainable Procurement

In seeking to deliver value for money and quality of service, procurement activities will take into account the need to ensure that goods and services purchased are manufactured, delivered, used and disposed of in an environmentally and socially responsible manner. To that end, procurement policies across DHBs must reflect the objectives included in this strategy.

Integrating sustainable practice into procurement activities will provide savings on a whole-of-life basis, safeguard the reputations of the DHBs as responsible public entities, and protect the health of staff, patients and the public generally. The key sustainable procurement objectives are:

- Minimising and reducing waste
- Reducing energy consumption and climate change impacts
- Reducing soil, air and water pollution
- Improving water efficiency
- Procuring from sustainably managed ecosystems
- Promoting fair working conditions through ethical procurement practices
- Complying with current, and anticipating future, legislation

Infrastructure Energy Efficiency and Decarbonisation Policy	
Type: Policy	**Version: 1**
Issued by: 2DHB Director Property and Facilities	**Level:**

Purpose:

Hutt Valley and Capital & Coast District Health Boards (2DHB) are committed to responsible energy management as a way to reduce our energy consumption and carbon footprint.

The Climate Change Response (Zero Carbon) Amendment Act commits New Zealand to carbon neutrality by 2050 while the Carbon Neutral Government Programme commits the public sector to carbon neutrality by 2025. The rising price of carbon presents an opportunity to decarbonise as quickly as possible to avoid future liabilities. In order to meet legislative commitments, energy efficiency and decarbonisation measures must be taken across 2DHB while maintaining healthcare service delivery and comfort.

This Policy provides guidance on the principals outlined in the Sustainability Strategy, in particular for Energy.

Scope:

Organisation wide 2DHB staff. This may include but is not limited to;

- Employees irrespective of their length of service
- Agency workers
- Self-employed workers
- Volunteers
- Consultants
- Third party service providers, and any other individual or suppliers, including personnel affiliated with third parties, contractors, temporary workers and volunteers
- Students

Definitions:

- EECA – Energy Efficiency Conservation Authority

Roles and Responsibilities

The Chief Financial Officer (CFO) is responsible for reporting to ELT and the Board on energy management progress. The CFO may delegate the following responsibilities:

- Preparation of reports on energy management progress
- Implementing the Policy and ensuring compliance with local regulation and legislation.
- Implementing the Infrastructure Energy Efficiency and Decarbonisation Implementation Plan.
- Providing relevant training to staff.
- Reviewing the Policy and its objectives
- Providing ongoing advice for the implementation of the Policy and meeting the requirements of ISO 50-001.
- Advising on outside funding opportunities for energy efficiency projects.

Targets:

2DHB will aim to significantly reduce our environmental impact without compromising service delivery. We aim to:

- Reduce energy consumption by 40% by the end of 2030[1]
- Reduce emissions[2] from energy use by 60% by the end of 2030[1]

An Energy and Decarbonisation Pathway will provide a roadmap of solutions to meet the above targets. The Energy Transition Accelerator report (October 2020) will provide the initial roadmap of actions to take in order to meet the targets.

Key areas to be addressed are;

- Reducing energy consumption through energy efficiency measures. This will ensure that energy can be easily supplied by efficient and well-proven technology.
- Continuous commissioning of building services. Planned, ongoing maintenance of systems will ensure optimally efficient operation of building services.
- Monitoring and targeting of energy consumption, emissions and costs will enable our energy savings journey to be assessed against our targets and carbon liabilities to be measured.
- Developing positive energy behaviours at all levels of the DHBs. Small actions through collective efforts can make significant savings across our campuses.

Policy:

In order to meet the above targets, the following policies and procedures will be implemented;

Staff Involvement and Communication

Energy and carbon savings cannot be made without the commitment of all staff. Large energy savings can be made through collective, everyday action. To leverage staff engagement, our carbon reduction journey will be openly communicated and promoted through the available channels. This will include energy savings campaigns, targets and successes. An energy efficient culture will be embedded into everyday practice through staff empowerment. An engagement and communications plan will be developed to ensure that a cohesive and coherent energy savings campaign is made.

Collaboration

We will collaborate across the Health Sector to learn from and share energy efficiency initiatives. We will collaborate with EECA as a resource of knowledge and funding opportunities.

Infrastructure and Assets

Whole of life costs and environmental impact will be considered for all capital, energy and maintenance projects.

[1] Relative to 2018 baseline
[2] This includes Scope 1 and 2 emissions using emissions factors as supplied by the Ministry for the Environment.

No new fossil fuel based technology will be installed. This will reduce the risk of stranded assets due to the increasing regulation and cost of fossil fuels. This does not apply to emergency generation

Each individual building and project must be assessed for its impact on energy consumption and alignment with our decarbonisation targets. New builds, refurbishments, and refits will need to accommodate for a reduced temperature reticulation system in order to future proof for decentralisation and a reduced hot water reticulation system.

New builds should achieve 5-star Green Star rating.

Business as usual and enhanced model performance must be projected and monitored during the project. Energy savings must be verified against real world outcomes directly.

Procurement

In addition to current legislative, MBIE and 2DHB requirements relating to procurement, all CAPEX purchases consider its impacts on energy consumption and efficiency. These purchases will require sign off from the Chief Financial Officer (or their delegated authority) in consultation with the clinical teams at the earliest stage. This ensures that a well-integrated delivery of services through location optimisation, dedicated service provision, and energy efficient alternatives has been considered.

Space Management

Any change to a use of space must be reviewed and approved by the Property & Facilities teams.

Implementation and monitoring compliance with/effectiveness of document

Compliance

2DHB will fully comply with all NZ legislative requirements including but not limited to the Climate Change Response (Zero Carbon) Amendment Act and the Carbon Neutral Government Programme. Our energy management system will align to the International Standard ISO 50-001 and international best practice.

Reporting

Monthly reporting of energy cost, associated emissions and consumption to the Chief Financial Officer (or their delegated authority)

Annual and quarterly reporting of energy cost, associated emissions and consumption to ELT. Annual and quarterly reporting of energy and decarbonisation progress relative to targets.

Related Documents:

- 3 DHB Sustainability Strategy
- ISO 50-001 – Energy Management
- Climate Change Response (Zero Carbon) Amendment Act
- Carbon Neutral Government Programme
- Preliminary Infrastructure Energy Efficiency and Decarbonisation Implementation Plan (Energy Transition Accelerator)

Keywords for searching: [energy, sustainability, carbon, efficiency]

Capital and Coast DHB and Hutt Valley DHB

CONCURRENT Board Meeting

Meeting to be held on 1 September 2021

Resolution to exclude the Public

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

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

TABLE

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

CCDHB and HVDHB Annual Plans 2021/22	As above	As above
Update on Implementation of 2DHB Strategic Priorities	As above	As above
FRAC items for Board Approval from meeting dated 25/08/21	As above	As above
Ratification of Tranche Two: Renewal of Vertical Transport (Lifts) – CCDHB	As above	As above
Woburn Masonic Review	As above	As above
3DHB Digital Report – Q4/End of Year Update	As above	As above
MCPAC update from meeting dated 25/08/21	As above	As above
Chair's Report and Correspondence	As above	As above
Chief Executive's Report	As above	As above
General Business	As above	As above

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

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